Thursday, 6 September 2012

(10.00 am)

THE CHAIRMAN: Good morning and welcome back to Banbridge.

Since the hearing adjourned on 27 June, there has been a two-day search in a warehouse in Mallusk of Trust documents. That search was conducted by inquiry staff and what they were particularly searching through were files which were Trust files, but from the former firm of Brangam Bagnall. As part of that exercise, the Brangam Bagnall files were separated by the Director of Legal Services, who facilitated the search, from private client files, which were the property of Brangam Bagnall. For instance, if Brangam Bagnall had done a careless driving case for somebody or a personal injuries case for somebody, those files were separate from the Trust files.

I should put on the record that one of the issues we were looking for was to ensure that there was a clear demarcation between Trust files and private client files so, for instance, we didn't see private client documents leaking or bleeding into Trust files.

And that indeed was the case with the exception of, I think, two or three files. There was a very clean demarcation, which encouraged us to believe that the files which we saw from Brangam Bagnall were the

complete files in that warehouse. As a result of that search, there are some outstanding issues, a few outstanding issues, between the inquiry and the Trusts, through the Director of Legal Services, about relevance and privilege.

However, those issue relate to a relatively small number of documents and I will keep you updated on how those discussions conclude. We have received some additional documents from DLS and the issues, as I've indicated, are confined to just a very few points.

Perhaps most significantly, we did not find any further notes from in and around June 1996 when Adam's inquest took place. You'll appreciate the significance of that because, when we adjourned in June this year, it was because a consultation note had emerged from 14 June 1996, which had information in it which appears on its face to be different from some of the evidence which has been given to the inquiry to date.

As I say, there is no further documentation from around that time on any of the files which have been inspected. Accordingly, the witnesses who will be giving evidence today and over the next few days will find that their questioning is focused on that 14 June 1996 document and I want to push on as quickly as possible this morning with that evidence. We have

a busy schedule. I would like to get through all three of the witnesses who are here today, if at all possible, and trying not to have to recall Dr Taylor tomorrow.

There may be some other issues, either about the continuance of Adam's case or about further issues beyond Adam and into Claire and so on. While I'm happy to deal with those, I hope that in the first place they can be discussed with inquiry counsel and solicitor who are here, and then anything which is still outstanding can be raised with me tomorrow or early next week. So having said that, unless there's any immediate issue which has to be addressed, I will ask Ms Anyadike-Danes to call Mrs Neill to give evidence.

MS ANYADIKE-DANES: Thank you very much, Mr Chairman. I think actually my learned junior, Mr Stewart, is going to deal with that evidence. Thank you.

MRS HEATHER NEILL (called)

Questions from MR STEWART

MR STEWART: Good morning. Thank you for coming. You have kindly supplied the inquiry with "Responses to witness statement request" and this is at WS260/1. May I ask you: are you content that the inquiry should take the evidence contained in this document as part of your formal evidence today?

A. Yes.

Q. Thank you. You have also kindly supplied the inquiry with a copy of your CV, which appears at 306-093-001.
A. Yes.
Q. There's page 1. I wonder if you can go to page 2. Here you set out your background, educational qualifications. Of relevance to the issues we're going to be discussing this morning are your level of educational attainment and your proficiency in English language and matters of chemistry and science.

I see also that you studied, at the University of Oxford, jurisprudence?
A. Yes.
Q. Which college was that?
A. University College.
Q. And did you, in the course of your chemistry A level, did you there gain knowledge of the sort of notational symbols used for the elements in chemistry?
A. Yes.
Q. If you could go over the page, please. You'll see that after university, from September 1985 to October 1986, you entered training as chartered accountant. That lasted only a year. Did you not like that?
A. Not really, no.
Q. And did you find more to your taste working for the Director of Legal Services at the Central Services

Agency?

A. Yes.

Q. What sort of work were you engaged in during that period from 1987 through to 1995?

A. General office work. I started off as a grade 2 clerical officer and finished as a grade 7 manager. General office work and particularly working on medical negligence cases where we would have been providing the defence.

Q. And were you involved in all stages of that litigation?

A. Yes.

Q. And were you engaged, in those years, in attending consultations, taking notes and taking instructions?

A. Yes.

Q. You have noted that you were instructed by the Director of Legal Services. Who was that director?

A. That was George Brangam.

Q. I see then that you go in March 1995 to work as the office and litigation manager for Messrs Brangam Bagnall & Co solicitors. Was that when you moved with Mr Brangam?

A. Yes.

Q. There we are. And in the office of Brangam Bagnall, were you engaged in different sorts of work or the same type of work?

A. It was basically the same. There would have been some private cases as well, but I was still primarily involved in the medical negligence cases.
Q. Did you find that your background training in law had any relevance to your work there?
A. It probably helped with just the -- well, obviously in dealing with cases and preparing proceedings, drafting proceedings, briefing witnesses, taking statements.
Q. Did you work closely with Mr Brangam?
A. I did, yes; he was the senior partner.
Q. The consultation with which we are concerned occurred on 14 June 1996. Can I draw your attention to page 122-001-006? This is the final page of that consultation note and there is, beneath the place for the date, a reference "HN/GMcC". Can I ask what that reference is?
A. It's a typing reference. "HN" is myself as the creator of the note and "GMcC" would have been the typist.
Q. Are you satisfied that this is likely to be your note of a consultation?
A. It would appear to be.
Q. Was there anyone else in Brangam Bagnall's office who might have shared your initials?
A. No.
Q. And on the same day, you took a note of an inspection of

equipment; is that correct?
A. Yes.
Q. And again, it bears the same reference and initials.
A. Yes.
Q. Do you have any recollection of an inspection of equipment?
A. I do have a vague recollection of that meeting at the Royal.
Q. What is that recollection?
A. Just very vague in relation to the fluid issues. For some reason, that has stuck in my mind.
Q. In the course of your work with Mr Brangam, was it a regular occasion that you attended consultations with doctors?
A. Yes.
Q. And prior to 14 June 1996 had there ever been any complaints about your note-taking or your taking of statements?
A. No.
Q. And did you ever take statements or notes by yourself?
A. Yes.
Q. Would it be fair to say that Mr Brangam trusted you in that regard?
A. I would think so, yes.
Q. In relation to the process that you adopted for creating

a typewritten note of a consultation, can you describe how you initially took a note of what was said?

A. I would have taken handwritten notes during the consultation.

Q. Would that have been longhand or shorthand?

A. Longhand.

Q. And then what would you do with those handwritten notes?

A. When I got back to the office, I would have dictated a note and would have tried to bring together issues because, during a consultation, you can wander from one point to another, but whenever I was going through to do the typewritten note, I would have tried to keep all the issues together and would have scored through the handwritten note as I dictated each piece.

Q. And your typist would have been within the office?

A. Once it was dictated, it would have been dictated into a Dictaphone and then they would have transcribed the tape.

Q. When the typing came back from your typist, would you have at that stage proofread it?

A. I would have read over it, yes.

Q. Would it have been proofread by Mr Brangam?

A. No.

Q. What would you have done with the typed note at that stage?

A. The notes were really just kept on file in the office. They weren't a transcript; they were simply a note of the consultation to be referred back to at a future stage if required or, if there were future consultations, they may have been brought along to those.
Q. So they were for reference?
A. They were for reference, yes.
Q. What would you have considered the object of your note-taking exercise really to have been?
A. To have a record of the consultation, of the main points which could be referred back to at a future stage, issues may be clarified later if need be.
Q. Can you say whether or not any comment, critical or otherwise, was ever made in relation to the accuracy of your work?
A. I don't think it was ever complained about.
Q. Do you have any recollection of attending any consultations in respect of the Adam Strain case apart from the one indicated in this note?
A. No.
Q. Did you know Dr George Murnaghan?
A. Yes.
Q. Do you have any memories of the staff of the Trust?
A. I knew Dr Murnaghan.

Q. Would you have attended consultations or meetings with him before this occasion?
A. Yes.
Q. And after?
A. Yes.
Q. How often would you have gone to the hospital to take notes and to attend upon meetings?
A. At the hospital, there would be a limited number of consultations; most consultations would have taken place in the Bar Library.
Q. Yes. Did you also take the note of the inquest into Adam Strain's death?
A. Yes.
Q. And these notes start at 122-044-003; is that your handwriting?
A. It is.
Q. Would you have had these notes typed up?
A. No.
Q. What was the purpose of you taking this note?
A. I would have taken notes at any hearing I attended. Really, if any issues arose during the hearing that people wanted to refer back to or discuss during the course of the hearing.
Q. Is there any possibility that you could have invented material to have been inserted into a note of

a consultation?
A. No.
Q. In terms of whether or not you might have correctly comprehended what was being said, what comment --
A. It's possible that I may have misunderstood.
Q. In relation to the particular consultation note -- and can I ask that we turn to page 122-001-005 and the sixth paragraph down?

"A query was also raised whether the new kidney had been properly perfused."

Three lines from the bottom, there is a reference to:

"... failing to operate a needle, which was put into the artery and no blood coming out."

In terms of comprehension and record, how would you describe that sort of information?
A. It would have been my understanding of what was said during the consultation.
Q. Do you have any other recollection of Adam Strain's case?
A. I don't, no.
Q. The note itself appears to, at one stage, be a series of points -- 1, 2, 3 and then 4 -- starting at the top of the page we're on now. Then it seems to move into a general discussion between the doctors present. In

terms of creating this note, were you guided by chronology or theme?

A. It would have been the theme really.

Q. In terms of the overall note, for example, it starts -- this is page 001-001 -- with a note of those in attendance. And it notes that Dr Savage -- as he then was -- joined the consultation after 10 to 15 minutes. Then we find, on 004, Dr Savage contributing to the discussion halfway down page 004, "Dr Savage commented". Can I ask: would halfway down page 4 represent, chronologically, when Dr Savage arrived and made his first contribution or simply be a thematic --

MR FORTUNE: Sir, I hesitate to rise. I have listened to, as we all have, a series of leading questions. If my learned friend had, in fact, asked, "What is your recollection of this meeting? How did this note come about?", we would have no objection. But the way this portion of the evidence is being dealt with is objectionable and very leading.

THE CHAIRMAN: Sorry, he did ask if she had any specific recollection and she has no specific recollection of this consultation. So he has asked a number of questions around that as to whether she was guided by theme or whether it's chronological and so on. I'm curious about your suggestion that these are all leading

questions. These are not a series of leading questions; these are exploring the circumstances in which this note, in which Mrs Neill came to be there, what her experience was, how she typically moves from having handwritten notes to preparing a coherent written record for future purposes. I don't regard any of these questions as offensive or objectionable.

Mr Stewart?

MR STEWART: Thank you. In terms of the note on page 5, 005, that sixth paragraph we were looking at. You gathered, you say, themes, thematic contributions together. If it were to be suggested to you that material might have been left out of your record, what would be your response to such a suggestion?

A. It's possible, but my aim was to record the main points of the consultation and the main issues discussed.

THE CHAIRMAN: Is that why, when you dictate your handwritten notes -- say in your handwritten notes, a point arises on page 2 and page 4, as you dictate those, you would put those two aspects of the point together and, I think you said, you put a line through those paragraphs on page 2 and 4 of your handwritten notes --

A. Yes.

THE CHAIRMAN: -- so that when you have reached what you

think is the end of your dictation, your handwritten notes in front of you should have ticks through all the different parts of the handwritten note to confirm that you've included everything?

A. Yes.

Q. And arising from that, what would have happened to your handwritten note with the strikings-off of paragraph after paragraph after the typewritten copy came through?

A. Once the typewritten copy came through, I probably destroyed the originals.

Q. During the course of proofreading the typed copy, might you have had recourse to your handwritten?

A. Because the typewritten one would have come back very, very quickly it was probably fresh in my mind, and if there was anything I wasn't sure about, I would have gone back to the handwritten ones.

Q. Okay. You left the employ of Brangam Bagnall in November 1998, working then in a surgery in Carryduff. Then you returned again to work for Mr Brangam or for Brangam Bagnall in October 2001, this time as a legal executive. Can you describe the circumstances of your return to Brangam Bagnall's employ?

A. I was moving to County Meath, my husband had got a job in County Meath, and I had phoned Mr Brangam to do our

conveyance and he had sort of said they were very short-staffed, so I said I would come in for a few hours a week just until they got the move sorted.

