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.

Q. So if you had an adverse incident, if you had a near miss, if you had a death, you would report that to Dr Gaston?
A. Yes.
Q. And to Dr Crean?
A. Yes.
Q. So you would do that. Did you understand that that was common practice amongst your fellow consultant anaesthetists?
A. In paediatric anaesthetists?
Q. Yes.
A. Yes.
Q. So if there was a death in theatre, a child's death, that is something that Dr Gaston ought to know about?
A. Yes.
THE CHAIRMAN: Sorry, specifically he ought to know from you about it?
A. If I was available to talk to him, if I was there, yes.
THE CHAIRMAN: You were obviously on duty the day that Adam died. Would that not be an issue that you would have to go to find Dr Gaston to report to him?
A. Yes.
MS ANYADIKE-DANES: Thank you. And what would that kind of report consist of?
A. I can't remember.

Q. Well, what sort of information did you think you would have to provide to Dr Gaston when you were reporting a death?
A. I would have to provide the information about the clinical information and also the information that took place as a consequence of the death. For instance, contacting the coroner.
Q. Yes. Would you provide him with any notes or records you'd made of what had happened?
A. Well, in a case like Adam their procedure following the death of a child would have been -- or a patient in intensive care -- would have been that the notes and all the medical paperwork, reports, et cetera, would no longer belong to the hospital; they'd belong to the pathology service. There would be a legal document and they would be sequestered by the coroner.
Q. Is that what happened?
A. I believe so.
THE CHAIRMAN: So the coroner is notified, it becomes a coroner inquiry --
A. Yes.
THE CHAIRMAN: -- in liaison with the State Pathologist's Department.
A. Yes.
THE CHAIRMAN: So they have to have access to all the

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

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

THE CHAIRMAN: Right.

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

THE CHAIRMAN: That's the original notes?

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

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

A. I can't remember.

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

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

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

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

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

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

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

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

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

A. I can't remember what existed in 1995.
Q. Do you ever recall being told what you need to do in those circumstances?
A. I think there was a procedure for incident reporting.
Q. Thank you.
THE CHAIRMAN: To your recollection, is that something that you just did because it was the right thing to do and you had to do it, rather than there was a three or four-page document issued around the Royal Trust?
A. Sorry?
THE CHAIRMAN: When you say that you think there was a procedure for incident reporting, is that a procedure in the sense of a, for instance, three or four-page written document or a procedure that everybody knew if there was an adverse incident you had to report it and you just did it because you knew that was the right thing to do?
A. I can't remember.
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: How soon do you think you had to notify Dr Gaston?
A. I can't remember. As soon as possible, I would imagine.
Q. As soon as possible. You were aware that Adam was deteriorating while he was in paediatric intensive care.
A. Yes.

Q. Were you aware when the brainstem tests were being conducted?
A. I believe so.
Q. And you knew the result of the first and then the result of the second?
A. I believe so.
Q. During that time, when it would have become clear to you that Adam perhaps was not going to recover from this, did you think to go and notify Dr Gaston that that was the situation we had?
A. I can't remember.
Q. Did you think to talk to anybody about it?
A. I fully imagine that other people in the Children's Hospital would have been aware of Adam's death --
Q. No, that wasn't my question. Did you think to go and talk to anybody about it?
A. I can't remember what I thought 17 years ago.
Q. But your first death.
A. Well, I can't remember what I thought, but I imagine I would have spoken to people around me. It would have been other consultants in the Children's Hospital, including Dr Crean.
Q. Can you remember how soon --
A. But I don't wish to speculate.

Q. I understand that. That's why I didn't press you on that.
A. I don't think it's helpful.
Q. Can you remember how soon you went to see Dr Gaston?
A. It's 17 years ago. I can't remember when I went to see Dr Gaston or when I contacted him or if I contacted him before I went to see him. I can't remember. I presume there would have been a contact first.
Q. After Adam was pronounced dead?
A. I can't remember.
THE CHAIRMAN: But do you recall that you did go to see him or --
A. Yes.
THE CHAIRMAN: You do? I'm trying to distinguish between what you think you would have done because you had a reporting line to him as head of ATICS and what you can actually remember doing.
On that day, on the 27th or 28th, do you remember actually going to Dr Gaston?
A. No.
THE CHAIRMAN: Okay.
A. Could I just add that 1995 was a long time ago?
THE CHAIRMAN: Yes.
A. Technology has improved a lot since and it's quite hard to imagine now -- in the days of mobile phones and

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

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

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

THE CHAIRMAN: Sorry, I understand.

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

THE CHAIRMAN: Yes. I understand.

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

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

A. Correct.

THE CHAIRMAN: Thank you.

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

actually spoke to him, didn't you?
A. I believe so.
Q. And you'd be trying to do that as soon as you could after you learned that Adam had died?
A. I can't imagine why I would have delayed contacting ...
Q. And Dr Gaston has given evidence that you did reach him, the two of you spoke and he's given his evidence as to what he thought that conversation covered. Do you remember the conversation?
A. No.
Q. None of it?
A. None of it.
Q. Sorry?
A. None of it.
Q. But you remember having it?
A. No.
Q. I thought you just said that you did remember.
A. I remember there was a meeting, but I don't remember having the conversation. So I might have -- I beg your pardon, I might have confused your question. Could you repeat the question?
Q. Well, do you remember meeting Dr Gaston?
A. I remember there was a meeting.
Q. You remember there was a meeting. What were you trying to achieve in that meeting?

A. I can't remember.
Q. Do you remember any other meetings?
A. I remember there were meetings. But 17 years ago, I don't remember and I would not wish to speculate what was discussed at those meetings because my memory's incomplete and I didn't have records to rely on.
Q. If I were to let you know what Dr Gaston thinks was raised and discussed during that meeting, do you think that might help you recall?
A. Well, it might.
Q. Right.
THE CHAIRMAN: Can I ask you, doctor, just to help us with this. Have you seen the transcript of Dr Gaston's evidence from Monday and Tuesday?
A. Yes.
THE CHAIRMAN: Have you seen or heard about what -- I'm not sure the transcript of Dr Crean's evidence is out yet. Dr Crean's evidence is not yet on the website, but have you heard what Dr Crean said yesterday?
A. No, I looked for it last night and I couldn't find it.
THE CHAIRMAN: We won't get it up until today. But you have seen what Dr Gaston said?
A. Yes.
MS ANYADIKE-DANES: I think if we could go to 18 June, page 130. Just to introduce you to it, it really starts

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

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

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

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

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

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

A. No.

Q. Were those concerns that you had?

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

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

A. Sorry, I'm just confused.

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

A. Are we talking about my conversation with Dr Gaston? Sorry, I'm really confused.

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

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

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

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

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

MS ANYADIKE-DANES: I understand. That's a fair answer. Let's approach it slightly differently. When you realised that Adam was not waking as you were trying to do that and then there was a period of time when you had to go -- you didn't have to, but you did go -- with Dr Savage to see his mother and then you learned that he had actually passed away.

A. Yes.

Q. What effect did it have on you?

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

Q. Were you distraught?

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

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

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

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

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

A. I think that's a different question.

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

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

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

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

Q. Did you perform that exercise?

A. I can't remember.

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

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

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

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

MS ANYADIKE-DANES: Then perhaps we could deal with it in this way: can we go to reference 011-002-003?

Do you remember sending that letter?

A. I actually don't.

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

THE CHAIRMAN: The two together?

MS ANYADIKE-DANES: Yes.

Is that your letter?

A. I signed it, yes.

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

A. I think it was sent to Dr Murnaghan.

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

A. I believe so.

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

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

MS ANYADIKE-DANES: That's fine.

Why were you writing this letter to Dr Murnaghan?

A. Because he asked me to.

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

A. I can't remember.

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

A. To explain my anaesthetic with Adam.

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

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

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

Then you say:

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

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

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

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

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

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

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

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

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

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

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

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

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

A. I think so, yes.

Q. That was your evidence?

A. Yes.

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

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

A. Yes.

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

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

A. Yes.

Q. And is there a reason for that?

A. I don't know.

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

A. Yes.

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

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

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

A. I don't know the reason.

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

A. Yes.
Q. Yes. And quite apart from that, subsequently you have an even lower reading, which comes from the laboratory, which is 119 millimoles, which is a very low reading. But that's not in the letter either.
A. No.
Q. No. Would you agree it should have been?
A. Yes.
Q. Thank you. Then you conclude that:

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

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

A. Sorry? I missed the start of that question.
THE CHAIRMAN: When you refer, in the last sentence, to being unable to explain how this happened because of the presence of normal monitoring signs, the question in effect is: the monitoring signs were not normal, you certainly did not have what you regarded as a reliable CVP, which would be one monitoring sign, and the results

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

A. That would be correct.

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

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

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

A. Yes.

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

A. Yes.

THE CHAIRMAN: -- and they were not normal.

A. Yes.

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

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

A. I can see that, yes.

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

A. No, sir.

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

A. I don't know, sir.

THE CHAIRMAN: Thank you.

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

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

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

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

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

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

MS ANYADIKE-DANES: Thank you.

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

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

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

"He weighed 20 kilos."

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

"He weighed 20 kilos."

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

"I administered IV fluids as usual."

Then you can see where it says in the deposition:

"I administered IV fluids as usual."

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

possible? It's 059-067-156.

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

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

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

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

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

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

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

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

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

go to the second line:

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

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

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

MS ANYADIKE-DANES: Yes.

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

"I wish to make the following observations."

Do you see that?

A. Yes.

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

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

If we just go over the page again, just so we see how it concludes, 099. You do, at 099, under "haemodynamic considerations", number 3, you go on to say:

"On measuring the CVP, the initial pressure reading

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

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

A. Yes.

Q. Thank you.

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

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

conversation.
Q. Sorry, you do remember being at the post-mortem?
A. Yes, I do remember that I was there.
Q. Okay. The reason I ask you that is in your third witness statement to the inquiry, which is 008/3, page 19, I believe you said that you didn't remember being at the autopsy, but you wrote -- we subsequently ascertained that you must have been because of the way you wrote.
A. Yes.
Q. In any event, you were there. Why did you go?
A. It was my practice to attend the post-mortems of patients who had died in intensive care -- as much as I could.
Q. Was Dr Savage with you?
A. I can't remember.
Q. Can you remember whether you were alone?
A. I can't remember.
Q. I think --
MR FORTUNE: Dr Savage accepts he was present at the post-mortem, sir.
MS ANYADIKE-DANES: Professor Savage has. I'm just not sure whether the two of them were there together. That's what I was trying to ascertain.
MR FORTUNE: Certainly Dr Armour remembers Dr Savage being

there.

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

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

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

A. That's correct.

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

A. That's correct.

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

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

Q. Sorry?

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

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

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

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

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

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

MS ANYADIKE-DANES: Yes.

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

THE CHAIRMAN: We understand.

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

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

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

Q. Yes.

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

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

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

Department.

Q. When would you get the copies back?

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

Q. We might have to check about that because I have to say, we have not had that before, that Adam's medical notes and records could be, for a period of time, not accessible by the clinicians or anybody else wanting to know what the details were. So we'll check that.

A. Thank you.

Q. Had you, before you attended the autopsy, discussed the case with Dr Savage or Dr O'Connor, for that matter?

A. I can't remember.

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

A. That's correct.

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

A. I can't remember.

THE CHAIRMAN: Would it seem logical that if the two of you were going to meet Debra Slavin that you must have had some discussion about how this very difficult meeting and explanation to her of what happened was going to go ahead and be given?

A. Yes, that would seem intuitive and correct, but I don't wish to speculate about a conversation that I can't remember.

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

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

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

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

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

Q. No.

A. I'm confused.

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

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

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

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

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

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

Q. And if you'd asked him, he would have told you presumably what his thoughts were.
A. I'm certainly sure he would have told me.
Q. Well, did he ever tell you that he thought that the problem that had given rise to Adam's cerebral oedema was too much low-sodium fluid?
A. I don't recall that conversation. I don't remember him saying that. He might have. I don't dispute it if he says he said it, but I don't remember him saying it.
Q. I think you've already said that you can't recall what happened in the autopsy room.
A. No.
Q. But as I understand it, from what Dr Armour said, it's an actual room, so there's not a viewing chamber. If you're going to look, you're literally there in the room itself where the autopsy is taking place; isn't that right?
A. Yes, you have to get changed into a gown and booties and a hat.
THE CHAIRMAN: Sorry, doctor, would it be your practice to stay for the autopsy itself? Because Dr Armour described that some doctors come down and talk to her, but prefer not to stay while she's performing the autopsy, whereas others do stay while she performs the autopsy. What would your practice be?

A. I don't remember with Adam.
THE CHAIRMAN: I understand.
A. My practice would be to stay, to make time available and to leave my other duties if I could get away.
THE CHAIRMAN: And to be present while she performs the autopsy?
A. My practice would be to stay as long as I needed to stay and as long as the pathologist wished me to stay. So as long as possible would have been my practice.
MS ANYADIKE-DANES: Thank you. Along with the investigation into his cause of death, which the State Pathologist is conducting, Dr Armour, there was also an investigation into the anaesthetic equipment; isn't that right?
A. Yes.
Q. Yes. And did Dr Murnaghan speak to you about that?
A. I don't remember.
Q. Well, were you part of the suggestion that the anaesthetic equipment perhaps ought to be investigated?
A. Well, I can't remember, but I know by reading the evidence that, yes, I was part of that.
Q. That you were part of that?
A. By reading the evidence, I understand that is true, but I didn't recall it at the --
Q. You don't recall it?
MR UBEROI: Sir, I don't know if the question could be made

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

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

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

A. I don't know.

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

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

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

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

A. Yes.

Q. Do you recall that?

A. I recall it because I've read it, but I don't recall being there with Dr Gibson.
Q. Can I ask you this: what is the first memory you actually have of Adam in relation to his transplant surgery?
A. What's the first memory I have of Adam?
Q. Yes.
A. I remember seeing Adam -- it's very difficult because I have been reading documents and it's hard to know what I remembered at the time and what I've read and gained knowledge of since. I have read so much documentation and I've gone over things ... I actually find my memory hard -- to be sure was that my memory or was that something that I've been reminded of.
Q. Does that mean that you're not clear at all what your memory is of Adam's transplant surgery, the process of it, the events after it, the inquest, the events after the inquest? You don't have a recollection?
A. For 17 years and everything that's gone on, I find it very hard to be sure that my memory is, of actually being present with Adam and the aftermath, correct.
Q. Did you have any difficulty with your memory when you provided the various statements that you have or wrote the various letters that you have written over the years?

A. I think that would be true.
Q. You didn't?
A. I would have had trouble with my memory.
Q. You would have?
A. I think so.
Q. Do you think you had any trouble with your memory when you wrote the letter to Dr Murnaghan?
A. I don't know. Because you're asking me for my memory of 17 years ago.
Q. Why do you think that you had a problem with your memory during the times when you were providing letters and providing other statements? Why do you think then, if you have no recollection, that you had trouble with your memory?
A. Because I can't remember.
THE CHAIRMAN: Doctor, let's put it this way. I understand now how, after reading documents over a number of years and thinking back over this, you find it hard to distinguish between what you remember from 1995/1996 and what you've read subsequently about what happened at that time, what other people have written about what you said to them and so on. That's fine. That makes sense and that's one of the problems with the inquiry coming so many years after the event. It's something I have to take into account.

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

MS ANYADIKE-DANES: That's correct.

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

A. That's right.

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

A. That's correct.

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

A. Exactly, sir.

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

A. That's correct.

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

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

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

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

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

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

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

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

Q. Were there three different machines?

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

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

"All cases were performed in the same operating room, that being the room used in the suite for all major surgical procedures."

A. I beg your pardon.

Q. So it would be the same equipment, wouldn't it?

A. Not necessarily. Equipment can move between the theatres, but I think there was a commonality that there was an environment commonality, although the cases and the individuals were different.

Q. Yes.

A. So I beg your pardon.

Q. No, that's all right. That's exactly the point you were making before about the difficulty of these things. Presumably, because it was the same anaesthetic equipment, that is actually why they wanted that investigated, in case the commonality you have identified was actually the anaesthetic equipment?

A. That's correct.

Q. Why were you to be discussing this with Dr Gibson?

A. That's a good question. You should ask somebody else. I can't remember.

Q. We will.

A. Could I assist the inquiry?

Q. Yes.

A. Whenever a piece of equipment is faulty, it is

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

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

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

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

A. Correct.

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

A. Well, sir, if I can just go back one step.

I believed -- and there's evidence -- that this equipment was not seriously concerned with causing the deaths of these three children, even though it was associated with the deaths. I believe that if it had been the critical fault with the three deaths, this investigation wouldn't have been performed like this. It would have been immediately quarantined and never

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

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

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

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

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

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

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

THE CHAIRMAN: Yes.

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

A. Well, can I ...

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

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

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

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

Q. Well, yes.

A. I can't remember.
Q. That's part of what we have to try and distinguish -- as you've been careful to point out -- is that which you do recall and that which you have construed from the documentation that you have read or whatever you've heard.
A. I understand.
Q. So you can't remember if you actually reached that conclusion at the time?
A. I can't remember if I reached that conclusion, that's correct.
Q. But you're deducing that?
A. I am deducing that --
Q. And in fact you really can't remember anything about the other two deaths?
A. I wasn't involved in the other deaths.
Q. So you wouldn't have known in what way anybody might have thought that the anaesthetic equipment could be remotely connected with those other deaths? You wouldn't have known that?
A. The other anaesthetist would have quarantined their equipment if they had thought it had been pertinent or a decisive element of the death of their patients.
Q. But it would have to be, would it not, the kind of connection that would be immediate and direct? It

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

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

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

A. I believe so.

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

A. No, I don't remember.

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

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

A. Well, I don't know.

Q. Did you give it to her?
A. I can't remember.
Q. Well, what would be available to her for her to get that clinical material, since you've said that the records were quarantined by the State Pathologist's Department?
MR UBEROI: I'm not sure this witness can comment on what was available to Dr Gibson. He can comment on his recollection what he told her, which he has done, but in terms of what was available to her when she carried out the inspection and wrote the report, I'm not sure he can properly comment; can he?
THE CHAIRMAN: He has rather suggested that his understanding is that the records would have been with the pathologist and therefore not available to Dr Gibson until they come back from the pathologist. That's his understanding, not from Adam's case, but generally.
MR UBEROI: He has suggested that, but I would still submit that he can't properly comment on what was, in fact, available to Dr Gibson.
MS ANYADIKE-DANES: Well, I think he can express a view as to what he thinks might be available for her. If he can't express that view, Mr Uberoi, I'm pretty sure he'll say he can't express it or he can't remember it.
A. There's another alternative information --
Q. Yes, thank you.

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

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

MS ANYADIKE-DANES: Just bear with me a moment. Can we go to the third line, case 3:

"In a child whose normal urine output was 100 ml per hour."

Is that what you thought Adam's normal urine output was?

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

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

A. As far as I can remember, no.

Q. No, you didn't think that?

A. No.

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

A. I don't think so.
Q. No. But you were working on the basis of 200 ml an hour; is that correct?
A. I made a mistake about his urine output.
Q. And you have said that. But as a matter of fact, you were working on the basis of 200 ml.
A. Wrongly, yes.
Q. Do you actually remember you were working on the basis of 200 ml or have you constructed that afterwards?
A. I don't know.
Q. The information that Dr Gibson had could have come from you. I mean the general clinical information.
A. Well, I don't know.
MR UBEROI: It could have come from Dr Taylor, it could have come from anywhere. It could have come from the notes, it could have come from any number of sources.
THE CHAIRMAN: This isn't going to take me anywhere.
MS ANYADIKE-DANES: I'm very grateful.
If we go to the last paragraph of the report:
"Protocols for monitoring anaesthetic set-up and drug administration in this area are among the best on the Royal Hospital site."
Do you know what protocols Dr Gibson was talking about?
A. I don't because she doesn't enumerate them. But there

were protocols present, as there are today.

Q. There were protocols governing anaesthesia?

A. Yes.

Q. The reason I ask you that is that when we were trying to identify that from the DLS, their view was -- and we have a letter which I will turn up shortly -- that there were no protocols.

A. Then why would Dr Gibson write that there were protocols?

THE CHAIRMAN: I'm afraid we can't ask Dr Gibson that. She's not available to be asked.

A. I recall protocols which have been updated several times and which are -- and new ones that have been introduced, but there were sets of protocols for emergency management of untoward events in every theatre in Children's, as there are today. Things like cardiac arrest protocols.

MS ANYADIKE-DANES: This might help. Let's look at what she says she was talking about:

"Protocols for monitoring, anaesthetic set-up and drug administration."

A. Yes.

Q. Were there protocols at that time?

THE CHAIRMAN: Sorry, can I ask you, is there a comma after "monitoring"?

MS ANYADIKE-DANES: On my copy there is.

THE CHAIRMAN: There is?

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: So --

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

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

A. Yes.

MS ANYADIKE-DANES: Thank you. Mr Chairman?

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

(11.25 am)

(A short break)

(11.44 am)

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

A. I don't think so.

Q. No controlled drugs were used?

A. No controlled drugs, no.

Q. Were any drugs used that had to be signed out for?
A. No.
Q. None?
A. I don't believe so.
THE CHAIRMAN: I'm sorry, forgive me --
A. I could be wrong.
THE CHAIRMAN: What is meant by "controlled drugs"?
A. A controlled drug is a drug that has to be kept within a locked cabinet. So morphine and fentanyl would be the two controlled drugs that would be used in 1995 and today.
MR UBEROI: [Inaudible: no microphone] a note of caution here in that this is not an issue that I've had the benefit of forewarning of and it's not something I have taken instructions on. So I'm happy for a few more questions and see how we go, but if there arises a moment where I would like to rise to take instructions, then I will certainly be asking for that.
MR FORTUNE: [Inaudible: no microphone] because of course Professor Savage had prescribed the immunosuppressants. Can I ask my learned friend to clarify what my learned friend means by "signed out"?
MS ANYADIKE-DANES: What I'm trying to ascertain is whether there was a system to record the drugs of the nature that have just been described as controlled drugs, that

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

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

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

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

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

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

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

THE CHAIRMAN: I agree.

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

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

A. Yes.

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

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

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

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

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

A. That's correct, sir.

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

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

Do you remember that difference?

A. Yes. I do.

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

isn't that right?

A. I believe so.

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

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

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

A. I can't remember.

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

A. I do.

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

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

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

A. Yes.

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

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

Q. Would it be challenging?

A. Yes.

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

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

A. Yes. That's his recollection.

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

A. Yes.

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

A. Well, I believe so, yes.

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

A. That would be correct.

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

A. That's logical.

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

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

that you provide to Dr Murnaghan:

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

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

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

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

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

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

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

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

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

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

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

A. That's correct.

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

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

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

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

A. That's correct.

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

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

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

A. Yes.

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

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

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

A. That's correct.

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

A. Yes.
Q. Yes.
THE CHAIRMAN: And just for the record, doctor, that is no longer the position which you maintain; isn't that right?
A. That's correct. I accept that I was wrong to criticise Dr Sumner.
THE CHAIRMAN: You might have a quibble or two, but in broad terms you accept --
A. I was wrong to discount his expertise and I regret that.
MS ANYADIKE-DANES: Can we then pull back up the document I just ...
THE CHAIRMAN: Is it the critique of Dr Armour? That's 059-036-072.
MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
So you've already had that view that you've expressed to Dr Murnaghan. You are now asking Dr Murnaghan to convey, effectively, these views to Dr Armour; isn't that right?
A. That would appear to be correct.
Q. Yes. Where you say, at the second paragraph, that you agree that the death was due to cerebral oedema and that hyponatraemia was present, but you disagree with the causes -- can I just paraphrase that? Essentially what you mean by disagreeing with the causes is that you

disagree it was dilutional hyponatraemia.

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

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

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

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

A. Yes.

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

A. Okay.

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

A. I understand.

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

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

A. I understand.

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

A. It would appear to be correct.

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

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

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

he had received too much low-sodium fluid?
A. I can't remember if I knew that information at the time.
Q. Okay. Do you know what response Dr Murnaghan gave to you?
THE CHAIRMAN: Did he respond to you?
A. I can't remember.
THE CHAIRMAN: The inquest was coming up in June 1996.
A. Yes.
THE CHAIRMAN: You were writing to Dr Murnaghan, as we've seen, both in February and then in May, saying: Armour is wrong and Sumner is wrong, this isn't what happened; right?
A. Yes.
THE CHAIRMAN: You must have been curious as to whether your rejection of their reports was shared by others who were involved in Adam's treatment.
A. I must have been more than curious, I agree with you.
THE CHAIRMAN: So if it makes sense that at some time in the early months of 1996, in spring 1996, you would have made efforts to find out what Dr Savage and Dr O'Connor thought? Particularly Dr Savage, if I may say so.
A. That would make sense.
THE CHAIRMAN: Would it have made sense that you would have been interested to know what Mr Keane thought?
A. Yes.

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

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

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

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

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

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

meeting?

A. No.

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

A. I can't help you.

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

A. That's correct.

THE CHAIRMAN: Okay. Thank you.

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

So if you look at the penultimate paragraph there:

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

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

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

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

What did you understand there to be any problem about?

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

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

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

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

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

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

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

A. Yes.

THE CHAIRMAN: Then he says in the last paragraph:

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

Taylor and Savage before the inquest."

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

A. Yes, I agree.

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

A. Yes, I agree.

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

A. I can't recall.

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

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

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

A. And I accept that.

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

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

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

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

A. Yes, that's right.

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

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

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

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

Q. Then it says:

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

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

Then over the page:

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

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

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

MR FORTUNE: I'm grateful.

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

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

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

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

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

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

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

A. It does.

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

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

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

after 4:

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

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

A. Yes.

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

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

preparation for the inquest.

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: Thank you.

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

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

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

MS ANYADIKE-DANES: Exactly.

A. -- textbook evidence for what --

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

A. That's right.

Q. But you hadn't added --

A. The textbook calls it isotonic.

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

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

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

A. I can't remember.

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

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

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

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

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

phrase it this way --

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

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

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

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

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

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

THE CHAIRMAN: Let's move on.