Q. So he took the opportunity to entice you back?

A. Yes.

MR STEWART: Thank you very much indeed.

THE CHAIRMAN: Right. Does anybody have any issues which they want to raise with inquiry counsel about questions for Mrs Neill? No?

In that event, Mrs Neill, thank you very much for taking the trouble to help the inquiry and you are free to leave. Thank you.

(The witness withdrew)

MS ANYADIKE-DANES: Mr Chairman, I wonder if we might call Dr Taylor, please?

DR ROBERT TAYLOR (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning, Dr Taylor.

I wonder if we could bring up the document, which is the note of the consultation on 14 June. Its reference is 122-001-001. Firstly, Dr Taylor, have you discussed this consultation note and any of the issues that arise out of it with any other witness in this inquiry?

A. No.

Q. Or with anyone other than your legal team in this

inquiry?
A. No. My family and my legal team.
Q. Have you ever seen it before it was released in June of this year?
A. I don't believe so, no.
Q. Does that mean you could have seen it?
A. It's possible I could have seen it, but I don't remember seeing it.
Q. I understand. Were you aware of whether there were other notes of meetings which you attended?
A. I can't remember. I'm not aware of other notes, no.
Q. Did you yourself make notes of any of the meetings that you attended to discuss the issues arising out of Adam's death or the preparation for the inquest into his death?
A. I can't remember making any notes and I've checked through my records and I haven't found any notes. So ...
Q. Did you prepare any documents for this meeting of 14 June?
A. I don't think so, but I can't remember.
Q. Do you recall this meeting of 14 June?
A. I recall there being a meeting, but I don't recall what was said and the detail of the meeting.
Q. Do you recall what the meeting was for?
A. I recall there being a meeting before the inquest for

people to get together to prepare for the inquest. I believe I recall that there was a meeting for that purpose.

Q. What do you mean by "prepare for the inquest"?

A. To prepare the legal ... For the lawyers to -- Mr Brangam to meet with me and others to prepare for the inquest and be told what -- when the inquest was about. I rarely give evidence at inquests and, as a junior consultant at that stage, I hadn't been to very many inquests, so I believe it was to prepare me for the purpose, what was expected of me. That sort of preparation for an inquest. That's what my recollection is.

Q. I understand. And did you think that part of it also might be an opportunity to hear what the clinicians who were primarily involved in his care had to say about what actually happened?

A. Well, I don't remember that being the purpose of the meeting, but I've read the paper and it appears that that was a purpose for the meeting.

Q. And do you recall that that's what happened?

A. I don't recall the details of the meeting.

Q. But do you recall whether people at the meeting shared their thoughts about what had happened to Adam and why it might have happened?

A. I don't remember that detail of the meeting.
THE CHAIRMAN: Does reading the note suggest to you that that's what did happen?
A. Reading the note suggests that that's what happened, yes.
MS ANYADIKE-DANES: Before we go into that point, can I ask you about something that you said before? You said that you had not discussed the note or the issues that arise out of it with anyone apart from your family and your lawyers. Why is that?
A. I don't understand.
Q. Why haven't you discussed it with anybody?
A. With other colleagues?
Q. Yes.
A. I didn't.
Q. I know you said you didn't; I'm asking you why you haven't.
A. It's not the sort of thing I would discuss.
Q. Well, given that you don't recall it very well yourself, why didn't you seek to see what others made of it?
A. I don't know.
Q. You said that now that you've read it, you see that one of the things that did happen in the course of it, at least one of the things that is recorded as happening in the course of it, is that those present, certainly

the clinicians, aired their views about what they thought had happened and why; do you accept that?

A. I accept that.

Q. Yes. Do you have any reason to doubt, as you read this consultation note, that that actually is what was happening?

A. That we talked about Adam's clinical course --

Q. And your views about it, yes.

A. It appears to be, yes.

Q. Yes, but do you have any reason to doubt that that's actually what happened?

A. I have no reason to doubt that's what happened.

Q. No, but you simply say you don't remember it.

A. I don't remember it.

Q. I wonder if we could pull up the transcript for 21 June, page 70. If you look at the top --

THE CHAIRMAN: This is Dr Taylor's evidence?

MS ANYADIKE-DANES: You're quite right, Mr Chairman.

This is your evidence. I have asked you some questions about what your colleagues thought and what you discussed, and now the chairman is asking you a series of questions.

The chairman is asking you whether you would have made enquiries either directly with your colleagues to find out what they were saying to Dr Murnaghan. And you

concede that that's all eminently sensible, that you're sure that would have been, but the upshot of it is that you can't remember what was happening then.

If you see the bit in the middle:

"It does seem sensible to me."

Then the chairman picks it up at line 25:

"Let me put it this way: you were robust, as I've said in your defence, that this was not dilutional hyponatraemia and that the experts were getting it wrong; right?"

Then you seek to clarify that. Then at line 9, the chairman picks it up:

"Well, if there had been a meeting with a group of people sitting around a table -- for instance Dr Murnaghan, Dr Gaston, maybe Dr Carson, maybe Dr Crean, Dr Savage, Mr Keane, Dr O'Connor -- this then would have been a meeting at which are there would have been the frank discussion where some 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 difficult for you, that your view was not supported by your colleagues -- would such a meeting have stuck in your mind, do you think?"

And your answer to that at line 21 is:

"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."

So there you're saying to the chairman that if you had had a meeting where you were faced with people who perhaps disagreed or actually disagreed with your understanding of what had happened, that you would have recalled that meeting. In fact, many things you don't remember, but there you say you're absolutely certain you would have recalled it. As we now go through this note -- and I understand you to not be challenging the accuracy of what is recorded -- and we --

THE CHAIRMAN: Is that right?

MS ANYADIKE-DANES: I think he said that he doesn't have any reason to.

THE CHAIRMAN: Can we confirm it? Doctor, I need to confirm this with you for the record. You've had a chance over the summer to look through this note.

A. Yes.

THE CHAIRMAN: Can you point to any significant error in the note?

A. There's one error that I certainly would feel is wrong. I can't remember what page it's on, but I think it's written down as "hypernatraemic". That is wrong.

THE CHAIRMAN: It's 004 and it is halfway down the page.

There's a paragraph starting "Dr Savage commented". Is it the first word on the next line, Dr Taylor?

A. I think that's not correct.

THE CHAIRMAN: Yes. It's almost certainly not correct that Dr Savage referred to "hypernatraemic"; he also almost certainly referred to "hyponatraemic".

A. Yes.

THE CHAIRMAN: Apart from that, is there any significant error or, in fact, any error at all which you can identify in the document, having had the summer to look through it?

A. As I said before, I can't remember what was said and who said it and what I said.

THE CHAIRMAN: Okay.

A. So if this is an accurate record of what was said, then I will accept that.

THE CHAIRMAN: Well --

A. I can't confirm it against my own memory.

THE CHAIRMAN: The notetaker has given her evidence. She doesn't particularly remember it. There's no reason why Mrs Neill should remember this consultation above other consultations. This is the note that she's prepared.

A. Yes.

THE CHAIRMAN: Mr Brangam is unfortunately dead. He can't give evidence about it. We're going to ask the

witnesses who were there to identify any errors which they can see in the note. Accepting that you don't remember any of the detail of this meeting, or beyond that there would have been a meeting --

A. Yes.

THE CHAIRMAN: -- what I'm asking you is: over the six pages of this note, can you identify anything and say, well, look, that couldn't have been said, that just is completely wrong and therefore I don't think it was said at all? You understand the point I'm getting at?

A. Yes, I understand. There's another error on this page, which I think isn't an error, but it was a confusion, and it was picked up by Dr Haynes. If you read on to what Dr Gaston felt, two lines below what is highlighted, it says:

"Secondly, was this the most appropriate fluid to use. The other options being 10 per cent dextrose and saline ..."

I think what was intended would be "either 10 per cent dextrose or saline".

THE CHAIRMAN: So the "and" should be an "or"?

A. I think it should be an "or" because Dr Haynes picks up in his response to a question on this topic and he said that 10 per cent dextrose in saline -- and that's the type of fluid that we now use -- but I do not

believe it was available at that time.
THE CHAIRMAN: Okay.
A. So that seems to be, possibly, a transcription error.
THE CHAIRMAN: Yes.
A. Dr Gaston could answer that better.
THE CHAIRMAN: In other words, whether it's a typographical error or whether Mrs Neill didn't quite pick it up exactly, the gist of what she's recorded is accurate. I mean, as I understand what you're saying, that sentence should be there in the note --
A. The sentence should be there.
THE CHAIRMAN: -- but there's a word in it which changes its meaning and makes it incorrect?
A. Correct. And if you look again at it, it says, "The other options". So that suggests there's more than one other option. So to me, it reflects that there should be two types of fluid that were alternatives rather than one bag of fluid that contained dextrose and saline.
THE CHAIRMAN: Okay. Thank you. But beyond that error?
A. The other bit that I feel is problematic from my memory and doesn't make sense to me is the bit that obviously you're coming to, which is the bit about the needle in the artery and the reason to -- it didn't matter anyway. In 05, I think it's halfway down.
THE CHAIRMAN: It is in 05 and we'll come to that. Before

we get to 05, because I'm sure Ms Anyadike-Danes has a number of questions to ask about that, in the preceding pages of the note, the mistakes which you've identified are on page 4. There's a reference to "hypernatraemic", which should be "hyponatraemic", and then there is the reference you have just given us to either an inaccurate transcription or a slight misunderstanding on the part of Mrs Neill when she prepared this note.

A. Yes.

THE CHAIRMAN: And then we go on to page 5.

MS ANYADIKE-DANES: Sorry, just to pick up where the chairman was then. I think you have said it yourself. If you're on that 004 page, that sentence which includes the bit where you say that you think there's an error, it says:

"The other options being ..."

And I think you were saying that lends support to the fact that actually what should have been there is "10 per cent dextrose or saline", that constituting two options?

A. I believe that's what I would have picked up from it.

Q. So it looks like -- anyway.

A. Dr Haynes actually is more confused by that, and he says "10 per cent dextrose in saline", which clearly is yet

again a different representation of the same --

Q. But the "options" part, to you, is correct?

A. Yes.

Q. Thank you. So what I was asking you really is: if this happened in this way and you were faced with Dr Savage's view, which is different from yours -- and we'll come to that in a minute -- why are you not able to remember this?

A. Well, it was a long time ago and I've said I can remember there being a meeting, but I can't remember the details of the meeting and what was discussed.

Q. I appreciate that.

A. I do remember there was a meeting.

Q. I appreciate that, Dr Taylor. It's not really even the details that I'm talking about. As the chairman indicated, what his thought was in the transcript that I took you to, this would have been a difficult thing. Dr Savage is a man that you respected, you've talked about that in your evidence before, how you relied on him in certain respects because you knew he was there and you could contact him and that was a very important element for you in going into this surgery. So after the event and, unfortunately, the child has died, there is Dr Savage in a meeting, if this is correct, saying that he fundamentally disagrees with you in relation to

the fluid management. So if that had happened, how is it that you don't remember that?

MR UBEROI: Can I rise at this point? Perhaps if the witness could have his attention drawn to the extract, which I believe is being discussed, which ends:

"Although there was correct logic in how the fluid calculations were done".

And I would also take issue with the characterisation of the evidence given by Dr Taylor previously in the extracts quoted and the characterisation of this meeting, where the extract quoted talks about no one sitting Dr Taylor down and saying, "Sorry, we go with Dr Sumner, you got this wrong", and my objection, in a nutshell, is that that is not what is going on in this meeting of the Brangam consultation note.

THE CHAIRMAN: You say that there isn't that sort of direct confrontation which I was positing with the witness on 21 June at this hearing?

MR UBEROI: There isn't. There isn't that synchronicity between them at all, in my submission, and I object to the previous evidence being characterised in that way.

THE CHAIRMAN: But if we look at page 4, the bit which you corrected, the bit that you think is wrong on page 4, which is still up on the screen, the first bit which

says:

"Dr Savage commented that one could not argue against the point that there was hypernatraemic fluid overload."

Let's assume that that should say "hyponatraemic fluid". Dr Savage, at that point in the consultation, is saying that it is unarguable that there was hyponatraemic fluid overload. And your next entry is you were strongly of the view that there hadn't been a fluid overload.