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

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

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

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

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

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

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

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

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

Do you recollect being involved in that process?

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

recollect the memory. The memory eludes me again.
Q. You understand that you were?
A. I don't dispute that I was involved in that process, yes.
Q. What did you understand was the purpose of producing this document?
A. I think I've answered questions on this document before in my transcript, and I don't wish to have two answers to the same point, if that's --
Q. That's because you might have two different recollections?
A. No, because I can't remember what I said to your previous answers and I don't want to give a second answer that I can't ... It was at the end of my second day under oath and I remember you asked me questions and I don't exactly recall ...
MS ANYADIKE-DANES: We'll turn that up.
MR UBEROI: Certainly, there was an exchange about the extent of the dissemination that should have taken place of this document. That's probably what the witness is referring to.
MS ANYADIKE-DANES: Thank you very much indeed, Mr Uberoi. We'll turn it up. I'm not trying to trip you up; I'm trying to follow through the sequence by which the only real document that the Trust issued emerged, if I can

put it that way.

Can we look at --

THE CHAIRMAN: I think you might be generous to say it's a document the Trust issued.

MS ANYADIKE-DANES: Yes, thank you, Mr Chairman. Can we look at 011-014-107A? Can we put up next to it 060-019-038?

Those manuscript amendments to the first draft, we understand were made by Dr Murnaghan. But in any event, your document is to the left, 107A, and you sign it. That's your signature, isn't it?

A. That's correct.

Q. And it is still headed up "draft statement". What was the purpose of you signing that document and having it submitted as part of your evidence to the coroner?

A. I can't remember. I can't remember who asked me to sign it, whether it was George Brangam or the coroner himself. But I think it was given in with my --

Q. Why would you sign a document?

A. I was asked to sign --

THE CHAIRMAN: Sorry, in fairness, let me take you back to what Dr Taylor's already said about this.

MS ANYADIKE-DANES: Thank you.

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

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

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

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

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

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

A. Yes, thank you.

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

A. Yes.

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

A. Well, sorry, my --

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

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

Adam previously received."

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

"I produce a further statement C5."

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

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

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

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

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

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

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

MR UBEROI: Yes, it looks like it.

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

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

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

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

MS ANYADIKE-DANES: "GBGA."

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

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

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

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

A. Yes.

Q. The question I was asking you is why?

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

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

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

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

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

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

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

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

MS ANYADIKE-DANES: Yes.

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

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

THE CHAIRMAN: Yes.

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

THE CHAIRMAN: Let's go to that.

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

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

A. In terms of dissemination?

Q. Yes.

A. I don't know.

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

A. That's ...

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

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

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

A. I don't know.

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

MR UBEROI: I appreciate the point, sir. I just rise again to say that the matter, in terms, was put during the clinical evidence, at which stage Dr Taylor accepted:

"It seems it should have been opened up for all patients undergoing surgery in retrospect."

THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: Well, can I press it in this way? Who did you think should have received it? Actually, let me help you with this because that may be an unfair way of putting it.
THE CHAIRMAN: Ms Anyadike-Danes, I think Mr Uberoi's right and it coincides with my note of Dr Taylor's last visit to this inquiry, where he says that he agrees, in retrospect, that it should have been more open than it was.
MS ANYADIKE-DANES: Yes. What I want to put to him, if I may, is his own witness statement to the inquiry.
MR UBEROI: One final point: that having made that concession, which was identified, Dr Taylor is of course not responsible for the dissemination. He has made the observation very properly in evidence that we've just discussed, but I would also add the cautionary note that he's not responsible for the dissemination.
THE CHAIRMAN: But he's in a position to influence it.
MR UBEROI: He is.
MS ANYADIKE-DANES: Witness statement 008/1, page 8. This is the first witness statement that you make for the inquiry and what we are asking you there is to:
"Describe in detail, including providing dates, the actions that you took to educate the medical profession

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

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

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

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

reasons for Adam's death?
A. Well, I think it would have been a bit presumptuous to have all the reasons for understanding the reasons for his death before we heard the coroner's verdict. So we couldn't have had a complete understanding prior to --
Q. So why were you drafting a document at that stage indicating what you were going to do? Why didn't you wait, receive the verdict, consult amongst yourselves and produce a slightly more useful document that could be disseminated more broadly?
A. That sounds a very good idea and I don't know why we didn't do that.
Q. Well, was it that you actually wanted the coroner to think that you were going to do -- not you personally -- that the Trust was going to do something and that that might affect the attitude that the coroner had when he reached his verdict, which you might have -- not just you personally -- but which you might have anticipated would be critical?
MR UBEROI: I'm not really sure that this witness can comment on --
THE CHAIRMAN: I will ask him to comment on this: there is a concern, doctor, which emerges from the content of this document, the timing of its production and its production to the coroner, that it was done or may have

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

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

Now, do you want to comment on that concern?

A. Could I go back to the document?

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

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

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

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

THE CHAIRMAN: Where are all those children treated?

A. Well, they would be treated in the Children's Hospital.
THE CHAIRMAN: Yes. So it's not going beyond --
A. That is why it didn't get distributed, I can imagine. But can I also just ... For the -- helpful to the inquiry to suggest that this document needs to be read with the other thing that went along with this document, I believe, which was the purchase and installation of a blood gas analyser and the purchase of dry heparin crystal syringes so that near-patient testing could be performed beside the children's operating theatres where major surgery would take place. And this document was therefore the written, if you like, guideline that would accompany the purchase. I have been trying, over the last few days, to discover -- I think it's somewhere in the statements to the inquiry -- the date that the blood gas analyser and the heparin syringes were purchased. I believe it was not long after Adam's death and before the inquiry, but that's speculation. And I think this document underlines the need that, once this blood gas analyser and in conjunction with the accuracy of the dry heparin syringes -- and I know that has been a matter of dispute, about the reliability of the previous blood gas analyser. But it was to inspire confidence among, not only myself, but my colleagues that a machine could be installed, maintained and that

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

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

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

A. Yes.

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

A. That's correct.

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

A. Yes.

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

A. That's correct.

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

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

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

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

Q. That's fine.

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. -- that there was a difficulty and, I think, you had talked about the biochemistry laboratory you didn't think was available, in 1995, for use, and you all had to use the main laboratory and that brought difficulties in terms of response times. Wouldn't that be fair?
A. For out of hours --
Q. Exactly. Were you aware, after this had been provided to the coroner, of the Trust doing anything to affect its turnaround times?
A. I can't remember, but there were meetings with Selby Nesbitt, the director of the laboratories, and ourselves about near-patient testing and about access to laboratories, I believe. I don't remember the dates or times, but he did visit us. I remember him walking into PICU and talking to us and discussing laboratory quality control, maintaining useful sodium and potassium levels.
Q. Thank you. In fact, I said I only had one question, I have two. The next one I want to ask you about is that you actually sat on the clinical audit committee for ATICS.
A. No. Sorry, I sat on the subcommittee of the clinical --
Q. I beg your pardon, the subcommittee.
A. I later sat on the clinical audit committee for the trust. I'm sorry to make a difference between the two.
Q. No, no.

A. There is a difference.
Q. There is and let me just find that for you. We can see that in your CV, 306-019-011. It is the audit subcommittee --
A. That's correct.
Q. -- ATICS directorate, 1992 to 1997. So over this period of time you were on the audit subcommittee. What did that mean?
A. Audit was changing from medical audit to clinical audit around this era and I was keen on doing clinical audits. The difference between medical audit and clinical audit is that medical is just doctors auditing and that was seen by the Trust to be inadequate, for want of a better word. That might not be the right word. And nationally, and certainly within the Trust, to give it better patient relevance, audit or quality assurance would be better done as a multidisciplinary procedure with nursing and the professionals allied to medicine, physiotherapy and the like.
Q. Some of the things that have been discussed in relation to Adam's case, in your evidence and in the evidence of others, those issues, were they raised at any audit committee meeting that you sat at?
A. The audit subcommittee met monthly, usually over lunchtime, and that was an administrative role that

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

Q. Sorry --

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

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

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

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

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

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

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

Q. Sorry. And did you attend them?

A. When available.

Q. Yes. Did you --

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

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

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

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

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

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

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

THE CHAIRMAN: What happens on that half day?

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

THE CHAIRMAN: Right.

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

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

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

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

A. That couldn't happen.

THE CHAIRMAN: Because?

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

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

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

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

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

A. That's correct.

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

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

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

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

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

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

Q. Sorry, Dr Taylor. If you can have a recollection of that being presented, surely one of the most striking things is whether we all agree with the coroner's verdict?
A. I just don't know.
Q. You can't remember that?
A. I can't remember that, no.
Q. Well, did you, at that stage, accept the coroner's verdict?
A. I ... I don't remember. I accept now that Adam --
Q. Yes. I appreciate that.
THE CHAIRMAN: We know what you accept now, but what you have accepted now or what you accepted in the witness box in April was different to your position before.
A. I can't remember.
MS ANYADIKE-DANES: You told the PSNI that you didn't accept the coroner's verdict and you told us in one of your witness statements, which we can pull up if you have difficulty with that, saying that you didn't accept the coroner's verdict. So it seems, on your own evidence, that you didn't accept the coroner's verdict. What I'm interested in is: who did you communicate that to, that you didn't accept the coroner's verdict?
A. I think what I did say was I had difficulty accepting

the mechanism that the --

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

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

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

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

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

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

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

later and say you did accept it.

A. That's correct.

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

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

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

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

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

A. Yes.

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

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

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

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

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

THE CHAIRMAN: Okay.

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

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

A. Yes.

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

A. Yes.
THE CHAIRMAN: What is the point of raising it at that meeting?
A. Presumably to inform other anaesthetists that during a renal transplant and hypotonic fluid administration, a devastating death, tragic event, can occur. And as outlined, the difficulties that were encountered could be aired and discussed. That would be the point of it, I presume.
MR UBEROI: Can I pick up on the "presumably"? I don't know if my learned friend or you, sir, wish to establish with the witness whether he has any recollection of who in fact presented it, which is something that hasn't been asked yet and I think is maybe the key to the last answer being prefaced with "presumably".
MS ANYADIKE-DANES: Did you present it?
A. I don't remember presenting it.
THE CHAIRMAN: Who else would have presented it?
A. My recollection -- and it's speculative -- is that it was Dr Gaston. But I can't --
THE CHAIRMAN: Well, it's either a recollection or you're speculating. You can't have a speculative recollection.
A. Sorry, I beg your pardon. I can't remember.
THE CHAIRMAN: I have no idea what that last answer means. I have no idea whatever what that means. I understood

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

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

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

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

THE CHAIRMAN: What came out of that meeting?

A. I can't remember.

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

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

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

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

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

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

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

THE CHAIRMAN: Yes.

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

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

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

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

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

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

MS ANYADIKE-DANES: I'm --

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

MS ANYADIKE-DANES: Thank you very much indeed.

(1.18 pm)

(The Short Adjournment)

(2.00 pm)

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

A. I can't say it was.
Q. Does that mean because it wasn't shared?
A. I can't say. I ... I don't remember the conversations we had and the conclusions of those conversations, so I can't say.
Q. Never mind about the conversations, I want to know whether you were of the view that your position in relation to dilutional hyponatraemia in Adam was either shared by your colleagues or not accepted by your colleagues. I would have thought that would be a fairly important point.
A. Yes, I'm trying to recall. I believed that my colleagues knew the Arieff paper and had difficulties applying it to Adam. In that way, they shared my views on that context --
Q. Yes.
A. -- of Adam's -- of the coroner's --
Q. But that's not the point I'm really getting at. The point I'm really getting at is whether they accepted your position that Adam was a child who, because of his particular condition, couldn't actually develop dilutional hyponatraemia and hadn't developed dilutional hyponatraemia. That's the point I'm getting at.
A. I don't know the answer to that.
Q. Well, would you not want to know whether your position

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: I'm sorry, doctor, that doesn't take me anywhere. That takes me nowhere at all. I don't know what that means and I don't know what that means about the extent, if any, to which they preferred your view to Dr Sumner's view.

A. Well, I'm sorry, sir, I can't recall what they expressed to me at the time.

MS ANYADIKE-DANES: Let's put it this way. If you were right and a patient who was polyuric couldn't actually develop dilutional hyponatraemia because of that condition, that would be a very important thing to know, wouldn't it, about their fluid management; yes?

A. Yes.

Q. Equally, if a patient who was polyuric could develop dilutional hyponatraemia and could develop it in circumstances because what that meant about their condition was that they had a fixed urine output, that

would be an important thing to know about that condition, wouldn't it?

A. Yes.

Q. Yes. So it would be quite important for you to be sure as to whether your colleagues agree with you because if they don't agree with you, it's possible that they could not be providing appropriate treatment to a patient who came in with that condition?

A. That's correct.

Q. Right. So then it would be very important to satisfy yourself about that; yes?

A. That sounds logical.

Q. Yes. But in fact, when Dr Crean was giving his evidence -- and we can go to that, yesterday, 20 June, page 45. It starts at line 24:

"You told us [I believe this is the chairman's line of questioning] that you felt that Dr Taylor had recognised his error in the period after the inquest."

If we go over the page:

"Sorry -- that's correct, yes."

So for some reason, Dr Crean thinks that you have accepted Dr Sumner's position, or rather the verdict on inquest, and that your thoughts about Adam not being able to develop dilutional hyponatraemia were in error. How could Dr Crean have that view or form that view?

A. I don't know.
Q. Well, did you ever tell him that, "We've had the inquest now and I see how the evidence has gone and I think my original position might not quite be correct"? Did you ever have a discussion like that with him?
A. I don't remember a discussion with him, but I don't dispute what he has said.
THE CHAIRMAN: I'm sorry, he wasn't sure. He doesn't express himself with any degree of certainty. If you were accepting an error on your part in 1996 after the inquest, what error could you have been accepting?
A. I don't know.
THE CHAIRMAN: Nor do I because if you were accepting an error or errors at that point, that would not be consistent with the line which you took with the police some years later, nor with the line which you took with the inquiry until February this year; isn't that right?
A. That's right.
THE CHAIRMAN: What struck me about Dr Crean's evidence was that it's highly unlikely that after the inquest, you started to say, internally within the Royal, "I made these mistakes or I made a mistake", and then when you're interviewed by the police or you're making statements for the inquiry that you reverted to saying, "I didn't make mistakes". That didn't happen, sure it

didn't. It seems to me that that's most unlikely that that happened.

A. I don't know.

THE CHAIRMAN: Let me just make it clear. You set out your stall at the inquest. The inquest verdict and Dr Sumner don't agree with you. If Dr Crean's right, you then come back into the Royal after the inquest and say, "In fact, I did make an error", and then you tell the police that you didn't make an error. And then you tell the inquiry that you didn't make an error. That seems to me to be unlikely though, of course, it's possible that you might have been saying things internally within the Royal that you weren't saying externally either to the inquest or to the police or to the inquiry. So were you saying different things internally and externally?

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

MS ANYADIKE-DANES: 306-090-001. This is a letter that Professor Savage wrote to Adam's mother. You can see the date, 19 February 1996.

THE CHAIRMAN: Doctor, could you just take a moment or two to read this letter. You won't have seen it before, so just take a moment to read it, please. (Pause).

Mr Fortune?

MR FORTUNE: Sir, as you probably know from information given to you over the midday adjournment that we have

produced this letter. We are not in a position to produce the letter from Debbie in the first place to which there is reference by Professor Savage when he says, "Thank you for your letter". In any event, even if we had that letter, there is the question that no one has asked Debbie if she would agree to its production in this inquiry.

THE CHAIRMAN: And it might be a very personal letter, which I don't need to see.

MR FORTUNE: Be that as it may, it didn't form part of the records, because if you look at the date, subject to any further evidence, the medical records would have been either with the coroner or indeed with the State Pathologist's Department, one way or the other. So that's how this letter comes now to be produced.

THE CHAIRMAN: Thank you. (Pause).

MS ANYADIKE-DANES: Doctor, have you had an opportunity to look at that?

A. Yes.

Q. So you see it is dated 19 February 1996. And then the second paragraph:

"After Adam came out of theatre and we knew his sodium was low, we realised this was dilutional and set about removing fluid. Tragically, we could not solve the problem because of the development of brain

swelling. Once the cause of Adam's death is established, it is right we should try and work out why. We want to avoid anything like this happening again."

And so on. Then if we go down a little further on:

"It is important we learn anything we can from Adam's death to make the operation safer for them. [that's the children undergoing transplant]. Mr Leckey has done all he can to make sure this is the case and so will I."

Have you ever seen that letter?

A. No.

Q. I wouldn't have thought so in the circumstances.

MR UBEROI: A point may arise and you can anticipate my objection. This is a letter from Professor Savage to Debbie Strain, not mentioning Dr Taylor and which he hasn't seen.

MS ANYADIKE-DANES: Could I formulate the question?

MR UBEROI: I'm intrigued to hear how the question could be relevant.

MS ANYADIKE-DANES: That letter, as I say, is written in the early part of February and it is setting out very clearly, isn't it, Dr Savage's views? He even uses the expression "dilutional". He is very clear about it. In fact, he was very clear in his evidence that that was a view that he and Dr O'Connor had formed even on the

27th.

So after this letter is sent, there are meetings, which you attend, where Dr Savage is also present. From our records we can identify three -- this is all 1996 I should say: 17 April, 28 May and 14 June. I think I have taken you to some of the letters that deal with those.

So the question that I was asking you was: in the same way as I asked whether Dr Crean understood your position, this is Dr Savage communicating his position. He's then in meetings where you are trying to discuss the preparation for the inquest. Does he communicate his position to you and do you communicate your position to him?

A. Well, I've already stated I can't remember what was discussed at those meetings, but I don't deny or dispute that there were meetings that I attended with Dr Savage following this letter.

Q. Okay. Then if we go to, I think, 023-045-105. Okay, we'll have to get a copy to you. 023-045-105. It's the same number. It's an e-mail from Christine Stewart at the Royal Hospital. She was the Press and Public Relations Officer at the Royal Hospitals to Colm Shannon at the department. It's dated 20 September 2004. Unfortunately, for some reason I can't pull it up on

screen.

MR UBEROI: On that note, I'm going to need to see a copy before the question is framed. I don't wish to be difficult, but we're straying a rather long way away from the lines of the questioning that we had prior notice of. So certainly, if a question is going to be put and an answer expected, I would like to see it and, if necessary, take time to take instructions on this document.

MS ANYADIKE-DANES: We will move from there and we will get copies of it. It is not straying from the point. This is to do with dissemination and so forth, but I understand that you won't have seen the document.

MR UBEROI: It's straying from the lines that we had prior notification of and the documentation we had prior notification of, is my point.

THE CHAIRMAN: We'll see the document when it comes back.

MR UBEROI: I'm grateful.

MS ANYADIKE-DANES: The final place I was going to take you to before we deal with that -- well, can I just clarify one point? The chairman had been asking you about whether Adam's case was presented or discussed at paediatric directorate clinical audit meetings.

A. Yes.

Q. I wasn't entirely sure that you were clear about that.

You certainly said you recalled it being presented at the ATICS audit meeting. But I don't think you were entirely clear as to whether it had been presented at the paediatric directorate meeting; would be that be fair?

A. Yes.

Q. 305-029-001. That is a letter from the DLS to the inquiry. You can see that what's being said there is:

"Adam Strain's death would have been discussed at the paediatric directorate clinical audit meeting in December 1995. The minutes of this meeting have not been retained."

In fairness, I don't think they're intending it to be that just those specific ones haven't been retained. They have a trust audit policy, which is something that will be taken up later on. In any event, the view seems to have been that it was discussed at the paediatric directorate.

MR UBEROI: Sorry, just on this question as well, my recollection was that Dr Taylor said he didn't recall Adam's death being presented at a paediatric audit meeting. Secondly, this is a letter, this is an opinion or a comment apparently being offered by a legal adviser in correspondence to the inquiry. I don't understand how it is supposed to be used as a document which can

elicit relevant factual information from this witness.

THE CHAIRMAN: It's also inconsistent with Dr Taylor's evidence that because of the inquest, Adam's case would not have been discussed at ATICS until after June 1996. And if that's right, unless the paediatric directorate took a different approach to inquests, it is unlikely to have been raised there in December 1995 either.

MR UBEROI: Yes.

MR FORTUNE: Sir, that will have been certainly our position as far as Professor Savage is concerned. He has no clear recollection, firstly, of attending such a meeting, and, if he did, of the matter being raised then.

THE CHAIRMAN: He wouldn't -- why would he recall being at a December 1995 meeting when it's raised so many years afterwards? I know that he would know if he went to these meetings, generally, but would he have a specific reason to recall or not to recall December 1995? Or is it specifically in relation to Adam being discussed?

MR FORTUNE: Save insofar as the matter was in the hands of the coroner at that time, there are two separate issues. Firstly, as Professor Savage will say, Adam's death was the talk, not just of the department but of the hospital.

THE CHAIRMAN: And Dr Crean said that yesterday.

MR FORTUNE: Yes, and that's accepted. But it doesn't necessarily follow that there was a specific discussion about it at the meeting in December, bearing in mind that there was a hospital investigation supposedly under way and, in any event, a coronial investigation under way.

MS ANYADIKE-DANES: I think we might all be at cross-purposes.

MS WOODS: Just to put a marker down on behalf of Mr Brown as well. This was raised with Mr Brown yesterday. I would like to support the points made by my learned friend Mr Uberoi because, when I saw this letter, I did wonder to myself how is this assertion being made by the Trust when there's no documentation in existence. It may be that there are witnesses who can say, "Yes, it was discussed at the December meeting", but I think until those witnesses give that evidence, we cannot take it for granted that it was at all.

THE CHAIRMAN: Mr Simpson, can you help on this?

MR SIMPSON: No, I'm just saying to Mr Lavery that we're going to have to take instructions as to whether that "would have been discussed", whether it was based on fact or some --

THE CHAIRMAN: Assumption.

MR SIMPSON: I'm just going to check with Ms Beggs.

MS ANYADIKE-DANES: That's why I was trying to interject to say some of this was a little bit previous. I was putting it to you, as I have on other occasions when we have received documentation from the DLS and we have asked that we know the basis of the assertions that are being made, so I offered it up as the best information that we have. Obviously, it is there for the witness to say, "It doesn't jog my memory, I don't think that can possibly be right", and then we will have to, as we have with a number of other matters, take it up with the DLS. So the legal representatives don't need to be concerned. These things are not being presented as fact, save that they are what we have received from the DLS, who in due course, will explain the information that was in their correspondence. That was the only reason and I might have been able to forestall some of that.

The final point you made, Mr Chairman, in relation to the documents or case notes and that this witness said, that that can be seen -- and this is a document that was presented yesterday. 059-071-164. It is from Dr Murnaghan to a number of people, including Dr Taylor and Dr Gaston and also Dr Savage, and for that matter Mr Brown. It says, because this is all to do with the inspection of the anaesthetic equipment:

"In order that you may prepare the requested report,

I am sending with this letter an extract copy of the recent case notes."

That's dated 6 December 1995, so it would appear that the undersigned or the undernoted had, at least, access to the recent case notes of Adam Strain.

MR UBEROI: Just for complete accuracy, an extract copy of the recent case notes, but I do take the point.

MS ANYADIKE-DANES: I hoped I read that out correctly.

Then the final point that I had wanted to take you to is, if you go to -- and Mr Chairman, you then might have a few minutes to look at the e-mail I wanted to put to him. But this final point before then.

If we can go to your witness statement 008/1, page 8, which is where we were before under section 4, you say:

"As a consultant in the Royal, with my colleagues I have had the opportunity to, since 1995, teach and train junior anaesthetic and paediatric trainee doctors in all aspects of fluid management in children undergoing major surgery."

In your CV, I think it's clear that you are part of the ATICS education subcommittee; is that right?

A. That's correct. That was correct, yes. I was.

Q. At that time?

A. At that time.

Q. At that time you were. Thank you.
A. I believe so, yes.
Q. So the point I'm going to put to you is: what would you have taught if a case like Adam's were to be discussed? This is a child, polyuric, needs fluid management during surgery. What would you have taught at that stage? Let's say in 1996.
A. My role as the education -- on the education subcommittee was administrative. It was to do with the organisation and training of the trainee anaesthetists spending three months on a rotation through Children's. I also -- added to that seminar, I organised seminars and journal(?) clubs for that period of time, so the educational subcommittee role was an administrative rather than a teaching role.
Q. Then if we move from that to go to your actual teaching. Let us say that you're in the middle of discussing fluid management and electrolyte imbalances and all sorts of things and you have a bright young spark who asks you, "What about polyuria and dilutional hyponatraemia"? What --
MR UBEROI: [Inaudible: no microphone] ask for. This is certainly the moment for, finally, a bit more flesh to be put to the bones as to what in fact would be taught, what, in fact, went along with being a member of the

education sub-committee. I asked for it to be asked of Dr Gaston, it wasn't. Dr Taylor can provide that evidence and then, I think, a follow-up question to that when it is put in its proper context may be the one that my learned friend has asked. But to parachute straight in at that scenario, I think, is not fair to the witness.

MS ANYADIKE-DANES: At the moment I don't particularly want to ask him further about the administrative function of the educational subcommittee of ATICS. What I want to ask him, because he's put it in his witness statement is:

"I have had the opportunity, since 1995, to teach and train junior anaesthetic and paediatric trainee doctors."

MR UBEROI: He hasn't been asked and, to my recollection, nobody has been asked to properly put some detail on what it means to sit on the education subcommittee of ATICS. He did sit on it, he is surely an ideal person to offer evidence on that, firstly, before we move straight to the question my learned friend has put. If this witness is not to be asked, then who is to be asked? And also I repeat, surely it cannot be fair for the secondary question to be put and taken out of context before that role is understood.