Is that not a direct contradiction between you and Professor Savage? He's saying, in effect, one cannot argue against hyponatraemia; you're saying there wasn't a fluid overload. Isn't that a direct contradiction between you and the professor?

A. That's apparently so, sir.

THE CHAIRMAN: Yes. And when I was asking you, on 21 June this year at this hearing, if the direct contradiction between you and somebody like Professor Savage isn't something that would stick in your mind -- I put it in terms of sitting you down and them saying, "Look, Bob, we don't agree with you, we're going with Sumner". In slightly different words, is that not what that entry means?

A. I accept that.

THE CHAIRMAN: So this was in fact, to put it in terms, a head-to-head between you and Professor Savage, a few days before the inquest. Professor Savage is saying, "You can't dispute the fact that Adam suffered from hyponatraemia", and you're resisting that very strongly, in Mrs Neill's words, and saying there wasn't a fluid overload. This is a head-to-head confrontation, isn't it? If this note is right.

A. It appears to be.

MS ANYADIKE-DANES: So then the question was: how don't you remember that?

A. Sorry, how?

Q. Why don't you remember that?

A. I can't explain that.

Q. In fact, now that we're here, I was going to come to that in a slightly later part, but now that we're here I would like to literally pick up from there and ask you about another phrase that comes directly on that page. It's the third paragraph up from the bottom, where is says "Again".

So you're strongly of the view that there had not been a fluid overload. That's what this is about. It is not the issue of hyponatraemia; it is that it is hyponatraemia caused by fluid overload and that's the bit that you fundamentally disagreed with because that's

the dilutional hyponatraemia element.

Then if you look at what you say, what is recorded at the third paragraph from the bottom:

"Again, Dr Taylor was concerned to say that one could not conclude that there had been fluid overload."

Then it says:

"And it was confirmed that this phrase would not be used."

How did that come about?

A. I don't know how that came about.

Q. Well, did you have any argument in relation to it not being fluid overload that would persuade Professor Savage that he was mistaken in characterising it in that way?

A. I don't know.

Q. Sorry?

A. I don't know. There's no evidence on this document --

Q. No, but did you have any argument?

A. I can't remember.

Q. So what we have really is Dr Savage talking about fluid overload and hyponatraemia, which is essentially dilutional hyponatraemia, that's all along the path of Dr Sumner, Dr Armour and Dr Alexander for that matter, all of whose reports you have seen, and he is effectively aligning his view of how the hyponatraemia,

and therefore the cerebral oedema, occurred. He's aligning his view with them and you are saying it's not. And the culmination of this, which is a preparation to go into the inquest, is that it is confirmed that nobody's going to use the phrase or the term "fluid overload". Because if you use the term "fluid overload", that would mean that all of you were agreeing with the analysis and the views of the coroner's experts and the pathologist; isn't that right?

A. That would be correct.

Q. Because that's the only difference between you, isn't it, that dilutional element of it? There are other things to do with whether there was a constriction or whether there might or might not have been in relation to the position of his neck and so on and the ligature and all that sort of thing.

But leaving aside that element of it, at the heart of what they are saying is that the cerebral oedema was caused by hyponatraemia, which you accept. What's different is that they say that hyponatraemia is characterised as dilutional hyponatraemia and you say it's not; isn't that right?

A. I think so.

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

A. I think so, yes.

MR UBEROI: Sorry to rise. I'm not really sure what the purpose of the questioning is and what it's attempting to elicit. The clause that has been alighted on is the confirmation that the term fluid overload would not be used. Is Dr Taylor being asked whether he remembers who said that and why it was said? I'm not sure where the questioning is taking us.

MS ANYADIKE-DANES: Sorry, I am going to be asking that, yes.

What I was asking you was: at this stage, all that lies between your colleagues and agreement on the fundamentals with the coroner's expert and the pathologist is the element of dilutional; isn't that right?

A. That appears to be right on this, yes.

Q. And if dilutional is accepted, then that's fluid management, because dilutional means too much given. That's right, isn't it?

A. Yes, or it could mean water retained as in the Arieff description of dilutional.

Q. Not too much fluid given? Sorry, just for me to be specific about it. Dilutional in this context, so that we're clear, is the amount of fluid that was administered to Adam; isn't that right? That's what everybody's talking about.

A. I think so, yes.
Q. Yes. So if that's the case, then that would mean your management of Adam's fluids because you're the person who's administering the fluids.
A. That would be right.
Q. Yes. So if there's going to be a common agreement that the term is not used, isn't that actually a way of shielding the coroner from the position that, actually, we all appreciate and acknowledge that Adam died because too much fluid was given him, it's most regrettable, but that's what happened?
A. Sorry ...
Q. If you leave out the reference to fluid overload, if nobody talks about fluid overload, you can maintain an argument that whilst it was hyponatraemia, it wasn't dilutional hyponatraemia, then you maintain an argument that he might not have developed his hyponatraemia and his cerebral oedema and died because of anything to do with the quantity and type of fluid that was given to him.
MR UBEROI: Sorry, I am confused, I have to say, and I wouldn't blame the witness for being confused. The witness's point of view is in this note. Those are the arguments he was putting forward at the time and we've gone into them in great detail in the past. To the

extent that they were agreed with by anyone else in the meeting, those are matters that can be gone into with other witnesses. To the extent that someone else said it confirmed this phrase would not be used, then that is again something that could be asked of other witnesses. It doesn't make any sense to cross-examine Dr Taylor on this because that is the endgame of the arguments he was putting forward at the time, which he has gone into and given evidence on in the past. So the suggestion or the subtext of the questioning seems to be that this was something being deliberately hidden from the coroner. That doesn't follow from what Dr Taylor was saying in this meeting at all.

THE CHAIRMAN: Let me tease that out with you, Mr Uberoi. The position which is set out by Dr Taylor in this note is different from the position which he has now adopted in the inquiry; isn't that right?

MR UBEROI: In many respects, yes.

THE CHAIRMAN: So the outstanding issue for this inquiry for Dr Taylor, as I understand it -- and you'll correct me if this is wrong -- is whether the hyponatraemia caused Adam's death, but he does not dispute that he had dilutional hyponatraemia as a result of fluid overload.

MR UBEROI: Yes, sir.

THE CHAIRMAN: Okay. And the only issue about whether it

actually caused Adam's death or the extent to which it contributed to Adam's death actually comes, curiously, from Professor Kirkham, an inquiry expert.

MR UBEROI: Yes, sir.

THE CHAIRMAN: Right. So absent Professor Kirkham, the position now adopted by Dr Taylor is Adam did have dilutional hyponatraemia as a result of fluid overload.

MR UBEROI: Yes.

THE CHAIRMAN: Let's go back to 1996. At this time, Dr Taylor wasn't accepting or facing up to that position. He had a different position.

MR UBEROI: Yes.

THE CHAIRMAN: And that's what was between him and Dr Savage at this meeting, according to the middle of the page.

MR UBEROI: Well, he did have a different position, which we know not just from this consultation note, but we know from the evidence he went on to give as a matter of public record at the inquest. And going back to my previous objection, the way these questions are being framed and the implication seems to be that there was this clear attempt on Dr Taylor's behalf to obfuscate in front of the coroner, when, in my submission, that's not what emerges from this note at all. There's a comment from Professor Savage -- not in the fashion, in my submission, which was discussed in June in Dr Taylor's

evidence -- where Professor Savage makes his view plain. But no one is sitting Dr Taylor down and saying, in the manner of an intervention, "You have got this wrong; we go with Sumner". He is holding fast to his views. We know what those views are and were because they have been gone into in great detail in the past. And then we've moved on to this comment where someone says, "We confirm fluid overload wouldn't be used".

THE CHAIRMAN: But surely the point of this consultation, insofar as we can try, from our knowledge as lawyers of how cases are prepared for inquests or hearings, surely the point of this consultation is that a lot of the relevant people in the Royal are brought together a few days before the inquest, in effect to finalise the line which the Royal will take at the inquest? That would not be an unusual meeting of lawyers and doctors before a significant event like an inquest; right?

MR UBEROI: I'm actually not sure a lay client would necessarily agree with that description, sir, of finalising the line. Each lay client is there to respond to questions and give their instructions to their lawyer, which is what Dr Taylor did, and this note and the instructions he gives are then entirely consistent with the evidence he goes on to give at the inquest.

THE CHAIRMAN: Well, let me spell it out. The interpretation which appeals to me at this stage, subject to any other evidence which comes out over the next few days, is that Dr Savage is saying quite strongly, in the terms which he has said there, one could not argue against the point that there was hyponatraemic fluid overload. Dr Taylor is still saying, "No, that's not right". Then towards the end of that page, after the discussion, there is a further input from Dr Taylor in which he, in essence, reiterates his position and then the words are used:

"It was confirmed that this phrase would not be used."

"It was confirmed" seems to me, on an ordinary reading of English, to go beyond Dr Taylor saying something to an agreement among the people at that meeting that the phrase "fluid overload" would not be used at the inquest. That seems to me -- and I'll allow Dr Taylor to comment on this, and no doubt I will take submissions when the time comes in the not too distant future about this, but that seems to me to be an obvious interpretation of the words "It was confirmed that this phrase would not be used", that this was the Royal setting out its position with its witnesses for the inquest.

MR UBEROI: Yes, it does, sir, which brings me full circle to my initial objection about my surprise that the original questioning wasn't along the lines of: can you remember who said that? It could have been anyone. It could have been Mr Brangam or anyone else in that room. My point is that for someone to agree with that or make that point, be it Mr Brangam or anyone else, ironically is entirely consistent with Dr Taylor because that is the view that we know he held at the time. It may be inconsistent with other clinicians who are going to give evidence -- and they can be asked about it -- but it doesn't actually make any sense to me to cross-examine Dr Taylor along the lines of: well, the import of that sentence about the phrase not being used was effectively everyone signing up to obfuscate in front of the coroner, when it was consistent with the information Dr Taylor was giving at the time.

THE CHAIRMAN: Save that it also reads as if Dr Taylor had, to a limited degree, won the argument at the consultation to the extent that the others who were at the consultation agreed that they would not use that phrase during their evidence.

MR UBEROI: Yes.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: That actually, Mr Chairman, is why I was

asking Dr Taylor if he could identify the arguments that he mounted that would have led to the result being "We're not going to use that term". I invited him to do that. That is what I was doing with him to see what could have been said to bridge the gap, if I can put it that way.

MR UBEROI: Surely the arguments are in the note. They're self-evident. We have been into them in great detail in the past and the witness has already commented that he doesn't remember the meeting. So I'm not sure where that line of questioning is going to take us other than into further confusion.

THE CHAIRMAN: Mr Fortune?

MR FORTUNE: Sir, we've sat silently because, of course, Professor Savage has been clear from the word go that there was a fluid overload. He explained that to mum, he has been consistent throughout. And in respect of this phrase, "It was confirmed that this phrase would not be used", we are anxious that what is effectively being suggested is that there has been a conspiracy between the clinicians to avoid the use of the phrase "overload", in other words to mislead Her Majesty's coroner.

Professor Savage has never been party to that because he's been clear throughout as to the cause

leading to Adam's death.

THE CHAIRMAN: That's exactly why the witnesses are being recalled, Mr Fortune. Because this document, among other things, does raise that question.

MR FORTUNE: I understand why the witnesses are being recalled and I've only got to my feet because of the objection raised by my learned friend Mr Uberoi as to the line of questioning that has been put forward.

THE CHAIRMAN: Sorry, are you supporting his objection or ...

MR FORTUNE: Well, yes and no. "Yes" in the sense I'm concerned about how the questions are going, but I'm also putting down a marker as far as Professor Savage is concerned that there is nothing in that document that specifically identifies Professor Savage as agreeing to the use or the absence of the phrase "fluid overload".

THE CHAIRMAN: You're quite right. It just says "it was confirmed". So the question is: between whom was it confirmed? We know the people who were at the meeting.

MR FORTUNE: Well, if that's --

THE CHAIRMAN: And I will listen to -- I will certainly listen to his evidence. The purpose of recalling the witnesses is so that they can give their evidence, maybe re-emphasise evidence they've given before, give any new evidence which emerges from this note or from their

memory being shaken by this note and being able to add to their earlier evidence. But it would be simply wrong not to look at that sentence and at least wonder whether what that phrase meant was that there was some sort of agreement at the consultation, perhaps in order to save Dr Taylor's blushes.