THE CHAIRMAN: Let's go back a bit. You say that your role on the education subcommittee was administrative.
A. Yes.
THE CHAIRMAN: Who decided what substantive areas of training and education would be developed by the education subcommittee?
A. I believe that was the postgraduate dean and the Postgraduate Northern Ireland Dental and Medical Training Committee, NIMDA.
THE CHAIRMAN: But would they welcome or accept suggestions from anaesthetists and paediatric anaesthetists about issues which could be developed, whether as part of the curriculum or whether as one of special lectures?
MR FORTUNE: Sir, I rise at this stage because I can see that my learned friend is probably building up towards questions for Professor Savage. And in this regard, what you're looking at, sir, here are postgraduates, not undergraduates. When my learned friend reads out references to "junior anaesthetic and paediatric trainee doctors", these are doctors who have already qualified and are registered and therefore postgraduates and come under the auspices of the postgraduate dean and not the university.
MS ANYADIKE-DANES: Thank you.
What I am still trying to get at, which I believe,

subject to correction from the chairman, is a proper question to put to you, since you have said that you are teaching and training these people --

A. Yes.

Q. Does that mean they come to the hospital?

A. Those doctors would be rotating through the paediatric -- the Children's Hospital.

Q. Could they accompany you on a ward round?

A. Well, we didn't really do ward round as anaesthetists, but we sat in theatre with --

Q. You sat in theatre?

A. -- and we went to the pre-operative visits.

Q. Could one of them ask you a question about dilutional hyponatraemia and polyuria and so forth?

A. Yes.

Q. So if they had done that, what would you have told them in 1996?

A. I would have taught them whatever was in the textbook. I would have stuck to textbook teaching about the management of fluids.

Q. Which would have been different from what you thought was the relationship between polyuria and dilutional hyponatraemia?

A. For Adam.

Q. For Adam, exactly. Well, if another Adam came across

your path, what would you have taught an enquiring trainee?

A. Well, in fact three polyuric renal failure patients presented when I was on duty in the intervening years and three anuric --

Q. Let's stick with the polyuric and stick with dilutional hyponatraemia. Those are the two issues that I'm asking you about. What would you have taught about that?

A. I would have taught what was relevant in the textbooks and --

Q. And what would that have been?

A. That the urine output was fixed and had to be managed with the discussion and communication of the nephrologist --

Q. Which would mean --

A. -- who would be in theatre and was in theatre with us for those cases.

Q. Which would mean that you would have taught something that was quite contrary to what you actually thought was the case and what you were propounding was the case in the interviews and so forth that you gave?

A. Yes.

THE CHAIRMAN: If that's right, why did you continue to hold that line with the police?

A. I think I've already indicated that my -- despite being

under caution, my answers to the police were, by and large, irrational --

THE CHAIRMAN: But, doctor --

A. -- and I cannot account for that.

THE CHAIRMAN: -- there are two different things here. It does appear now, to go back to the questions I was asking you after lunch, about whether you were holding a different position internally on dilutional hyponatraemia than you were holding externally. If I understand your answer to Ms Anyadike-Danes correctly, what you would have taught junior doctors about polyuria and fixed urine output was different to the mistake you made in Adam's case, but also then different to what you said to the police, and equally different to what you said to the inquiry. That's not just irrational; that's dishonest. That is knowing that you have made a mistake, perpetuating that mistake by saying something to the police which you don't believe to be true and saying something to this inquiry which you don't believe to be true. You've gone beyond irrational. Do you dispute that?

A. I can't account for the fact that I held a different view than what I practised and what I taught.

THE CHAIRMAN: I've got the point.

MS ANYADIKE-DANES: Nothing further. But I wonder if

I might just take some soundings as to whether anybody else does.

THE CHAIRMAN: You need --

MS ANYADIKE-DANES: I beg your pardon, there is, sorry, Mr Chairman. Could you just have a look at that, which is, I think, in the same vein?

THE CHAIRMAN: I think you need to speak to Mr Uberoi and others maybe about that.

MR SIMPSON: I thought my learned friend was only going to be five minutes at 2 o'clock. The difficulty is that Dr Mulholland has to leave after today. He has a flight tomorrow back to London. We need to be finished today.

THE CHAIRMAN: I will take a five-minute break now. That will leave time to sort out this document I've received and any further questions to Dr Taylor. When I come back at 2.45, we will finish Dr Taylor, we'll start with Dr Mulholland and we'll finish Dr Mulholland.

(2.40 pm)

(A short break)

(2.47 pm)

MS ANYADIKE-DANES: Mr Chairman, I don't propose to take that document to the witness. I have just got one more question I have been asked to put.

After Adam's death, did you attend any meetings where his death was discussed with the Children's

Hospital consultant paediatricians that you can recall?
A. I can't recall.
Q. You can't recall that at all?
A. No.
Q. We have spent most of your evidence talking about your discussions with your colleagues in the sense of anaesthetic colleagues.
A. Yes.
Q. Do you recall ever discussing anything with the paediatricians in relation to Adam, of course?
A. Other than Dr Savage and Dr O'Connor?
Q. Yes.
A. I don't remember.
MS ANYADIKE-DANES: Thank you. I have nothing further.
THE CHAIRMAN: Any more questions? Mr Uberoi?
MR UBEROI: No, thank you, sir.
THE CHAIRMAN: Doctor, thank you very much for coming back to us. You are free to leave.
(The witness withdrew)
THE CHAIRMAN: Mr Stewart?
DR CONNOR MULHOLLAND (called)
Questions from MR STEWART
MR STEWART: Doctor, good afternoon. Thank you for coming. You have provided us with two witness statements, WS243/1 and 2. Can I ask you: are you content that the

inquiry should formally adopt those statements as your evidence?

A. I am.

Q. Thank you. Could we go to the cover page of WS243/1? We see that, in 1995, under your previous position and institution, you were "clinical director of paediatrics (acting)" at the Children's Hospital and "clinical director in cardiology and cardiac surgery".
At November 1995, you held both those posts?

A. I did.

Q. Also, under "Membership of advisory panels and committees", "Hospital council 1991 to 1997", so you also served on that council at the time of Adam Strain's death?

A. That is right.

Q. So, in fact, you were a very busy man.

A. I was.

Q. Were you also practising as a paediatric cardiologist at the same time?

A. Yes.

THE CHAIRMAN: About how many sessions a week were you doing?

A. I was full-time at that stage.

THE CHAIRMAN: Is that seven?

A. Ten.

MR STEWART: You set out the circumstances of your appointment to the "clinical directorship of paediatrics (acting)", at page 3 of that document, 243/1, page 3. That's at paragraph (e) in italics:

"My appointment arose out of a need to address the issues of financial and clinical management structures in the directorate and improve liaison with staff. Prior to my appointment, a support [query] supervisory group was set up to work with the then clinical director, Mr Stephen Brown. It included myself, the Director of Nursing and a couple of other clinical directors."

Can I ask you further about the circumstances of your appointment? Why was it necessary for you to address these issues of financial and clinical management structures?

A. Because it became apparent to the Hospital Council that the paediatric directorate was significantly overspent and because of that, the advisory group was set up, of which I was part. And I can't remember how many months it met for, but after a few months I was asked would I consider coming in as an acting director of the paediatric directorate. Initially, it was proposed I would work alongside Mr Brown, but in the end he declined that offer and I was asked to take over.

Q. I see. For the few months you were serving in that advisory capacity, you were also "[query] supervisory". Were you really making sure Mr Brown was doing what he should or was there a problem?
A. No, it was just a choice of words on my part, but it was a group that met with him and discussed the issues that were current in the directorate and gave advice on that.
Q. How bad was the financial problem at the directorate?
A. I can't remember details, but it was probably at that point the directorate which had the highest overspend, proportionately speaking.
Q. Were you a troubleshooter, as it were, brought in to try to sort it out?
A. I think that was the role, yes.
Q. What were the problems with clinical management structures that you refer to?
A. It became clear to me as I got into the advisory group that the directorate was managed completely by Mr Brown and a nurse manager, business manager, and the degree of involvement of the consultant and other staff was unusually small. I think that would be fair.
Q. So in other words, Mr Brown was trying to do it with a very small group of people?
A. Yes.
Q. Not drawing on the broader talent in the directorate?

A. Yes. Well, the way in which one can get a directorate or any group of people to function is to involve them in the decision-making. They're the people on the ground, they know what is going on and they can be involved.

MS WOODS: I don't want to make a big point about it, but I just note that Mr Brown wasn't asked any questions about the circumstances in which he stopped being clinical director. So I say, I just want to make a note that what we're getting here is perhaps one perspective.

THE CHAIRMAN: Okay, thank you.

MR STEWART: Did you take any steps to improve the structural framework within the directorate?

A. I took a number of steps. Firstly, I asked a number of other clinicians from different specialties to become sub-directors, with whom I would have regular meetings and discussions. One from the surgical side, Mr Victor Boston, who was subsequently succeeded by Mr Trevor Taylor. On the medical side, Dr Dennis Carson, and then I invited Dr Crean because although he was under the ATICS directorate in terms of the overall management, he clearly had to work with clinicians and he knew what the intensive care set-up was like and was able to provide input to the paediatric directorate for that.

Q. Yes. And he gave evidence yesterday and gave evidence that his line of reporting, as it were, was to Mr Gaston of ATICS. He also said it also lay to yourself. Would that have been how you interpreted the set-up?
A. Not in terms of ultimate accountability, but he was a source of communication to me because, obviously, what happened in theatre had implications for the intensive care unit, it had implications for physicians or surgeons who had previously referred their patients to that unit.
Q. Yes. You are touching on there exactly what I want to find out from you and that's these lines of accountability. Because if his line of accountability lies outside your directorate, but yet he has very specific knowledge and potential input into your directorate, is that a potential problem?
A. No. The Children's Hospital is literally a hospital, it's not -- it's a small version of any other large general hospital, although with fewer staff. And the different staff within it need to find a way of working together and coordinating.
Q. Yes.
A. And as a consequence, I was in the cardiology directorate, but I attended paediatric meetings of the paediatric directorate. There are others who had

cross-directorate functions and you simply had to work with that.

Q. Further down the page that's in front of you on the screen, four lines from the bottom, you have underlined to give emphasis:

"However, one critical feature was that the anaesthetic and intensive care consultants were part of the ATICS directorate."

And then you go on to describe the close working relations that of necessity developed. Why did you give that emphasis to "critical feature"?

A. Well, because it was critical in terms of my focus and involvement in things which happened in theatre that I was not directly responsible for that.

Q. Did that mean that there was a potential of you not hearing about things from anaesthetists that, perhaps, you might have needed to know?

A. It might well have.

Q. And do you think there was a flaw or potential flaw in the overall structure, as it were?

A. Well, with hindsight one can say that there were things I didn't know that might have been helpful.

Q. Of course, specifically in this case, if the anaesthetist drawing up the recommendations that you may have heard about earlier and making reference to the

Arieff paper had brought the Arieff paper to the attention of the paediatricians in the directorate, it might have received a broader publication, distribution?

A. That is so, yes.

Q. And that might have had consequences down the line for other patients?

A. It may have, yes.

Q. Can I ask you in relation to your report lines to whom you were accountable, step-by-step?

A. I was accountable to the chief executive.

Q. Would that have been a direct accountability or via the medical director?

A. No, my understanding it was directly to the chief executive.

Q. We have drawn up what now appears to be an unfounded corporate structure document, 303-043-510. This was compiled on the basis of information received. It was shared with the Trust, who did not point out any error in it. In any event, you'll see on the right-hand side that Dr Ian Carson serves as an executive director, alongside Miss Duffin, Mr Bennett, the chief executive, and you see in what are meant to be reporting lines going to him are all the individual clinical leads named as at November 1995, with yourself appearing as acting paediatric director.

You say you, in fact, reported directly to the chief executive, Mr William McKee?

A. That was my understanding and certainly while I would have had discussions with Dr Carson, where appropriate, in terms of major changes or issues which were important, I would have been discussing them with Mr McKee. I would also say that, at some stage, this was raised with Dr Carson. He will be able to speak for himself later, but he emphasised that at that time, anyway, we were not accountable to him.

Q. What sort of things would you have raised with Dr Carson and what sort of things did he deal with? What was his function as medical director?

A. Issues affecting the trust as a whole, the ...

THE CHAIRMAN: Can you illustrate that with an example?

A. I'm trying to think of one.

MR STEWART: Would it have been broader strategic or policy matters?

A. It would have been more on that line, yes.

Q. Mr William McKee, to whom you were accountable, was, of course, a non-medical man. He was, as it were, a corporate affairs individual.

A. Mm.

Q. Would it have been entirely sensible for a clinical lead to report to a non-clinical director?

A. There would have been issues of the management side that would have been relevant to the chief executive.
Q. Yes.
A. And others that -- it would certainly have been discussed with Dr Carson and some sort of agreement come to in relation to that.
Q. What I'm trying to get at is that if a clinical director had an issue in relation to a clinical matter, perhaps a clinician underperforming, and he felt he had to report it up the line, would it not be more logical that he should report it to somebody who would be versed in medical matters as opposed to administrative matters?
A. Well, that in fact would have happened, that issues of professional competence or behaviour or things of that sort would have come to him.
Q. Would they as a matter of course?
A. Yes.
Q. Would they be direct to him or via Mr William McKee?
A. Directly to him.
Q. Can you recall, was there any guidance given to clinical leads at the time to help them work out the corporate structure and what they were to report to whom?
A. I don't recall any.
Q. I wonder, can I ask you some questions about what is called quality control or internal control. These

questions have been asked of a number of witness, all of whom professed not to know the answers and said it was up to, essentially, you as the acting director of the time to answer.