MR FORTUNE: When you start using a word like "wonder", you're into speculation, sir.

THE CHAIRMAN: I'm sitting here to hear the evidence, Mr Fortune, to develop these ideas. And I have to say I'm surprised that you are raising this point. I would be negligent if I did not explore these issues with these witnesses. And frankly, I don't care how distinguished they are if there is a concern about how they approached the inquest. Because it is not only -- well, I won't go beyond that. It would be ridiculous for me to sit here today and over the next few days and not explore these issues.

MR FORTUNE: Sir, we're not criticising you for that. We're just anxious to -- well, you'll hear Professor Savage in due course.

THE CHAIRMAN: I will.

Can we move on?

MS ANYADIKE-DANES: Yes, we can indeed.

As a matter of fact, Dr Taylor, did you, when you

were giving your evidence to the coroner -- and we've only seen your deposition and the short note over it, although there is a longer note that was taken by Mrs Neill. But when you were giving your evidence to the coroner, did you alert the coroner to the fact that one of your colleagues, a nephrologist, who perhaps knew Adam's fluids the best, thought that there had been fluid overload?

A. Sorry, what's ...

Q. Did you inform the coroner that--

THE CHAIRMAN: Professor Savage --

MR UBEROI: Professor Savage gave evidence at the inquest.

THE CHAIRMAN: He gave evidence at the inquest --

MS ANYADIKE-DANES: Yes, I know that he did. I'm asking whether Dr Taylor, when he was giving his view, caveated with the fact that some of his colleagues hold different views -- the clinicians who are treating Adam, not the experts.

A. I can't remember what I said at the inquest.

Q. Okay. You've said that you don't remember the details of this. So I'm going to take you to certain things that are recorded and ask you for your view as to what is recorded.

A. Okay.

MS ANYADIKE-DANES: Before I do that, Mr Chairman, in ease

of yourself, when you were addressing Mr Uberoi, you put to him what the purposes of these sort of meetings that we know going into a proceeding such as the inquest. Mr Chairman, I didn't seek to set this particular meeting in the context of a series of meetings because I had done that before in June. But you will be aware that from at least 17 April, meetings were being arranged specifically with Dr Taylor to try and identify what his views were, specifically in relation to the reports of Sumner, Alexander and also the pathologist's report. We went all through that in June. I have the references, and that is why I didn't do it again. But there is no doubt, if one looks through it, that those meetings were all being arranged to try and see what the possible differences might be and how strong those differences were between Dr Taylor and those experts.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: If we could have this note up. If I can take you to 005 of it. Can we go to about halfway down? It starts "a query was also raised". And if we carry on down to:

"Perhaps 5 to 10 per cent of transplanted kidneys will not work."

Highlight that:

"A query was also raised about whether the new

kidney had been properly perfused. The kidney was not performing well and it was felt that more fluids were required. It was pointed out that one can get a situation where the new kidney just simply does not work and, in fact, perhaps 5 to 10 per cent of transplanted kidneys will not work."

I read you that to give you the full context, but if you can stick with the first two sentences, the queries being raised. Do you have any idea who might be raising such a query of the people who were at that meeting, which is Dr Murnaghan, Dr Gaston, yourself of course, Dr Savage about 10 to 15 minutes into the meeting, and then Mr Brangam, and presumably the notetaker, Mrs Neill? But of all those, do you have any idea who would be raising or was raising that query?

A. I don't know who raised that query and it doesn't become evident, when I read it, who raised the query.

Q. Then:

"The kidney was not performing well and it was felt that more fluids were required."

If that sort of response was given, who at that meeting would be giving it? Would it be you?

A. Well, it could have been me or it could have been someone who had read my note. I think I wrote in my note to the deposition that once the kidney was in,

I reassessed my fluids and felt that more fluids might be needed. But I don't think that's actually what I said in my deposition exactly. I don't think I actually gave more fluids after the kidney was in; I think all I did was reassess the fluids to make sure I wasn't behind. So --

Q. We can take you to what you said in your deposition.

A. Thank you.

Q. You say things at two points. One is at 011-014-108, which is in answer to a question from Mrs Higgins. You said:

"The new kidney did not work, leading to a reassessment of fluids given."

A. Yes.

Q. There it is in the middle. And then:

"This made us think we had underestimated fluid and we gave a fluid bolus at 9.32."

A. Although we now know that the kidney wasn't plumbed in until 10.35. So I think there's a -- the fluid bolus given at 9.32 was in relation, I believe, to the blood gas and the low haemoglobin count. So it was blood that was given as 9.32. I don't believe when I have gone through this that a fluid bolus was actually given after the kidney was, if you like, anastomosed or plumbed in, if you like.

Q. Yes. What I was asking for your help with is the statement that:

"The kidney was not performing well and it was felt that more fluids were required."

Is that actually correct? You had given evidence that the kidney wasn't performing well. Did you also form the view that, as a result of the kidney not performing well, more fluids were required; is that correct?

A. I think what I did when the new kidney was in and it wasn't performing well was to reassess my fluids. I don't think there was a fluid bolus given at 10.35, which was the actual time when the kidney was anastomosed to the blood vessels. So I think the fluid bolus given at 9.32 is out of sequence, if you like, with the time that the new kidney was not performing well.

Q. Well --

A. So I think all I did at the time the kidney wasn't performing well was to reassess the fluids to convince myself that I wasn't, in fact, behind with the fluids.

Q. If we go back to 003 on the consultation note, can you see the first line freestanding off the continuation of a paragraph:

"The kidney was not working and it was felt that

more fluids were required"?

What I'm trying to find out is: who is in the position to be able to be communicating that kind of information at this meeting? Is it you?

A. It would -- it could have been me, yes. It would appear to have been me, and yet it's not consistent with what happened at the time of surgery to my view, I don't think.

THE CHAIRMAN: Let's be careful to be fair to you, doctor. It could have been you, but it is virtually certain that before this meeting took place with the lawyers that the lawyers had also met Mr Keane and Mr Brown and that there must have been various discussions going on between the various doctors who were involved. So while it may have been that you did say at that meeting on 14 June that the kidney was not working and it was felt that more fluids were required, the first part of that may actually have come from notes of an earlier meeting, which are simply unavailable to us.

A. I see.

THE CHAIRMAN: One of the things we'll be looking at over the next day or two is it is likely, though not certain, that there had previously been a consultation with Mr Keane and Mr Brown.

A. Right.

THE CHAIRMAN: But they were not obviously there on 14 June. So there may have been information from other earlier meetings which was being fed into this meeting shortly after the inquest actually took place; okay?

A. I understand. Thank you.

MS ANYADIKE-DANES: There may be a bit of help from the inquest note. Mrs Neill also attended the inquest and she made a note of the evidence that was being given, which is obviously fuller than what the coroner took down. If one looks at 122-044-043, it's handwritten, so it might be a bit difficult to fathom. You can see just at the top there's Mrs Higgins who's asking questions. And then you see a "Dr T". Unfortunately, there's a hole there, but that is "Dr T". You're starting off talking about the CVP increasing. Then you see:

"New kidney not working."

Do you see that? Four lines down:

"New kidney not working. Consider that need more fluid. It became pink, but then paled. Fluids reassessed."

What I'm putting to you, or at least what I'm inviting you to help us with, is it seems in that consultation note you had linked together the new kidney not working with a concern that you needed to provide more fluid.

A. Well, that appears to be right, that I considered that more fluid might be needed, but I don't think actually any more fluid was administered, but it certainly would have been a time to reassess the fluid if the kidney was in any way dysfunctional.

MR UBEROI: May I rise simply to try and assist? I don't know if this is a potential way forward. If Dr Taylor could be asked what he thinks he would have meant when he says "new kidney not working there". And the phrase that was being discussed from the Brangam consultation note a few minutes ago was a separate example of the phrase "kidney not working". An example entirely separate from the most surprising paragraph in that note. So it's a subtly different collection of quotations and perhaps it might be better if we establish what ground we're on through Dr Taylor being asked if he can think what he means by "new kidney not working" as it appears in that note.

MS ANYADIKE-DANES: Yes.

What would you mean by that? What would you mean by the reference to "new kidney not working"?

A. Well, to me a kidney not working would be not producing a quantity of urine. That would be my interpretation of why a kidney worked or not.

Q. Okay. Can we look further down in this note, where it

says:

"When kidney did not function, the team discussed fluid and concluded we had underestimated and needed to give a bolus of fluid, acting on evidence before us."

This is your evidence to the coroner. So what did that mean?

A. I would need to go back to my anaesthetic record just to confirm if fluid was given at 10.35. My memory was that there was no bolus given at that time.

Q. We can, but at the moment I'm actually trying to discover what you meant by what you said.

MR UBEROI: Again, if I might assist. There might be some confusion over the vexed issue of fluid calculations is coming in at the end of that sentence. I'm only attempting to assist. As I understand it, my learned friend is probably specifically referring to, again, the phrase "when kidney did not function". And if the question could be broken up in that way, it might assist the witness in answering it.

MS ANYADIKE-DANES: I'm dealing with two things. I have asked Dr Taylor what he means by "the kidney did not function", and Dr Taylor has answered that by saying he thought it meant didn't produce urine.

THE CHAIRMAN: Let's double-check that.

When you said a few lines up in that note that "the

kidney not working" means that the kidney was not producing urine, is that the same as you mean when you say, "When the kidney did not function, the team discussed fluid", et cetera? Was that the same, "function" and "not working"? Is that the same thing?

A. I think so. I think I would understand a kidney working as it is performing its function, which is to produce urine, but I know also that a percentage of kidneys do not function for a while immediately after they are effectively anastomosed and arterialised. So the fact that it doesn't produce urine doesn't mean that it's never going to work, but it certainly would be a question raised by the surgeon and by the anaesthetist to ensure that the fluid is at least adequate to perfuse the new relatively large kidney in the space of a child's body circulation. So it would always lead to a reassessment of the fluids.

THE CHAIRMAN: Does that mean that when you used the term "the team", that the team there is you and Mr Keane?

A. I can't remember a discussion, but it would be very unusual for there not to be a discussion between the surgeon and the anaesthetist at the time of the anastomosis of a new kidney. That would be certainly a time when there would be a team talk.

THE CHAIRMAN: So on that interpretation, the kidney was not

functioning or working in the sense that it was not producing urine. The team, you and Mr Keane, discussed that.

A. And presumably a nephrologist. Usually the -- my usual practice would be for a nephrologist to be present at this key point of the transplant where the kidney is -- the clamps are released, if you like. That's the key point when the nephrologist would also want to be there to give the immunosuppressant drugs and to watch the kidney perform. So it may well, although I can't remember, include a nephrologist as well as the surgeon and the anaesthetist.

THE CHAIRMAN: And on the evidence we have at the moment, the nephrologist at that stage would have been Dr O'Connor rather than Professor Savage, given the respective evidence which they've given?

A. Yes, correct.

THE CHAIRMAN: So breaking this down, it seems to mean -- and correct me if this is wrong -- that when the kidney did not function in the sense of producing urine, you discussed with Mr Keane and Dr O'Connor fluid and concluded that you had underestimated and needed to give a bolus of fluid.

A. Well, that's what's written, but I'm not sure if that was actually enacted.

THE CHAIRMAN: But sorry, unless this note is wrong, that's what's written because that's what you told the coroner --

A. Yes.

THE CHAIRMAN: -- in 1996.

A. That's correct.

THE CHAIRMAN: I'm asking you this question based on what you told the coroner 16 years ago, at a time much closer to Adam's operation and death.

A. Yes, that's correct.

THE CHAIRMAN: And in 1996, can I assume that your memory would have been clearer than it is 16 years later?

A. That would be a reasonable assumption, yes.

THE CHAIRMAN: Right, thank you.

MS ANYADIKE-DANES: Two points out of that, and I'm thankful to the chairman. Firstly, you are aware that Mr Keane's evidence is that the kidney, the new kidney, did produce a few drops of urine?

A. Yes.

Q. Secondly, when you were answering the chairman, you also used the expression "perfusion". Just so that we're clear, in your view, is part of the kidney functioning or not functioning whether it perfuses, or is your reference to functioning solely confined to whether it produces urine?