Firstly, in relation to the clinical audit committee of the paediatric department. There was such a committee in 1995?

A. Yes, there would have been.

Q. And what would have been its function and remit?

A. Well, to audit a variety of clinical issues and to look at consequences of certain things if those were brought to them. Audit in those days was in quite an early stage and it certainly didn't have any major legal requirements attached to it. The doctors, by and large, would have chosen areas of interest to them and reported on them, brought back perhaps a survey of patients undergoing particular types of surgery and issues around that or things on the medical side.

Q. So the audits would have been undertaken on the basis of what doctors themselves chose to bring to the audit committee as opposed to the audit committee going out and doing, as it were, a spot audit?

A. Yes. Very much so.

Q. And who would have sat upon the audit committee?

A. There would have been representatives of the different

medical and surgical groupings within the hospital.

Q. So it would have been multidisciplinary?

A. Yes.

Q. What about the disciplines that did not belong to the directorate, such as anaesthetics or laboratories?

A. They would probably have had a representative on it or one might have been invited to come along for particular issues.

Q. From your directorate, would individuals have ever gone to the clinical audit meetings of other directorates if there was a cross-disciplinary interest?

A. If there was something of significance, yes. I mean, when I was in paediatric cardiology and before I was a director, I would have gone to the cardiac surgical audit meeting from time to time as well as the adult cardiology one and the paediatric, or at least -- yes, the paediatric audit group.

MR STEWART: I give way to Ms Woods.

MS WOODS: Mr Chairman, it may be that I have misunderstood and if I have, then I apologise, but it seems to me that we may be assimilating two different groups that may or may not, in fact, be separate. I wonder, could the witness be asked if there is a difference between an audit committee within the hospital and then the clinical audit meetings?

MR STEWART: I'm very grateful for that.

Is there any difference between the clinical audit meetings and the clinical audit committee?

MS WOODS: It's that phrase that my learned friend Mr Stewart has used.

MR STEWART: This phrase merely reflects my own need to learn.

A. The clinical audit committee would have been one that was established to promote audit within the hospital and, arising out of that, they probably, within their own subsections, would have been expected to take things forward. Not necessarily always at the audit meetings, which were a, I think, monthly feature of the directorate. I'm not sure if they were running in 1995. I think they probably were when cases of note or interest would have been presented.

Q. And would those meetings have been minuted when cases of note were presented?

A. I don't know for sure about that.

Q. If minutes had been taken, would those have been sent to the committee?

A. I don't think so.

Q. The trust, did it have an audit department at that time?

A. Yes.

Q. Can I take you to WS243/1, page 6, just to refresh your

memory? If I can bring you down to --

THE CHAIRMAN: This is your own statement, doctor, the first one.

MR STEWART: Yes. 11(h):

"To whom the results of medical and/or clinical audits are sent. Ideally to the audit department and relevant clinicians."

Is that right?

A. That is what one would have hoped would happen, but not always did happen.

Q. Are you perhaps suggesting a breakdown at the time in these things?

A. Sorry?

Q. Are you suggesting that perhaps things were not working as they should have done at that time?

A. I think they weren't working then as we would expect them to be working now, and even as they would have worked five years ago. All of it was in a very early stage of concept and of the involvement of clinicians at that point.

Q. Mr Gaston gave evidence the day before yesterday on ATICS audit meetings and he said -- if we can go to the 19 June transcript, page 8, at line 4. Ah. Forgive me, that is indeed the wrong page. In any event, what Dr Gaston was saying was that:

"Sometimes the paediatric audit and the cardiac audit occurred at the same time as the ATICS audit, which meant that we very rarely would have input from the paediatrics."

He was saying that there was some clash and perhaps paediatrics didn't always get to ATICS or maybe vice versa.

A. Absolutely.

Q. Would that have been right?

A. Yes.

Q. Was that something --

THE CHAIRMAN: Does that reflect what Dr Taylor said this morning, that there was a half day each month and it was on that half day each month that all of these committees met?

A. That is how they tried to arrange it within the Trust. That again was an evolving process and I think, by 1995, it was quite early still. It moved, as I said in my statement, from being the sort of thing that enthusiasts did to being something that was encouraged for everybody to do. And then there were these clashes when someone who was, let's say, in the paediatric cardiology audit set up, was working in another hospital and had responsibilities there that they didn't have in the Royal at that time. So they didn't get to it or,

alternatively, as you've suggested, as it became more controlled, a specific half day was identified. Firstly, within each hospital and then it gradually spread out through Belfast and through the Eastern Board so that each hospital group knew that that was happening. So there was a difficulty if people covered more than one specialty.

MR STEWART: Can you remember when that rolling half-day audit programme commenced?

A. I don't. I think it was later than the period we're talking about.

Q. Did you take any steps to improve the audit regime within the Children's Hospital?

A. No, I didn't take any specific steps.

Q. The nephrologists, were they within the paediatric directorate?

A. Yes.

Q. Did they take part in the audit meetings?

A. They would have from time to time, certainly.

Q. As and when necessity arose?

A. Yes.

Q. What about what are called the mortality/morbidity meetings; is that the same thing?

A. No, it wouldn't have been. Mortality/morbidity meetings were something that really where surgeons tended to meet

together to discuss outcomes of surgery and physicians would have gone to them where it was appropriate. I would have attended the surgical ones or my colleagues from cardiology would have, paediatric cardiology, would have attended them if a child's particular problem or death had come up for discussion at that time.

Q. Would Adam Strain's case have come up for discussion before a mortality/morbidity meeting?

A. It may have. I don't know. I wasn't --

Q. And you have no recollection of --

A. No.

Q. -- any such thing. Would minutes have been kept of such meetings? Or should they have been kept?

A. They should. Some minute of the meetings should have been kept.

THE CHAIRMAN: Sorry, should Adam's case have gone to a mortality/morbidity meeting?

A. I would have thought that it would have.

THE CHAIRMAN: Right.

A. Whether any degree of detail would have been given at that stage in the light of the subsequent coroner's inquest is questionable.

THE CHAIRMAN: It might go on an initial basis and then might come back after the inquest?

A. That could happen. I have no knowledge as to whether it

did or did not.

MS WOODS: Mr Chairman, I only rise because I hope this will assist you: In the papers I have, there are minutes of mortality meetings. The first that I have is dated 13 April 1995. The reference is 305-011-576. Unsurprisingly, the details of the cases that are being discussed are blacked out, but certainly we can see that there were minutes taken.

THE CHAIRMAN: Thank you.

What is the purpose of the mortality meeting?

A. Well, I think going back to that time, it would have been to discuss the circumstances of individual patients, where there were problems, and people would have shared their experience in the past in such situations. And then whether anything went any further than that would depend a great deal from one group to another.

THE CHAIRMAN: This would be attended by surgeons and perhaps physicians. So if you take Adam's case as an example, you think that there should have been one, but perhaps deferred or deferred until after the inquest. In terms of the people who treated Adam, who would you have expected to be at that?

In terms of surgeons, Mr Brown, who was assisting Mr Keane, was not based in the Children's Hospital;

he was based in the City. Was there a practice, if that happened, that somebody in Mr Keane's position would be invited over to take part?

A. I can't speak for the surgeons, but I would have thought that the invitation would be there because it would have been of common interest.

THE CHAIRMAN: Right. And would you expect the nephrologists to be there?

A. Yes, if possible.

THE CHAIRMAN: And would you expect the anaesthetists to be invited?

A. If you're referring to Adam's case, yes.

THE CHAIRMAN: Right.

MR STEWART: By implication, are you saying that there would not have been an invite necessarily to paediatricians?

A. General paediatricians, no.

MS WOODS: Mr Chairman, again I do hope that rising will actually assist you.

THE CHAIRMAN: So do I.

MS WOODS: I'm sure you'll tell me if it doesn't. You'll be aware, of course, that a number of these minutes have been sent to the inquiry team. It would appear that these have been sent because these are random ones that have escaped the shredder, for want of a better phrase. The letter that accompanies those minutes from the DLS

does describe the minutes as "paediatric directorate clinical audit meetings". So Mr Chairman, I don't know whether that assists in whether the mortality meetings are something separate entirely or whether they fall [inaudible] by the DLS under the description of clinical audit meetings in the paediatric directorate. The reference for that letter is 305-011-572.

THE CHAIRMAN: Do you see that?

A. Yes.

THE CHAIRMAN: Is that different from the mortality/morbidity meeting that you were talking about a moment ago? Have I got that right? Or is there a bit of confusion generally about the titles to these meetings?

A. I'm not quite sure what the point is. It's headed "Paediatric directorate clinical audit meeting". Are you asking is that the same as the mortality morbidity?

THE CHAIRMAN: Yes.

A. No, I think ... This is something that, as I said, evolved over a decade or more to what we knew by the end of the 20th century. And morbidity/mortality meetings were something that surgeons held generally, but as audit came in, they would have contributed some of the stuff from the morbidity/mortality meeting into an audit process.

THE CHAIRMAN: Okay.

A. I think it varied quite a bit from one discipline to another and from one hospital to another.

MR STEWART: Can you recall: did individual contracts contain requirements on clinicians to engage in audit?

A. When that started?

Q. Mm.

A. Some time in the mid to late 90s, I think.

Q. I think certainly the inquiry has seen a 1995 example of, I think, a consultant paediatric anaesthetist with such a requirement in it.

A. Right.

Q. Would that be in accordance with your recollection?

A. That would be.

Q. Can I ask you about another committee, the Medical Records Committee. According to your witness statement there was such a committee within the Children's Hospital.

A. Yes.

Q. What would its function have been?

A. I know there was one because in the 80s I, for two or three years, was a member of one in the Children's Hospital. At that time -- and I don't know how much it changed over the next five or seven years, the main focus of it was on records being available for

outpatient consultations, for children's admissions, that sort of thing. And then it moved on from that towards the type of records that were being kept and the different reports and results that would have gone into the records.

Q. Are you suggesting it would focus more on the quality and adequacy and completeness of the records?

A. Yes.

Q. Would any audit have been taken in relation of medical records at that time?

A. None that I'm aware of. It was a fairly frequent cause for concern among clinicians trying to run departments and outpatients and so on -- not almost always, but there would frequently be records that were not available for a patient when they came to the consultation.

Q. Would the Medical Records Committee have kept minutes of its deliberations?

A. I think they would have, yes.

Q. Did the trust also have a Medical Records Committee?

A. Yes. The trust had a Medical Records Committee and there would have been a representative of the medical records department coming to the directorate records meetings.

Q. Your committee, your Medical Records Committee, would

they have been answerable to you or to the Trust?
A. I think to the Trust.
Q. Would your Medical Records Committee have had --
A. Sorry. I think they'd have been answerable through to the medical records department of the Trust and anything that arose that was significant would have been passed on then to the Trust.
Q. Was it any part of the Medical Records Committee's role to, as it were, implement and enforce guidance about medical records?
A. I don't know precisely what the role of the Records Committee, by the 1990s, was concerned to be. The guidance would have been there and there would be encouragement, I think more than anything else, to work towards meeting high quality records.
Q. Would any enforcement measures ever have been taken to ensure compliance with guidance?
A. No.
Q. In relation to guidance coming down, in theory, in a hospital with a corporate structure like this, we're told by Mr McKee the chief executive in his witness statement that:

"Published guidance, handbooks, Health Department circulars would arrive in his office. They would then be distributed to the relevant clinical leads and this

information would cascade down and it ended up in the hands of the correct person to implement it."

And then it would be monitored, assessed to be working efficiently, and the word would go back up the line again that all was well. Can you recall now in the mid-1990s guidance coming into your directorate from the chief executive or wherever?

MR FORTUNE: Sir, this question is predicated on the basis "in theory".

THE CHAIRMAN: I know where Mr Stewart's going and I'm clear with it. Mr McKee has said that was what happened and I think we're moving on to, in the next few questions, to a specific example. If it's theory at the moment, it won't stay theory for long.

MR STEWART: Do you recall a system for the dissemination of guidance documents and so forth at that time?

A. Yes. There would have been.

Q. And what was that?

A. A whole variety of documents would have come down either to me or to the business manager. And my practice would have been to send it on to the clinical leads who were responsible or, if it was something that had a wider application, including, say, the nursing staff or others, to them also.

Q. And was there any procedure whereby you could make sure

that it was put in place in order that you could pass the assurance back up again?

A. Not at that stage. There wasn't a process.

Q. Because there was an example we know about in 1995, in October 1995, when a guidance handbook on consent was sent to the Trust for implementation by a particular date and confirmation was sought that it would be implemented and so forth and that was not forthcoming. And the point about the guidance was that it contained a model new consent form to be used by clinicians when obtaining consent from a patient. And correspondence has revealed that that consent form was not actually put in place until some five years later.