A. It could be the perfusion as well as the urinary output because I would have been aware that a kidney could be perfused, but be in a state where it may not produce urine for a period of time, although again most of my experience would be a kidney, that when the clamps are released, would mostly, most commonly, produce urine and continue to produce urine --

Q. But --

A. -- in the operating room.

Q. But also an issue is whether it perfuses, in other words whether the blood enters it.

A. I think that's correct, yes.

Q. Yes.

A. Although -- sorry, I would be in a lesser position to judge. Not being a surgeon, I would be in a lesser qualified position to judge the perfusion of the kidney and the state of arteries, the artery to the kidney, than I would be to look at the urine output. So for me, I believe the urine output would be a more valid measure of the function of the kidney.

Q. And from --

A. But that doesn't mean -- I don't include the overall perfusion. Maybe words are being given to me about the concern for the kidney. I don't know.

Q. I understand that, but just to tidy one point up: where

you are positioned, at roughly towards Adam's head end, are you in a position to see whether a new kidney is producing any urine?

A. Yes, I would place myself so I could see over the ether screen into the abdomen, the wound, and the kidney would be visually -- would be visualised from that position, yes.

Q. So one way of interpreting that is, having positioned yourself in that way, you couldn't see that kidney producing any urine?

A. Yes.

Q. Thank you. I just want to, again, slightly out of order in the way that I was going to take it, but now that you mention the timing -- I think you referenced when the anastomosis could have happened. It was another part of this note that I wanted to take you to, to have your explanation, and that is 122-001-003. If we go to the top of that page, the second, if you would, sentence:

"In this case, the kidney was in at around 9.30 am. The vein was in and the arteries were being finished."

What does that mean so far as you understand it?

A. Well, I think it suggests that the kidney was in the abdomen --

Q. Yes.

A. -- and one of the anastomoses was done.

Q. Yes.
A. And the other anastomosis, the arteries were being finished. So I think that's what the note suggests, that all happened at around 9.30.
Q. So then you, I think, have referred to the ... Let's pick that up again and I'll come back to where I think you were taking us to in the medical notes. If we go back to the inquest note where we were at 122-044-048. You'll see, "9.32, the clamps removed". That's Mr Brangam putting that to you at that stage. As this note records it, I should say in fairness:

"9.32 clamps removed, critical rime."

And you respond "yes".

And:

"The team took the view that this op would be over shortly."

And you thought that was a reasonable view. You'd been involved in many kidney transplants.

So why I put that to you is that that seems, on the face of it, to fit with what the consultation note says when it says that the kidney was in around 9.30 and the vein was in and the arteries were being finished.

Then what I'm going to ask you about is the note that Dr O'Connor makes as to when the anastomosis was complete in Adam's medical notes and records. She says

that happened at about 10.30.

A. Yes.

Q. It may be that all these things aren't entirely correct, but if we have orders of magnitude ... If the note, coupled with your own evidence to the coroner, is correct, so it's roughly at about 9.30/9.32, and -- well, in fact, on your evidence to the coroner, it's even more advanced because the clamps are being removed.

A. Mm-hm.

Q. So if the clamps are being removed at 9.32, does that not mean that the arteries have already been joined at that stage, if the clamps are being removed?

A. Well, yes, that would suggest that the arterial clamps are being removed and that's a critical time, but it doesn't tie in with the time on other documentation when the clamps were removed. So I can't account for the difference between the two times.

THE CHAIRMAN: This is exactly the family's problem, and it has become my problem, as to knowing what was going on between 9.30 and midday. Because the notes cannot all be correct. And if the notes are not all correct, then there's a question of human error. There's a question of whether there is, in fact, the full story being told from the people who were there at the time about what actually happened.

An hour's difference in the notes is very significant, isn't it?

A. It is, yes.

THE CHAIRMAN: As I understand it from earlier evidence, the family has a real concern that, in fact, it may have been realised at about 9.30 or soon afterwards that everything had gone terribly wrong. But then we have a subsequent note saying: "10.30, anastomosis complete".

Can you help me make sense of that, or do you say that, in interpreting that, I have to find that some notes are wrong?

A. 9.32 does seem to be an important time from my side of things because that's when I checked the blood gas, that's when things seemed to be happening. But it clearly doesn't tally in with the other notes that suggest the cross clamp wasn't released until 10.35. Other than that, I have no explanation or memory of why there should be such a large time difference.

THE CHAIRMAN: Could they have been removed and then put back on and removed again? Do you think that happened?

A. It's possible, but I can't remember. I was busy at that time checking blood and erecting blood, so I would have not been concentrating on what was happening at the surgery between 9.30 and 10.30 because I was administering blood and checking blood and --

THE CHAIRMAN: Okay. But for them to be put back on would be an indication that something had gone very badly wrong.

A. That would be better addressed by the surgeon, but it may well be that initially when you release a clamp, there can be an anasomotic leak, requiring the clamps to be reapplied and a suture replaced, but that is something I'm not an expert in and I would be speculating to say that --

THE CHAIRMAN: And do you agree that there's nothing in the records which suggests that the sort example that you've just given me is actually what happened?

A. I have not read anything about that or heard anything.

THE CHAIRMAN: And you have pored through the records for the purposes of this inquiry?

A. I have, yes.

THE CHAIRMAN: So although you're trying to be helpful and although you've given me an example -- and I understand why you have given it the -- example you have given me does not tally with what's in the notes. In fact, the problem is the notes don't tally at all. Isn't that right?

A. Certainly in this area, there's a discrepancy in the notes, yes.

THE CHAIRMAN: I think we have to give the stenographer

a break, so I'll come back out at a quarter to --

MS ANYADIKE-DANES: Mr Chairman, could I just ask one question just to follow on from that?

But what does tally, Dr Taylor, doesn't it, is that your evidence there about 9.32 and the point that was made in the consultation about 9.32? 9.30, rather. Those two times do tally.

A. They do tally with several things happening, yes.

MS ANYADIKE-DANES: Thank you very much indeed.

(11.35 am)

(A short break)

(11.50 am)

MS ANYADIKE-DANES: I wonder if we could put up two pages side by side? They're both from Mrs Neill's note of the inquest. 122-044-046 with 122-044-048. Just carrying on a little bit from your position, what you expected was going to happen around about 9.30, if you see right at the top of the 046 page:

"Expecting op to finish in 10 to 15 minutes. Then do all post-op tests."

And then you see:

"But things changed somewhat. Concerned about the reading. After discussion, we would then check at end of op."

Then if I could highlight -- where I wanted to put

that with is at the 048 page. You've already seen the clamp its being removed. Start with:

"Team took the view that this op would be over shortly. Involved in many kidney transplants. Reasonable view. Later proved not the case."

Do you see those there, Dr Taylor?

A. Yes.

Q. It's a bit difficult because of the small size of the writing, but the bits I'm particularly interested in is, given where you thought you were, if I can put it that way, if this is an accurate record of your evidence, in relation to the end of the operation, what do you mean by "things changed somewhat" in the first bit that's highlighted and "later proved not the case" in the second bit that's highlighted?

A. So in the first marked reading, page 046, "expecting op to finish in 10 to 15 minutes", so presumably that's when the skin was being closed, towards the end of the operation.

Q. It's your evidence. I'm simply trying to ask you what you were meaning, what you meant by "things changed" from when you thought you would be finishing rather speedily and what you meant by the team thought that the operation would be over fairly shortly, but then that later proved not the case. What is it that has become

problematic, apparently?

A. Well, I can't remember, so I'm trying to pick up what I said. So I'm surmising that if I was expecting the operation to be finished in 10 to 15 minutes, it would be at a stage when the kidney would have been transplanted, the various muscle layers would be closed and we would be presumably putting in the skin stitches. That would usually ...

Q. So as to help you in what you're doing, I don't want you to be taking things out of context. Perhaps if we look at the previous page, 122-044-045. Right at the bottom, you say:

"The new kidney is in, the team busy ensuring vital signs and blood support."

Next:

"List of tests done: sugar and electrolytes."

That's what you're going to do:

"Once happy blood et cetera normal."

And so on. Then you go on over the page to say you were expecting the op to finish in 10 to 15 minutes and then do all your operative tests, but things changed somewhat. So that's what I was asking about, what could have changed.

We know from earlier on the 045 page when you say the skin closure actually did happen. You say that

actually happened at 11 o'clock. But you have been talking here of things coming to a relatively speedy close in or around 9.30, 9.32, and this is the point that the chairman was asking about just before the break. That's what you were expecting. In fact, in the 048 page, that's what the team was expecting:

"But things changed somewhat [on the 048 page] and later proved not to be the care."

And you end up with your note that actually skin closure occurred roughly at 11 o'clock.

A. Yes.

Q. So you can see that what the chairman is concerned to know and what I'm inviting you to try and help us with is, if you were moving on towards finishing up fairly soon after 9.32, something happened. That's your evidence that something happened, although you don't say what, and ultimately, the skin closure happens at 11. What is going on between those two periods of time?

A. Well, as I said, I can't remember, but 9.32 was clearly a time that was important to me --

Q. Yes.

A. -- as I've said. Because that's when I checked the haemoglobin, the blood gas, noted the haemoglobin to be low and started checking blood and giving blood from that point onwards. So clearly, that was an important

time of the operation.

Q. Yes.

A. I have documented that that was a time when a clamp was released.

Q. Exactly.

A. I don't know whether that was a venous clamp or an arterial clamp. It appears to be in my documentation that it was an important time of the operation.

Q. I understand.

A. The other doctors have said it was 10.35 when the clamps were finally released and the kidney was finally anastomosed. I was busy, presumably at that time, erecting blood, checking blood against the patient's arm band, going through quite a lot of anaesthetic tasks. That's what happened in my side of things between those two times, and I'm unable to comment or nothing became clear to any about -- that I documented that happened on the surgical side of the --

Q. As you know, we're going to come to a paragraph that deals precisely with that. You say in the 048 page that you've been involved in many kidney transplants. When you then describe that you were doing, the 9.32 is important for you, the haematocrit was low, you were addressing that point and so on. From your experience, is that the kind of thing that would have stopped the

operation from concluding?
A. The anaesthetic? Putting up --
Q. No, no, what you say that you were doing. You say 9.32 is important for you.
A. Yes.
Q. You took certain steps at that stage because you noted his haematocrit was low and in other evidence you have said as far as you were concerned, you appropriately and adequately addressed those things.
A. Yes.
Q. So the question that I'm putting to you is: is that the kind of thing that in your experience would have delayed the operation? Could that have constituted, "later proved not the case", or the other expression that you use with this "things changed somewhat"?
A. Well, I'm trying to understand. Are you trying to ...
THE CHAIRMAN: Let me ask what I think is the question in a slightly different way. The things that you were doing at 9.32, are those the things which you would do if you understood that the operation was coming to an end shortly?
A. No. The things I would do if the operation was coming to an end shortly was to start getting my anaesthetic drugs ready to wake the child up.
THE CHAIRMAN: Right. So at 9.32, let's look at the note on

page 048. Mr Brangam says to you:

"9.32, clamps being removed, critical time."

And you said:

"Yes. Team took the view that this op would be over shortly."

A. Yes.

THE CHAIRMAN: So whatever you were doing at 9.32 would be part of the work being done by different doctors on Adam, which you expected to result in the operation ending shortly?

A. Yes.

THE CHAIRMAN: And let's try to put some time on "shortly". By "shortly", do you mean 15, 20 minutes, something like that? Is that right?

A. That's right.

THE CHAIRMAN: So the work that you were doing at 9.32, allied to the work which is being done by the surgeon at about 9.32, should mean that Adam's operation is complete and he's removed from the theatre before 10 o'clock.

A. Okay.

THE CHAIRMAN: Right. We're not sure at this point if in fact Mr Keane was there at 9.32. I think you thought that he was the team, though if he leaves it's not entirely clear when he leaves, he said he did the first

muscle layer and then left Mr Brown to do the final two.

A. Yes.

THE CHAIRMAN: But at 9.32, your expectation is that over the next, shall we say 20 minutes or so, maybe 25 minutes, the operation will be complete?

A. Yes.

THE CHAIRMAN: For some reason, something changes.

A. Right.

THE CHAIRMAN: There are two obvious things which may have changed. I'm sorry. As part of that, as part of the operation being brought to a conclusion, Adam is brought out of the anaesthetic; isn't that right?

A. No, he's not.

THE CHAIRMAN: He's eased off it?