A. Mm.

Q. Can you imagine how such a set of circumstances could prevail?

A. Well, essentially, there would be a need at that point for you to ensure that the people to whom it was sent for implementation did so and then gave the feedback up to the clinical directorate and, if it didn't happen, there would be some way of ensuring that those who didn't did do that, but in fact there weren't systems in place to ensure that.

THE CHAIRMAN: Can you turn up the reference?

MR STEWART: I'm just scrabbling for the reference. I don't

have it to hand. I will certainly make efforts to find it.

THE CHAIRMAN: What we're referring to, doctor, you may be aware, is that this consent guidance with the new consent form was issued by the department in October 1995 with a covering letter, asking that confirmation comes back to the department, in December 1995, that it was implemented.

As we understand it from Mr McKee's description, that would come into his office, he would then ensure it made its way down through the organisation and that's what you've described as happening. But it doesn't appear that that consent form did become the standard consent form for some years as opposed to a few months. So it's an issue really at a level, Mr McKee's level, as to how he was going to get reassurance and then, at departmental level, about what they would have done when they didn't get reassurance that the consent form was introduced. Because this consent form appears to have been the result of a number of years of work and looking at models elsewhere and so on. You probably know this better than I do.

And once it comes out, it's not a consultation document; it's a document to be implemented. And what we're interested in is how it was -- what mechanism

there was to implement it because it's relevant generally, but it's also specifically relevant to this inquiry because in 2002/2003, hyponatraemia guidelines were issued by the department, which were to be implemented and we have a query around the death of Conor Mitchell about whether those guidelines had been implemented. So there is a double reason or dual reason for asking you about this episode.

MR STEWART: It may assist to go to WS243/1, page 7, towards the bottom at 18(b). The guidance we're referring to is known as circular HSS/GHS295. In fact, Dr Mulholland has already been asked about this, about the steps taken to disseminate it, enforce it and to describe arrangements put in place to notify of the implementation and so forth, to which Dr Mulholland clearly stated he had no recollection.

Professor Mullan, who is an expert witness on clinical governance matters, who'll be giving evidence, will, I hope, say that one of the things he would have expected to have been done in 1995 where a new form came in to a department was that the old form should be physically taken out of circulation so that nobody could use it and a new form put out so that no one had any choice but to use it, and he described that as a very clear, obvious, practical approach. Would that have

been something that might have occurred had this situation arisen to your knowledge?

A. I'm not aware that any attempt was made to do so.

THE CHAIRMAN: That would be a practical way to do it.

A. Yes.

THE CHAIRMAN: If a new consent form was issued, the simplest way to enforce it is to take out the old consent forms and replace them with the new forms.

A. Yes.

THE CHAIRMAN: Do you have a reference?

MR STEWART: 306-058-001. That's not it, sorry.

THE CHAIRMAN: Unless you can open that, which I doubt you can do. Okay. The point is there -- and Dr Mulholland has said in his statement that he doesn't have a recollection of this -- and he is saying, I think more importantly for our purposes, that there wasn't actually a system in place to ensure that what should have happened did happen.

A. Yes.

MR STEWART: In fact, I have been handed a copy of a document, it seems to be 306-058-002. I'm not sure I can take the matter very much further forward. It is the document which arrived and this is the covering letter. If we go over the page to 003, the instruction's given to the recipient of this letter at

paragraph 5 at the top:

"Boards/HSS Trusts are asked to confirm by 31 December 1995 that this has been done. Confirmation should be sent to Mr Lunn, General Hospitals Policy Branch, to whom any enquiries about this circular should be sent."

And upon enquiry, the inquiry has been informed that no such confirmation was in fact received by Mr Lunn. So it seems that it was sent out to the Royal and nobody knows what happened to it. It certainly wasn't implemented.

THE CHAIRMAN: I know it's going back some time, doctor, but do you remember the new consent form either coming out or eventually superseding the old consent form?

A. Um ... This was 1995, wasn't it?

THE CHAIRMAN: Yes. Could we put up the two pages together, 002 and 003, please?

A. I remember a change of consent form coming. I retired in 2003 and there was a change certainly by -- before then.

THE CHAIRMAN: Right.

A. But I don't remember the process or the mechanisms involved in that coming in.

THE CHAIRMAN: You see, if you look at paragraph 1 on the screen on the left for a moment, you'll see that this is

more than just issuing a new form. It's also introducing -- it's referring to "the patient's fundamental right in relation to consent" and it says:

"This circular introduces a handbook of guidance about patients' rights in accepting treatment, advice to health professionals and advising the patient on obtaining consent and advice for patients who are suffering from mental disorder."

So this isn't just: look, you take away form 14B and here's 14C; there's substantially more to it, isn't there?

A. Yes.

THE CHAIRMAN: And it does seem worrying whether it just lies around for a while before it gradually becomes the accepted norm.

A. I would agree. I think that this is something which happened in a number of changes that were either suggested or supposed to be put in place. It's very much a matter of perhaps there being no suggestions of the sort that you have made as to how to implement these things and just take away the old one and get on with the new. But I really don't have anything further to contribute.

THE CHAIRMAN: Thank you.

MR STEWART: If we could go back to that page in your

witness statement, 243/1, page 8, that we had on screen a moment before, to go to 7, "record keeping", at 21:

"In 1995, did the Children's Hospital have guidance, policy or procedures in place which governed the issue of clinical record keeping? I have no clear recall of the above. My memory is that engaging in the King's Fund organisational audit process was the main stimulus to improving record keeping."

You had some engagement with the King's Fund and did you act as a member of a shadow assessing team?

A. Yes.

Q. So would you, in the mid-1990s, have been focused on the various areas that the King's Fund might have looked at and scrutinised?

A. I would have known them, yes.

Q. Is there an implication in your answer to this, "the main stimulus to improving record keeping", that record keeping needed improvement?

A. Yes. The King's Fund highlighted what the acceptable standards were and what should happen. For example, printing rather than writing the name of a prescribed drug and making notes of not only what your course of action for a patient's management was, but also what you said to the patient or, in the case of children, what you said to the parents. Again, if it's in a consent

situation, how much information you gave to the parents at that time when they were signing the consent form.

Q. We have heard that the Trust applied for accreditation with the King's Fund in 1995. Accreditation was achieved in 1997 and provisional accreditation, whatever that may mean, somewhere in between, 1996.

A. Mm.

Q. Were you part of the King's Fund's initial assessment of the Children's Hospital or were you still in cardiology at that time?

A. I was in ... In the initial one, I was in ... I think it was in the early part of the year.

Q. Yes.

A. In which case, I wasn't in the paediatric directorate as director at that point. But the sorts of things that came through from it were very generic and applied to all directorates in one form or another.

Q. Was there any particular weakness in paediatrics highlighted by that?

A. Not that I can recall.

Q. You mentioned communications with parents there as part of something that was mentioned by the King's Fund. Was there a particular interest of yours --

A. It was.

Q. And did you develop that interest when involved in

paediatric cardiology with heart transplant operations for children?

A. No, it really developed from my time in the Sick Children's Hospital in Toronto where I did my basic paediatric cardiology training and the example there of the time taken by staff to ensure that parents knew what was happening to their children and what the risks and so on were, was something that I brought back with me and developed further.

Q. Did you bring any of that learning to the Children's Hospital?

A. Well, I brought it to the paediatric cardiology part. I didn't disseminate it deliberately round the rest of the hospital.

Q. I'm wondering, did you have a sort of discussion or did you give a paper on it?

A. No.

Q. Would Mr Brown, for example, have come to learn about communication with parents through your interest or, indeed Professor Savage or anyone else involved in this case?

A. I don't think so at that time. I was concerned particularly in focusing on the development of the paediatric cardiology centre.

Q. Can I ask you now: can you remember when you first heard

of the death of Adam Strain?

A. I have no definite memory of hearing about it. I have a recollection that I had heard that a child had died following a renal transplant. But it didn't go any further than that. I wasn't involved in anything at that stage and my assumption was that anything that would be taken forward, firstly to the coroner, would have been overseen by Dr Murnaghan and that, as the anaesthetics director, Dr Gaston would be paying attention to the anaesthetic aspects.

Q. Would you have expected to receive, as clinical director, a report into this death?

A. I think it would have been appropriate.

Q. It didn't happen?

A. No.

THE CHAIRMAN: It would be appropriate because, if you didn't know very much, it would be unsafe for you to assume that if there was a failing, it was on the anaesthetic side? It might have been, for instance, something that the nephrologist had done wrong, which would come under your remit, wouldn't it? We're now looking back on this and saying: primarily, the finger's pointing at Dr Taylor. That's anaesthetics. But at the time when you didn't know very much, you couldn't assume or understand that that's the direction in which

responsibility was pointing. So that would make it important for you to receive information, would it not?

A. That is true.

THE CHAIRMAN: Mr Fortune?

MR FORTUNE: Sir, isn't this actually a question better directed to Dr Murnaghan? Because this witness has said, "I would assume".

THE CHAIRMAN: I think it is -- well, when Dr Murnaghan gives evidence, he will certainly be asked about this. But it seems -- I'm just clarifying. Mr Stewart asked this witness:

"Would you have expected to receive the report into this death?"

And Dr Mulholland says:

"I think it would have been appropriate, but it didn't happen."

I'm then teasing out why it would have been appropriate and I will certainly raise this when Dr Murnaghan comes to give evidence because we have to be careful that we're now looking back and there's bits and pieces of criticism of Dr Savage and others, but the focus is on Dr Taylor. But there's a question about how quickly that was known and whether, in fact, it was exclusively Dr Taylor or other things might have been done wrong, which is exactly, I think, Dr Mulholland,

why you agree that you should have been kept informed to a greater extent than you were informed.

A. I would agree with that, and, with hindsight, I should have been more active in pursuing it. But as we said at the start, I was director for cardiology and for paediatrics as well.

THE CHAIRMAN: I accept, as a basic point, you were very stretched.

A. Yes.

THE CHAIRMAN: Okay.

MR STEWART: Can I ask you now what, with hindsight, you could have done in being more active?

A. I think that I would have maybe added something to the analytical assessment of what was going on. But I would still stress that in the context of what we know now that it was Dr Murnaghan and Dr Gaston who were taking it forward.

Q. Yes.

A. And I had no qualms at that time that it was in the right hands for that.

Q. Can I ask for document 059-071-164? This is a note from Dr Murnaghan of 6 December 1995, about ten days after Adam's death. It is asking for statements as soon as possible from clinicians involved. This is circulated to Dr Savage, Dr Taylor, Mr Brown and Dr Gaston, Dr Webb

and Mr Wilson. As I understand it, within your directorate, there had been Dr Savage, Mr Brown. Dr Webb, would he have been part?

A. Yes.

Q. And indeed the death occurred in the Children's Hospital's operating theatre, so presumably the equipment is Children's Hospital equipment.

A. Mm-hm.

Q. So it's very much, at that time, notwithstanding the general knowledge pointing towards anaesthetics, very much within your directorate.

A. Yes.

THE CHAIRMAN: And could I just add to that? For these purposes, I assume that Dr Gaston is circulated because he is the head of ATICS.

A. Yes.

THE CHAIRMAN: Which begs the question even more: why is the head of paediatrics not included?

A. Okay.

MR STEWART: So you didn't seek a report? Did you feel that perhaps because doctors Murnaghan and Gaston were so versed in these matters, it was entirely proper that it's out of your hands and into the hands of those perhaps further up the structure?

A. I think it was a combination of feeling assured about

that and also having an agenda that was very full.

Q. Was this something that you felt that Dr Carson should have been informed about?

A. Yes, I would have thought he would have been informed.

Q. As a matter of routine?

A. Yes. I would have thought -- I mean, I wasn't in that level of the organisation, but I would have thought that it would have come to him in one form or another.

THE CHAIRMAN: Sorry, Mr Stewart, can I just ask one question: did you have any idea, doctor, in November/December 1995 about how long you would be acting director of paediatrics for? Do you remember? Was it likely that that was going to stretch on for another year, two years, or ...

A. There was some indication, I think at that stage that Dr Hicks was willing to take on the directorate and I would have expected to be handing over within a six-month period.

THE CHAIRMAN: By summer 1996?

A. Yes.

THE CHAIRMAN: I know it turned out that you stayed, I think, a little longer than that. But in December 1995, you were not therefore on the cusp of leaving or didn't see yourself as being on the cusp of leaving?

A. No.
MR STEWART: Were you kept informed of the developments in the six months or so after Adam's death?
A. No.
Q. Did anyone share with you the reports of Dr Sumner or Dr Alexander or the post-mortem report?
A. No.
Q. Did you take any steps to inform yourself or ask?
A. I didn't, and I regret that, but things moved on and kept changing, and I was responding to that.
Q. When was the first you heard of the inquest and the outcome, the finding?
A. Probably in the summer of 1996.
Q. Were you aware of the Arieff paper --
A. No, I wasn't.
Q. -- at that time --
A. I wasn't.
Q. -- because that had a general application, not just for major paediatric surgery or even lesser surgery, but really for all paediatric patients?
A. Yes.
Q. Do you think now that it might have been appropriate for that message in relation to the Arieff paper to have been brought back to the directorate when this death happened?