A. He's not woken up until the skin is closed, which is at 11 o'clock.

THE CHAIRMAN: But what you expected to happen at 9.32 -- let's stick to 9.32, let's not complicate it with other notes, which we can come back to. At 9.32, if you expected the operation to be over in about 20, 25 minutes, before 10 o'clock, the completion of that would have included the skin being closed and Adam being eased off the anaesthetic?

A. That's correct.

THE CHAIRMAN: Right. For some reason, according to other

notes -- although we're not sure if they're reliable -- the clamps weren't released until 10.35 and the skin wasn't closed until 11.

A. Yes.

THE CHAIRMAN: What changed between 9.32 and the following few minutes, which meant or which could explain that the later notes are correct, or do you know?

A. I can't remember, because I was doing things at the top end of the table. There is a period -- if I can put it this way to be helpful. In my experience of kidney transplants before Adam, which were largely adult kidney transplants or children's kidney transplants in Toronto -- that is what I was basing my experience on because he was the first transplant I did in Belfast.

THE CHAIRMAN: Yes.

A. So from my experience of that, once the vascular anastomoses are done, then the bladder's opened and the ureter is implanted into the bladder, and that can take 15 or 20 minutes if it's straightforward. And once the bladder and all -- that's the third anastomosis, if you like. The vein goes in first, I believe. The artery goes in second. That's when the clamps are released. Then there's a period of time needed to open the bladder and put the ureter, in a special surgical procedure, into the bladder. And then the surgeons recheck all the

haemostasis to make sure there's no bleeding, check everything, and then there's a period of closure.

So I reckon -- I suggest that once the vascular clamps very released -- which I've said is 9.32, although I accept that that's not a time that has been confirmed by other observers --

THE CHAIRMAN: Let's assume for a moment that it is right --

A. Then there would be15 to 20 minutes, I estimate, of putting the ureter into the bladder and then another 15 to 20 minutes of closing the muscles layers and the skin before I would attempt to wake the patient up. So possibly 30 to 45 minutes from that time if everything -- plan A, if everything has been secured and there's no difficulty with the patient producing urine or the blood supply.

THE CHAIRMAN: Sorry, I misunderstood you or must have misunderstood you because I thought you'd agreed that from 9.32 to about 10 o'clock, we give time for the concluding steps to be taken and for Adam to be taken out of the operating theatre and into intensive care; is that right?

A. No, the usual practice was to wake the patient up in the operating theatre. That takes a while. And then to take him to intensive care --

THE CHAIRMAN: Okay.

A. -- breathing on his own, but that didn't happen with Adam.

THE CHAIRMAN: I know that didn't happen with Adam; we're trying to work out what went on in between. So did you not indicate that you would have been easing Adam off the anaesthetic by about 10 o'clock, if the clamps were removed at 9.32?

A. As I've said, there would be a time to put the bladder connection and then to close the skin. That could take, depending on factors, 30 to 45 minutes, I would have expected. I would expect that now and I believe I would have expected it then, all being well.

THE CHAIRMAN: Okay. So 30 to 45 minutes takes us, at, most to 10.15 from 9.32.

A. Yes.

THE CHAIRMAN: Okay. If something happened that appears not to have happened for the better, it happened for the worse.

A. Yes.

THE CHAIRMAN: So what happened for the worse over the next 40 or 45 minutes?

A. I can't remember anything untoward happening that was drawn to my attention during that period.

THE CHAIRMAN: Do you agree that if Adam remained in theatre until about midday that something clearly did go wrong

after about 9.32?

A. As I've said, the bladder -- getting the ureter, the transplanted ureter attached to the bladder can take a variable amount of time, and then the wound closure can also take a variable amount of time. I have suggested that that could all be done in 30 to 45 minutes. It may well, in a difficult case, take longer. And I believe that the operation was concluded, the skin was closed, before 11 am, and I then attempted to wake him up after the skin was closed. I wouldn't have attempted to wake him up before the skin was closed. So we're looking at a period between 9.32 and 11 o'clock to get from releasing the clamps to closing the skin.

THE CHAIRMAN: And that would be an unusually long time?

A. It would, in my experience of transplants before Adam, it would be longer than I would have expected.

THE CHAIRMAN: And in your experience of the transplant you did after Adam, that would be longer than expected because you did do a transplant within the next few months; isn't that right?

A. Yes.

THE CHAIRMAN: And it didn't take that long.

A. I don't believe it took that long after the clamps were released to close the skin.

MS ANYADIKE-DANES: I want to take you to 122-001-002 of the

note and to go right down to the bottom. We see it says:

"Dr Taylor pointed out it was very possible that this kidney could have been in place within an hour. Therefore, one needed to have the child adequately perfused to take the new kidney, ie he needed to be preloaded with fluids so that the kidney could be properly perfused and would not fail initially."

Then you go on to talk about the failures of the new kidney, particularly in a child, especially if there is a lack of fluid. If we then go over the page to 003, that's when you pick up:

"'Preload' is a standard term relating to fluids for kidney transplants. In this case, the kidney was in at around 9.30."

And so on, as you've already seen. The vein was in, arteries being finished.

What I wanted to ask you is: whether that transpired to be the case, you were working on the basis that that kidney would be in within an hour; yes?

A. Apparently, yes.

Q. And also, you had a view, which you have held to, that Adam came into the operating theatre with a fluid deficit, which needed to be addressed.

A. That was my evidence, yes.

Q. And you've also said, apart from addressing a fluid deficit, he would have to have his maintenance fluids.
A. Yes.
Q. So over that hour, whatever are the fluids he would normally have, that would have to be provided as well?
A. That was my evidence.
Q. And because he was having a kidney transplant, he would have to be preloaded with fluid because that is what is required to give the transplant its best chance of success?
A. Yes.
Q. So you had three things to think about in terms of fluid, all to try and get them sorted out within that hour; isn't that right?
A. Yes, although one estimates an hour, one always keeps an eye on things, and that hour can vary quickly and go into a longer time.
MR UBEROI: As a general principle, could the witness be allowed to finish when he's answering?
MS ANYADIKE-DANES: Of course. I wasn't actually taking him to that. What I was saying was that I understand that. I was referring to his plan, his intention as he came into the operation, was working within that kind of time frame.
A. I believe so, yes.

Q. And what I wanted to ask you is: if for any reason things took much longer, what was the effect on your plan of effectively having got him up to where you thought he would need to be within the hour and then, when that wasn't when you needed to have him preloaded for, in fact you needed to have him preloaded for some much later period of time when the surgery reached that stage, what was the effect of that on the fluids you administered?

A. Well, as I've already been through his fluids and I've accepted that I overestimated Adam's urinary output and then delivered a larger quantity of fluid than Adam should have been given, and I've admitted that recently.

Q. Yes, you did, Dr Taylor, and I'm not trying to go over that ground. You very fairly did and you've explained the error that you made in terms of his urine, his hourly urine output. I'm putting to you a slightly different point. What I'm asking you to consider is that perhaps a complicating factor was that you had been planning to administer a certain quantity of fluid, which you thought you would have to do if he had to be at a certain stage within an hour, and then he wasn't actually at that stage within the hour, he wasn't at that stage until much later on. What I'm asking you is, could that have had any effect on your fluid

administration?

A. I can't remember. It could have. It's plausible.

Q. In other words, you had preloaded him too quickly, as it turned out; is that possible?

A. That would appear to be possible, yes.

Q. Thank you. You have mentioned it, and I just want to tie off this one quick point and then we will get to the main part of the consultation note that has given rise to some concerns. Just that bit where you said you later on realised your error, that you had incorrectly considered him to have an urine output of 200 ml. And I think you've also given evidence to say that you had not worked on the basis of his urine output being fixed; isn't that correct?

A. Yes.

Q. Why I ask you that is, if one looks at the consultation note on 122-001-002, and if one looks just a little above halfway down, you will see:

"His urine output was assumed to be fixed, but was not measurable as the child was in nappies."

And then if one looks a little bit lower down, you see:

"His maintenance requirements were therefore [and in a box] 100 ml per hour to compensate for urinary output."

That's being discussed on 18 June. I know that you have given evidence of the error that you believe you made at the time. Sorry, I beg your pardon. On 14 June, this note seems to be recording that his urine output, Adam's, was assumed to be fixed, so there's no difficulty there. People assume that he has got fixed urine output and you'll have heard the evidence that that's part of the reason of polyuria. But more to the point, his urinary output is, or at least what's required to compensate for it, is considered to be 100 ml per hour.

What I don't see in the consultation note is any discussion as to how you came by your assessment of what his urine output was and what his needs were in terms of compensating for that so that one could see the difference or at least so that you could see the error that you fell into.

A. Yes, I don't see any reference to the 200 ml an hour. That was a mistake that I somehow made.

Q. When Dr Gibson produced her report, which was ultimately sent to the coroner, and you met with her, her report says that Adam's urine output was 100 ml. So what I'm trying to see is, if 100 ml is the figure that's being included in this consultation note -- it's something that was told to Dr Gibson -- how could you end up with

a position where the evidence you're giving is that you based your calculations, made your error, in terms of 200 ml with his urine output not being fixed?

MR UBEROI: I echo an objection I made at the time Dr Gibson's report was last mentioned, which is this witness can only give evidence on his calculation of the urine output and not as to what Dr Gibson was told, where she got the information from. She could have got it from notes, she could have got it from any of the other clinicians.

THE CHAIRMAN: We will stick to the information at the consultation at which he was present and this note which he has accepted is accurate on this page.

MS ANYADIKE-DANES: So how then does that square, Dr Taylor, with the evidence that you were giving?

A. I don't know. I don't know why --

Q. If I could help you in this way with why I'm really asking you about this. It's because the evidence that you gave was that you thought that his urine output was, at a minimum, 200 ml, but in fact you thought nobody had really figured out what his maximum urine output might be. Because of that, if you like, it then gave an argument in relation to the quantity of fluids. Couldn't have been too much for him because he had this ability to pass vast quantities of urine. But in this

consultation, one's talking about his urine output being fixed and it being 100 ml an hour is what you need to compensate for it. So that would have had a significant effect, would it not, on the cogency of your argument?

A. Yes, it would. I can't remember this figure of 100. Sorry.

THE CHAIRMAN: Doctor, you were specifically asked when you came to give evidence if there were any significant errors in this document. And you pointed out a couple of mistakes on page 4.

A. Yes.

THE CHAIRMAN: On page 2 you are recorded -- unless you say this isn't your contribution, but it appears to be your contribution -- that Adam's output was perhaps up to 100 ml per hour. You've accepted to the inquiry when you were giving evidence in the spring that when you calculated Adam's fluid output in 1995, you got it wrong. This note from June 1996 seems to suggest that at that time, in June 1996, you may have realised that you'd got it wrong. And that's what the calculations in this box suggest. Do you understand that?

A. My problem is I don't know if I came up with this table. I'm not sure if this is my calculations or somebody else's.

THE CHAIRMAN: Well, can I ask you: looking at the other

people who were at the consultation, if these are not your calculations, who do you suggest they might be?

A. I don't know how this group got this information from --

THE CHAIRMAN: If those are not your calculations and that information on page 2 did not come from you, do you agree that there's nothing in that note on page 2, which indicates you disagreeing with the calculations?

A. That's correct. There's no objection.

THE CHAIRMAN: Because one possible reading of it, which I want you to respond to, is that at that consultation you were not making the case that Adam had unlimited fluid output but rather you were accepting, either because this calculation came from you or else because you didn't challenge it, that Adam's fluid output was 100 ml per hour. What's your response to that?

A. I can't explain why I would have accepted this and not objected to it.

MR UBEROI: May I rise for completeness simply to draw attention to the second paragraph of the page?

THE CHAIRMAN: "Dr Taylor mentioned the analogy of a colander".

I have got that point, Mr Uberoi.

I have to follow my last question to Dr Taylor with this: if that is the position, you can't explain this -- you can't explain specifically, to be fair -- you said

you can't explain why you would have accepted this and not objected to it. One explanation might be that it was right. And that's why you accepted it and did not object to it.

A. Yes.

THE CHAIRMAN: But if that's so, on what basis could you have possibly made your statements to the police and to the inquiry about the calculation of Adam's fluid output?

A. I don't know.

THE CHAIRMAN: Is that what you meant when you first gave your evidence in the spring and said that you couldn't stand over or explain or defend the statements which you'd made to the police or to the inquiry?

A. I think so yes.

THE CHAIRMAN: I really do not intend to go over all that again. The only point which comes from this page is whether, in fact, you realised, at the latest in June 1996, that your calculation of Adam's fluid output was wrong, but when you were being scrutinised and questioned about this by the police and by the inquiry, you reverted to a position which you knew was wrong. Sorry, in other words, to put it bluntly, whether you deliberately said things to the police and to the inquiry which were wrong, knowing that they were

wrong, because you had accepted a contrary position in June 1996.

A. I don't believe I intentionally or deliberately said things that were wrong that I didn't believe at the time.

THE CHAIRMAN: But you can't explain how you came to make statements which you yourself said were outrageous and indefensible?

A. I can't explain that.

THE CHAIRMAN: Shall we go on to page 5?

MS ANYADIKE-DANES: Yes. Page 122-001-005, please. Almost literally halfway down that page starts a paragraph:

"A query was also raised about whether the new kidney ..."

And can you highlight the entire paragraph? Thank you.

Let's take this by stages. We've already dealt with the first part of this, which is the kidney not being -- well, this is a different thing:

"A query was raised about whether the new kidney had been properly perfused. It wasn't performing well and it was felt that more fluids were required."

And then about halfway down, it says:

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

Pausing there, what do you understand that to mean, and at which stage might we be talking about?

A. Well, as I say, I can't remember the actual exchange of views or who said what. But on reading this, it appears that it's a reference to the fact that once the anastomosis is made, although I've heard that there was a small amount of urine produced, that it wasn't working well, which I --

Q. Sorry. You said you'd heard?

A. I read Mr Keane's statement to say there was a few --

Q. But you didn't see that?

A. I can't remember whether I saw that or not.

Q. Sorry, carry on.

A. So I'm reading this and seeing that it says the kidney wasn't performing well, which I presume is a reference to the fact that it wasn't continuing to make urine during the time after the cross clamps were released and it was being attached to the bladder. So I presume that's what -- I presume that is what is meant by the context of saying it wasn't performing well. And it's also to be borne in mind that 5 per cent to 10 per cent of kidneys will not work. I do not believe that's a figure that I would have expressed at this meeting. I wouldn't have maybe known the statistics around the percentage of transplanted kidneys. But I was aware

that there was a number of kidneys that would work even though they didn't initially produce urine.

My side of it, and the anaesthetist's side of the transplant procedure, as I've explained, is to ensure that there's adequate blood flow, blood supply, blood pressure, with dopamine and fluid, to make sure there's no blood flow reason for the kidney to fail and also to make sure the immunosuppressant drugs are injected at the right time with the nephrologist.

Q. I understand. So the first part I had asked you was at what stage you thought that was referring to and what you thought "failing" meant. And I think -- correct me if I'm wrong -- that you were saying that you thought that would be at some stage after the clamps were released; is that right?

A. Yes.

Q. And "failing" would mean, at that stage, in your view, not producing urine?

A. Well, I think the comment is "not performing well".

Q. No, it says, "Was failing to operate".

A. Yes.

Q. That's where I'm at --

MR UBEROI: In fairness, the witness was answering with reference to the first sentence, where the clause is "not performing well" and we have now moved on into the

second sentence.

THE CHAIRMAN: His answer was, "It was not continuing to make urine", which leaves open the issue about whether it ever produced any urine. But he's saying, "I didn't see it, I am told that Mr Keane saw it, I've read a statement from Mr Keane that he saw it", so an interpretation is that it was not continuing to make urine, which raises the issue about whether it made any urine at all.

MR UBEROI: [Inaudible: no microphone]. I understood him to be answering with regard to the first sentence in that paragraph and I now think we're moving on to a second tranche of questions about the last sentence or two.

MS ANYADIKE-DANES: To be clear I am at, "During the surgery when this kidney was failing to operate", and seeking your help as to when you think that was. I put to you that I was understanding you to say that was at a time when the clamps were released; is that what you mean?

A. It would appear to be.

MR UBEROI: [Inaudible: no microphone] sentence needs to be read, otherwise it is just a recipe for confusion.

MS ANYADIKE-DANES: Well, there's an action taken in relation to that. The first step is to find out where we are. Then I am going to ask him -- of course I'm going to ask him -- about the rest of the sentence,

which talks about what was done as a result of that. But first I am trying to locate where we are at this stage in the surgery.

MR UBEROI: I would repeat that that's a recipe for confusion because we can't locate it because it's a comment in the abstract. It's time-marked in that sentence by the phrase, "When the kidney was failing to operate a needle was put into the artery". So if that is the time that's being asked about, in fairness to the witness, it should be made clear to him that that is the time he is being asked about.

MS ANYADIKE-DANES: Let me ask it this way: was there more than one occasion during the surgery when it was thought that the kidney was failing to operate?

A. Well, you would only be concerned after the clamps were released.

Q. Thank you. So we've got after the clamps are released. Then the sentence goes on to say:

"A needle was put into the artery and no blood came out and clearly the kidney was not working when the operation site was closed."

And we'll leave the "however" for a moment. Let's deal with the kidney [sic] being put into the artery and no blood coming out. Firstly, are you aware of such a procedure?

A. I am aware that a needle is put into an artery, but it's the purpose of that ...
Q. That's what I'm going to ask you. Do you know why it's done?
A. The purpose of that is usually to inject a drug to stop the spasm, potential spasm. I'm not an expert in this area; I observe surgeons doing this procedure. I'm not trained or skilled in doing this procedure personally. So I'm talking about my view, my observation of several kidney transplants.
Q. Yes. Well, have you seen that happen often?
A. A needle put into the artery?
Q. Yes.
A. Yes, to inject drugs.
Q. At a time when a kidney is failing?
A. At a time when the surgeon is concerned about the arterial spasm or the arterial blood supply to the kidney.
Q. Yes. Sorry, at a time when the surgeon is concerned about the arterial blood supply?
A. Well, I may be confusing here because it's not an anaesthetic job. I'm not doing this, so I'm giving my observation of several surgeons who I've watched. So I'm really not an expert --
Q. I understand --

A. -- in this area --
Q. But you had helped us a little bit --
A. -- so I could be wrong in my observations.
Q. I understand that. You had helped us a little bit by saying part of your function was making sure that there is an adequate blood supply, if you like, so that when the anastomosis was complete and the clamps were released, there wasn't some negative effect of that because a kidney, possibly even a large kidney, will absorb quite a bit of blood and you don't want to have an adverse reaction to that. And part of your role in the management of fluids is also to manage the provision of blood and make sure the pressure is at an adequate level and so forth. You've already given that evidence.
A. Yes.
Q. So when you say that when there's a concern about the blood -- I think you said the arterial ...
A. The renal artery, the new artery is maybe not getting sufficient pressure, sufficient blood, then the surgeon can inject a drug called papaveritan(?) to overcome any potential spasm, I believe. I believe.
Q. I understand.
A. I'm not familiar with that drug. I don't know its side effects.

THE CHAIRMAN: Okay, let's slow this down a bit. You're saying this because this is something which you have seen during other transplant operations.

A. I've seen a needle going in for the purpose of injecting a drug, not for the purpose of confirming blood flow. This is not a common witness [sic] procedure that I have seen.

THE CHAIRMAN: But this is something which you've seen -- not frequently, but occasionally -- during other kidney transplants?

A. A needle placed in the artery to inject a drug is what I have seen before. What I have not seen is a needle inserted to check flow.

MS ANYADIKE-DANES: And even when it is to insert a drug, it is because there's a concern about perfusion?

A. Yes, that's my observation.

Q. Exactly. This whole paragraph starts off with a sentence about a query being raised about when the kidney had been properly perfused. That's how this starts off, a concern about perfusion.

A. Yes.

Q. Exactly. And then that particular sentence goes on to say that when the needle was put in to the artery, no blood came out.

A. Yes, that's what it says.

Q. And then it says:

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

A. Well, that's another bit I don't understand because if -- the reference now is to when closure of the wound has occurred.

Q. Yes.

A. So when the operation site is closed, the skin is closed, so the kidney's ... Sorry, the kidney's in place and the ureter is inside the bladder so the only way one could confirm if the kidney was working when the operation site is closed is to measure the urine output produced. But presumably, the urine would be going into the void of a bladder, and I don't know how one could make that statement. I don't know how one could make that statement at that time.

Q. Might it mean something as simple as there's a concern about the perfusion of the kidney? A needle's put in, when the needle is removed, no blood comes out, so there is no blood flowing into that kidney, the kidney's not working and the operation site is closed? So by the time the operation site is closed, the kidney's clearly not working. Is that not an interpretation?

A. One couldn't observe the kidney when the skin is closed.

Q. No, before then. One interpretation -- I'm asking you

to comment on it -- is that the kidney could already be recognised not to be working.

A. That's one conclusion, but I do know there is a percentage of kidneys that will work even though they don't initially appear to work.

Q. Even if there's no blood going through them?

A. I don't know any more than that, and that's a perfect -- as an observer, not as a transplant surgeon.

Q. When I asked you about the kidney not working in the way that you had coined it, which is not producing urine --

A. Not continuing to produce urine.

Q. Not continuing to produce urine or producing any urine at all, I asked you whether you were in a position to be able to see whether the kidney was producing urine and you said you were.

A. At some points, when the surgeon holds the ureter up, I would be able to observe it because they would be in the wound and visible to me at some stage in the procedure. As it is being tied into the bladder, I would lose the visualisation of the urine production, clearly.

Q. Did you see a needle being used?

A. I can't remember if I saw a needle being inserted into the artery.

Q. You can't remember that. Could it have been and you

just didn't see it?

A. It would be difficult for me to see something happening at that angle because I'm at the head of the table, there's the ether screen. The wound in the abdomen is open.

THE CHAIRMAN: So this may have happened, but if you didn't see it, that wouldn't be surprising because you have other work to be doing?

A. Also it's beyond the kidney, it's below the kidney so it's hidden from the observer who's standing at the top of the table. It's not a thing I would easily have been a witness to.

MS ANYADIKE-DANES: Well, I stand to be corrected from the transcript, but my understanding of your evidence this morning is you said the kidney was visualised from your point of view.

A. That's correct. I could visualise the kidney, but the artery would be anastomosed deep within the pelvis, so the artery is on the far side of the bulk of the kidney. So I can see the kidney, I can see the wound, but I'm uncertain, and I would be unlikely, in my experience, to have seen any needle inserted in the artery on the far side of the kidney, below and beyond where I was standing.

THE CHAIRMAN: But on the other few operations where

you have seen a needle being used to inject a drug, is that because you have seen it or because you've been told about it?

A. I've been told about it, sir.

THE CHAIRMAN: So --

A. I would be in an unlikely position to observe either needle being placed in an artery.

THE CHAIRMAN: But even if you were to be in a position to observe, you may not actually see it because you're doing something else?

A. That's another option, sir.

THE CHAIRMAN: So if a needle was put into Adam's kidney, it's not really surprising if you did not see it?

A. I would be more surprised if I did see it.

THE CHAIRMAN: Right. But would you be surprised if you didn't know at the time that that was happening?

A. No. I wouldn't be surprised. It could have happened without my knowledge or without --

THE CHAIRMAN: We're talking about the team in the theatre at this stage, and you thought the -- the team at this point might still include the nephrologist, but it would certainly include the surgeon.

A. The surgeon, yes. The surgeon would be doing it. He may have consulted me, he may not. I can't remember in this case. It wouldn't be a common item for discussion,

I don't think. It's very much a surgical procedure.
MS ANYADIKE-DANES: If this is being prompted by a concern over perfusion and you have said even in the experience you've had of it being done, it is still being prompted by concerns over perfusion because it is a drug that is being administered to improve that. One other way of interpreting this is it's being done to check and see whether the blood supply's getting to the kidney. Either way, it arises out of a concern with perfusion. If there was that kind of concern, is that not something that would be being discussed?
A. It probably would be being discussed.
Q. And if a drug --
A. Sorry, it probably would have been discussed between the surgeon and the nephrologist. It may not have included me because it was related to the graft, it was related to the ... My impact would be to make sure there's enough fluid and blood pressure to supply the kidney.
THE CHAIRMAN: I don't quite get this at the moment. Because earlier this morning, before the break, there was discussion about a note and the note was to the effect that the team discussed it. And you confirmed that the team was you and the surgeon, which you probably I think is Mr Keane, and probably Dr O'Connor. And what you were discussing was that the kidney was not

working in the sense of not producing urine.