A. Yes, it would have been helpful.
Q. Were you ever contacted after the inquest to sound out your availability for a seminar, a symposium, a discussion, meeting about the Adam Strain case and any lessons that might have been learned?
A. No, the first I learned of that when was the papers were circulated to me in April with the --
Q. The inquiry papers?
A. Yes.
Q. Can we bring that up? 059-001-001. I think there may be a second page, 002, if that might be placed beside it. This is a note taken by Dr Murnaghan on the day of the conclusion of the inquest. He says:

"Generally, the outcome was satisfactory with a fair write-up in Friday's Evening's Telegraph. Other issues identified which relate to paediatric renal transplant services. Agreed with IWC ..."

I think that's Dr Carson.

A. Yes.
Q. "... structure and processes of paediatric renal transplant services green light ... should be dealt with as an RM issue ..."

I think that's "risk management issue".

A. Yes.
Q. "... and arrange seminar with HM, Mulholland, doctors

Hicks, Gaston, Taylor, Savage, O'Connor, Keane, Carson and Murnaghan present as soon as possible."

Do you have any idea what those structures and processes relating to the paediatric renal transplant services might be that he was referring to? We will ask him about that ourselves, but does that convey anything to you?

A. No, I don't really know what that refers to.

Q. Dr Gaston did talk about the structures that might have been addressed in that meeting. Before I leave that, were you asked, for example, that summer about your holiday plans or your proposed vacation dates?

A. No.

Q. I wonder if we can go to the transcript of Dr Gaston's evidence of 19 June 2012, page 124, line 8? I'm sorry, Mr Chairman. It's the same thing again. There's an error in my note of the transcript.

THE CHAIRMAN: It's the same transcript, but sometimes there's an original version and a later version, which don't have exactly the same page numbers.

MR STEWART: Dr Gaston felt that some of the structures in the directorate had perhaps derived from an earlier administration and that they had had the modern, more modern corporate structure overlaid and that there were problems deriving from that as to the gist. I stand to

be corrected if I'm wrong. Do you have any comment to make in relation to that and how it might have applied to the paediatric renal transplant services at the time?

A. I'm not sure that I have. It evolved, I understand.

Q. To what extent were you involved with the running of the Paediatric Renal Transplant Service? Because you have made reference to it in your second statement, WS243/2, page 4. Do you see there:

"The management and delivery was led and coordinated by the paediatric nephrologists in collaboration with the transplant surgeons. The directorate would only have been involved if there were any resource issues."

A. Well, that would have been my perception at the time, that it was an established service. It appeared to be running smoothly and the directorate might -- I have no recollection of it actually being approached, but the directorate might have been approached had there been a requirement for additional funding for further development.

Q. So "resource issues" is money?

A. Yes, or staff, which again has money implications.

Q. I suppose everybody was always asking for money.

A. Quite often.

Q. And you made reference earlier to the financial deficit.

A. Yes.

Q. So there wasn't much money for the renal transplant service?
A. Well, I don't recall it being requested.
Q. Just a couple of last questions. WS243/1, page 12. This is in relation to the learnings that might have been had from Adam Strain's case. Paragraph 33. You are asked:

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

Can I ask you a bit more about the "Possibly, yes".
A. Just that if there had been a clear-cut decision by those involved as to what the factors were that needed to be disseminated, then it is more likely perhaps that they would have been disseminated.
Q. Do you recall any disagreement in relation to the view between Dr Taylor and anyone else in relation to the findings of the inquest?
A. No, I was not aware of that.
THE CHAIRMAN: Just to get it clear, you're completely outside the loop on Adam Strain, are you?
A. Yes.
THE CHAIRMAN: But on the general point, the question at 33

is asking whether it is easier to learn lessons if there is agreement on the inquest. I think, self-evidently the answer must be yes, but once the coroner returns the verdict, do you think that the hospital has any discretion about whether it accepts or rejects that verdict in whole or in part?

A. I would have thought that there would need to be a very strong reason not to do so.

THE CHAIRMAN: Right. And I asked you that in terms of the hospital, but let's break it down a bit.

Within the hospital, as you have probably gathered from the evidence today and before, there was one doctor, namely Dr Taylor, who did not accept the verdict completely.

A. Mm-hm.

THE CHAIRMAN: But the other doctors involved did accept it. Would you agree that in that situation it is necessary for the dissenting doctor, if I can describe Dr Taylor as that, to either persuade his colleagues that the coroner's got it completely wrong or else accept the verdict and then enable everybody to move forward on the basis of that verdict?

A. I think that that would be the best possible solution. But it could be that the Trust took a view that this is something that needs to be acted upon --

THE CHAIRMAN: Okay.
A. -- and therefore go ahead.
THE CHAIRMAN: Well, in terms of needing to act upon it, what appears to have happened is that a statement was prepared and given to the coroner with input from doctors Gaston, Taylor, Crean and McKaigue. So you have the head of ATICS and three paediatric anaesthetists who prepare a statement, which doesn't go beyond the paediatric anaesthetists. It doesn't, for instance, go to any of the junior doctors, so it doesn't contribute to the learning of the junior doctors. And it doesn't go beyond the anaesthetists more broadly within the paediatric directorate. Does that seem to you to be inadequate?
A. I was trying to think as to whether, had I been involved in it, I would have taken the view that it should go further than that. But I'm not sure, given the argument that was put up at the time, and which was generally understood, that paediatric surgery was being done in the Children's Hospital and that that is where the major operations took place. I might have been persuaded that it was sufficient to pass it round.
THE CHAIRMAN: Yes, but that would be the outcome of a debate which goes beyond the paediatric anaesthetists. That might be the outcome of a debate in which you're

involved as the acting director of paediatrics and in which other senior staff in paediatrics are involved. You might have that meeting and you might conclude when, in fact, there's a narrow view to Adam Strain's death, so it's enough for any lesson to be learned in paediatric anaesthesia. But that debate never took place, sure it didn't.

A. No.

THE CHAIRMAN: And that can't be good enough, doctor, I suggest.

A. Yes.

THE CHAIRMAN: Do you agree?

A. I agree, yes.

MR STEWART: Moving on down the page to number 35:

"Please state whether there existed a formal approach to: (a) assessing and developing the competence of the staff involved in the treatment that led to Adam's death; (b) disseminating outcomes and lessons learnt internally both before and after the inquest. I am unsure how formal and standardised it would have been, but for (a) and (b) there would have been a process."

Can I ask you what you meant by that answer? What the process might have been first of all for assessing the competence of the staff?

A. Well, there would have probably needed to be an outside clinician or clinicians involved in that. I can't remember when the National Centre for Clinical Assessment came into being. It was around about that time where they would give advice to chief executives, to medical directors and to other doctors about situations if there was a concern and it would be looked at in conjunction with the Trust. Out of that, a decision would be made: there isn't a problem here, carry on the way you're doing; or somebody needs retraining or this is a more major problem; or it's a systemic problem and you need to address it. And that is the system that would now exist. So that would be the sort of assessment, maybe not in the full form that I've set out now, but --

Q. Was there an earlier process known as the "three wise men"?

A. Yes, I've heard of it.

Q. You've heard of that?

A. Yes.

Q. Just heard of it in passing or do you know something about it in theory?

A. Well, it would have been three senior experienced, relevant consultants who would come together to discuss a particular problem and advise the chief executive as

to their conclusions about it or what might be done.

THE CHAIRMAN: Were you ever a wise man?

A. Was I ever?

THE CHAIRMAN: A wise man.

A. Not very.

THE CHAIRMAN: Okay.

A. I've been involved in one or two things like that, but much more recently.

THE CHAIRMAN: Okay.

MR STEWART: Finally, (b):

"There may have been a process for disseminating lessons internally."

What might that process have been?

A. Well, I think it's deciding what the lessons are and circulating the information to directors and having it cascaded down, and if necessary, holding a training session for staff to underline it. Those would be the sort of things I would imagine.

Q. Did that sort of thing happen in the Royal Group of Hospitals Trust at that time?

A. Not that I can remember.

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

THE CHAIRMAN: Can I pick up a broad issue with you? It's about the evidence you gave a few minutes ago about how it wasn't unique in your experience that the consent

guidelines didn't really make their way down and find themselves being implemented. I think you said that you have experience over the years of a number of other examples where there was that sort of feeling.

I assume that you could, when you were working in the Royal, have papered your walls with all sorts of guidelines and notes and so on. But at the time when you retired, was it still a problem about implementing centrally-issued or departmental-issued guidelines and protocols and so on?

A. No, very much less so.

THE CHAIRMAN: Okay.

A. The situation has changed in that the whole process of assessing doctors on an annual basis, consultants, and what is required within the trust for different things, that is much more now a rigorous process, and the expectation is that things which are expected to happen should happen. It often takes some time to push through to get close to full involvement in it, but it certainly --

THE CHAIRMAN: Well, how would that affect, for instance, new consent guidelines being issued or the hyponatraemia guidelines being issued? How would that be picked up in the annual assessment of consultants?

A. Well, the clinical directorate -- the clinical director

does an annual assessment of everybody. This is part of what goes into, ultimately, the re-validation of doctors. And if there were issues where it was clear something like this had not been complied with by individuals, then that goes down on a record and would be acted upon.

THE CHAIRMAN: Is that assessment carried out internally within the Royal?

A. Yes.

THE CHAIRMAN: Right. But let's suppose the Royal has not cascaded down to those consultants the new consent forms or the hyponatraemia guidelines or, I'm sure, various other documents. Then how would you hold it against a consultant that he or she wasn't familiar with something which had never reached him?

A. Well, I don't think it could be then.

THE CHAIRMAN: No, but that's what I'm getting at. I can understand that if the hospital has clearly and definitively introduced, to take this example, the consent guidelines and the doctor's being assessed at the end of a year but is unaware of the consent guidelines, that would be the failing on the doctor's part.

A. Yes.

THE CHAIRMAN: But that wouldn't be a failing if that had

never reached him. So what I'm concerned about, because it's a general issue for the inquiry, is what better systems have developed or should be developed to make sure that guidelines or consent guidelines, hyponatraemia guidelines or other guidelines do make their way down to the people who are taking consent from Debra Slavin or Mr and Mrs Ferguson in Altnagelvin or Mr and Mrs Roberts in the Royal?

A. I think this is one of the things that, again, an audit committee could usefully take part in, that you could -- and again, this depends on having staff, not necessarily clinical staff, but also audit staff, who would do an audit of a hundred charts from one surgical area or another through the year and see what degree of compliance there was within that. That would be reported back up.

THE CHAIRMAN: Right. Okay.

MR STEWART: I'm asked if I can ask for you to confirm, please, your date of retirement.

A. 2003.

MR STEWART: Thank you.

THE CHAIRMAN: Ladies and gentlemen, any questions for Dr Mulholland? No? Ms Woods?

Questions from MS WOODS

MS WOODS: Just one matter, very quickly.

Dr Mulholland, you say that you now think it would have been appropriate to have received a report or reports about Adam's death. Just so I'm clear, did you as clinical director seek any such reports?

A. No, I didn't.

Q. You've given some reasons about that. You knew other competent people, apparently competent people, were looking into the matter. Would that also have been in part because in 1995 there were within the trusts no protocols, policies, guidance, call it what you will, with regard to clinical directors seeking reports in cases like this, or indeed clinicians or any member of staff providing reports in cases such as this?

A. I certainly wasn't aware of any definite guidelines or requirements.

MS WOODS: Thank you.

THE CHAIRMAN: Mr Simpson, this is your witness. Are you content?

MR SIMPSON: Yes.

THE CHAIRMAN: Thank you very much for your time, doctor, you're now free to leave.

I don't think, Mr Fortune, there's any point in starting Professor Savage at 4.10, given that the stenographer will want a break after an hour and a half. We will get through his evidence tomorrow.

MR FORTUNE: Sir, can I have a realistic estimate? Because I have to say that some of the estimates I've been given in the past have proved unreliable.

THE CHAIRMAN: We're getting better.

MR FORTUNE: Well, it's Friday, and I see that learned counsel, leading counsel, has just arrived. Perhaps leading counsel would like to give us her best shot.

MS ANYADIKE-DANES: I thought we might start early.

MR FORTUNE: 9 o'clock?

THE CHAIRMAN: That will lead to an outcry. We'll start at 9.30, as you asked. I think I have seen lines --

MS ANYADIKE-DANES: Yes, you have.

THE CHAIRMAN: It certainly should not go before the afternoon break and I would hope that it might finish before then.

MR FORTUNE: I'm not quite sure. "It certainly should not go before the afternoon break"?

THE CHAIRMAN: Sorry, I meant he should not go beyond the afternoon break, which is about 3.15 or so. I'd be hopeful to get Dr Savage's evidence finished before then.

Mr Simpson, could I remind you, that there's a query from this morning about the DLS letter about what would have been discussed. I think it'd be helpful if it's at all possible to have that answered tomorrow because

we'll need it, not so much for Dr Savage, but for next week's witnesses.

MR SIMPSON: We certainly will, yes.

THE CHAIRMAN: Thank you very much. Tomorrow morning at 9.30.

(4.15 pm)

(The hearing adjourned until 9.30 am the following day)

I N D E X