A. Yes.

THE CHAIRMAN: So if there is a team discussion and your evidence to the inquest was that there was a team discussion, and it's about whether the kidney was working or not, then why would you not also be part of or at least hear a discussion about checking the kidney or checking what was happening, for instance, by the insertion of a needle?

A. Well, as I said before, my role in that discussion would be related to the fluid and the blood pressure and making sure that there was no deficit to allow the kidney to be provided with enough blood flow. Other than that --

THE CHAIRMAN: But you also hear what's going on.

A. I may.

THE CHAIRMAN: We're talking about three people talking within a few feet of each other, aren't we?

A. Yes.

THE CHAIRMAN: And on your evidence, those three people were talking?

A. Yes.

THE CHAIRMAN: And even if there was then an element of that conversation which didn't include you, you would have been sufficiently close to hear the other two talking?

A. That's very likely. Most likely. But I don't recall hearing that element of the discussion about Adam. I perhaps was doing other things like checking blood and making sure my monitoring was okay. I can't remember that.

MS ANYADIKE-DANES: If there really is a concern about perfusion, that does involve you because you're concerned with the pressure --

A. Yes.

Q. -- and pressure is part of the answer to perfusion.

A. Yes.

Q. You're concerned with the administration of further blood products.

A. Yes.

Q. So if there is a concern that, for some reason, that new kidney is not getting an adequate supply of good or an adequate supply of blood sufficiently quickly, that is an issue in which you'd have some contribution.

A. That's correct.

Q. Right. So if they have this concern about the new kidney being properly perfused, then you would be part of that discussion because you might be part of the solution to it.

A. Yes, and they would certainly -- the team would certainly -- the others would certainly make sure that

my element was sufficient to ensure the blood pressure was okay. But I'm trying to help the inquiry by suggesting that once it gets down to looking at the anastomosis and the cross clamps and injecting drugs directly into the kidney that don't have an effect on the rest of the child's body, then my part of that discussion becomes much more limited.

Q. Just to clear one little point up. If the purpose of the needle was to administer a drug in the way that you say you have some knowledge of in other transplants --

A. Yes.

Q. -- that would be recorded on the drug sheet, wouldn't it?

A. If it's not given by me, I wouldn't necessarily record it on the anaesthetic sheet.

Q. But it would be recorded somewhere?

A. The surgeon may record it in his surgical note.

THE CHAIRMAN: It should be recorded?

A. Yes, it should be recorded.

THE CHAIRMAN: If you give a child drugs during an operation, you're supposed to record them in the records.

A. That's correct. The person who administers the drugs should give a record of it. That's correct.

MS ANYADIKE-DANES: Can I ask who was in a position to

provide the information in this consultation about a needle being used?

MR UBEROI: I think that's a slightly unfair question because anyone in the consultation is in that position.

MS ANYADIKE-DANES: I don't think Dr Murnaghan is.

THE CHAIRMAN: He may be because we know that, by this stage, there have been various discussions with various people, so we don't know what information various people are bringing to the consultation, which is I think is your point.

MS ANYADIKE-DANES: That's fair, Mr Chairman. I can rephrase that.

MR UBEROI: If it was a question based on a meeting that took an hour after the operation, there may be some merit in it, but for a meeting that took place months after the event, populated by individuals who have had numerous conversations, that have been discussing the issue --

THE CHAIRMAN: I accept that.

MS ANYADIKE-DANES: I understand that entirely. Let me rephrase the question.

Has it ever been brought to your attention or were you aware of at all prior to this consultation a needle being used in the way that it is described here?

A. I have to say no.

Q. No?
A. Usually the surgeon checks pulsation in the artery with his fingers. That's the usual test of blood flow to --
Q. Sorry, I'm asking you a different question.
A. I'm not aware of a needle being used to check for blood flow.
Q. No, no. Were you aware before what is recorded here in this consultation note of a needle being used in Adam's operation in the way this is described here?
A. No.
Q. Is that because you don't remember or you positively know that that was never told to you?
A. Well, my memory is not good for 17 years ago, and all the events that happened, but ...
Q. So could it have been mentioned before?
A. It's possible it could have been mentioned before.
Q. If it had been mentioned, who is the person who is in a position to be able to provide that information?
A. Well, I was at the operation. I don't think I would have provided the information about the needle to this meeting because it's not procedure that I would have visualised or seen or had any memory of, in particular.
THE CHAIRMAN: And for the record, if a needle was put into Adam's kidney, it was not put into Adam's kidney by you?
A. That's absolutely correct.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: Thank you.

So can you help us then with what the latter part of that sentence means, which is:

"The performance of the kidney was no longer relevant at this stage."

A. Well, yes, I've read and re-read this quite a lot, and it doesn't make sense. If it's, as the first part of the sentence says, during the surgery it's no longer relevant, it doesn't make sense because the timing of the performance of the kidney and the relevance of Adam not surviving the operation are completely different events. So I did not know Adam had suffered irreversible brain damage until his CT scan was done at 1 o'clock and that showed a serious cerebral oedema. So to say that the performance of the kidney wasn't relevant during the operation doesn't seem to make sense in the timing of the surgery.

I wouldn't have even attempted to awaken Adam from his anaesthetic until the skin was closed. So if it's during the surgery, which is the context of the initial part of the sentence, there was no point during the surgery that I knew Adam was not going to survive his operation. That only became apparent initially when I tried to waken him up and he didn't breathe, and that

was confirmed later by a CT scan, and then subsequently the next morning by brainstem tests. So I wasn't in a position to make a decision or be part of a discussion that would make a decision about the performance of the kidney not being relevant during the surgery.

Q. You've said that so far as you are aware, nothing happened to lead you to believe that Adam would not survive his surgery. In fact, you didn't appreciate, I think is your words, that he was in that stage until his brainstem death. You knew you hadn't been able to bring him around, but you didn't appreciate that he had failed in the way that he had until his brainstem death.

A. That would be the definitive test.

THE CHAIRMAN: The CT scan.

MS ANYADIKE-DANES: Sorry, the CT scan, which is obviously some time after that.

But is it not possible that the people towards the end of Adam's surgery feared that something quite serious had happened adverse to his interests and really the least of their concerns at that stage was whether the kidney was perfusing or not?

MR UBEROI: Sir, there are these serious questions being put in this manner of "is it possible", and I'm concerned that that leads to further confusion down the line.

Anything's possible and it's an unfair way to put

such a question to a witness, in my submission. Anything is possible and it's not a helpful way to try and elicit factual evidence on such an important point.

THE CHAIRMAN: Okay, well, let's rephrase it because I think it is right to say -- and the witness has said a number of times -- that things are possible without that taking me very much further this morning. Let's put it this way: this note goes on for six pages; right? This note that we're looking at here.

A. Yes.

THE CHAIRMAN: You have confirmed this morning that -- and let's ignore this paragraph at the moment. Apart from this paragraph, this note is very, very detailed and seems to be consistently accurate and reliable.

A. Yes. With a couple of ...

THE CHAIRMAN: Yes, a couple of bits and pieces, but it's not --

A. Overall.

THE CHAIRMAN: It's not perfect, but it is consistently accurate and reliable.

A. I agree.

THE CHAIRMAN: It's also, we now know, written by a very well-educated lady.

A. Yes.

THE CHAIRMAN: That being the case, you understand why this

paragraph on page 5 jumps out at us and demands an explanation. But if this isn't a rogue paragraph, which makes no sense at all, and that would be entirely out of keeping with the rest of the note, I want to try to understand what the note means --

A. I know.

THE CHAIRMAN: -- if it isn't the meaning which does strike me as being a plausible interpretation of the note. And just to spell it out, doctor, but I think you'll understand this, a plausible interpretation of that paragraph is that the kidney never worked, it was known not to have worked, but everybody kept quiet about that because that didn't really matter as Adam was dead anyway.

A. I understand.

THE CHAIRMAN: Can I ask you, first of all, do you understand how I see that as a possible interpretation of that paragraph?

A. I do, sir.

THE CHAIRMAN: Right. Can you now help me with another explanation of the paragraph or parts of the paragraph, which would be consistent with the evidence which I've been listening to from the spring, or does it just not make any sense to you at all?

A. I can try.

THE CHAIRMAN: Please do.

A. To me, if you read the first part, during the surgery, it seems wrong, simply wrong, that a decision was made by one or several people to say during the operation, in other words before Adam was attempted to be awakened when the first concerns arose about his survivability, later confirmed by his CT scan -- so up until that point there was no reason to suspect that Adam's survival was in doubt. So I don't believe, as it appears to read, that a decision was made just to close Adam up because he was going to die, if that's what the implication is that you're concerned about.

What I think might have been going on here -- the context of this document is about preparation for the coroner's inquest. That's the context of the document.

THE CHAIRMAN: Yes.

A. I think -- a thought occurred to me that if you take "during the surgery" out of the first part of the sentence, what is being asked of the clinicians present here is to prepare for cross-examination by the coroner about the cause of Adam's death and to try and discover the cause of Adam's death. And it's clear from this document that the big focus of Sumner and the coroner will therefore be on the fluid management of Adam and my

obvious role in that. And I believe that the context of this is to say Adam's inquest and coroner's inquest, indeed this inquiry, is going to be focused on the fluid management, and therefore, after several months of looking at Adam's case, the state of the kidney was not of the main importance leading into the coroner's inquest.

THE CHAIRMAN: So on that interpretation, the final words "at this stage", could that be interpreted, do you suggest, to mean at the stage of the inquest?

A. At the stage of this document, at the stage that this is being written.

THE CHAIRMAN: For the inquest?

A. For the inquest, to get all the lawyers, to get instructions from each clinician. This is the stage we're at and perhaps Mr Brangam or others have suggested that we've spent a bit of time here worrying about the function of the kidney, but in fact the coroner will be more interested in the management of the fluids.

THE CHAIRMAN: Okay.

A. Perhaps.

THE CHAIRMAN: Because the management of the fluids was effectively the cause of Adam's death. Adam did not die, so far as we understand, because the transplanted kidney did not take.

A. I believe that's their interpretation.
THE CHAIRMAN: Let's lend your interpretation to the final bit of the last sentence and interpret that to mean that Mr Brangam or somebody's saying the performance of the kidney is no longer relevant at this stage, ie the stage at which the inquest is about to be heard; okay?
A. Yes.
THE CHAIRMAN: So even if we take that interpretation, how do I interpret the previous part of that sentence, which says, "Clearly, the kidney was not working when the operation site was closed"? Because all of the evidence which I've heard suggests that the kidney was working when the operation site was closed, and in fact the operation site would not have been closed if the kidney was not working. I understand how there might be some ambiguity about "at this stage", but I don't understand how the rest of the sentence can be made to reconcile with the evidence to the coroner or to the inquiry.

For instance, Mr Keane's statement to the inquiry says the surgery was a success and he explained here that that meant that the transplant worked; right? This paragraph says, "Clearly, the kidney was not working when the operation site was closed". Can you help me understand that?
A. Well, I do, sir, and I am merely coming up with

something that occurred to me when I read it on numerous occasions ... However, what appears to me is this is a summary of a discussion that was held among interested parties and there has been a lot of discussion about the anaesthetic management, which is obviously relevant, and then there appears to be in this paragraph, from the start of the paragraph, a discussion among clinicians, I'm not sure if I was involved in that discussion. It doesn't seem to make any -- it doesn't appear to have any contribution directly from me into this paragraph that I can acknowledge.

THE CHAIRMAN: Yes.

A. And I think the final statement about "not being relevant at this stage" is merely almost recognition or perhaps an exasperation by perhaps Mr Brangam -- I'm only surmising -- to say, "We've had a long discussion here about the state of the kidney, but at this stage the function of the kidney wasn't relevant to Adam's overall clinical outcome".

THE CHAIRMAN: I've got that point, Dr Taylor. But if I went with that interpretation, that might explain the last nine or ten words in the sentence.

A. Yes.

THE CHAIRMAN: But if you go back before the comma, what could the note mean when it says, "Clearly, the kidney

was not working when the operation site was closed"?
MR UBEROI: Sir, I'm sorry to rise. I do think Dr Taylor had answered that earlier when he said he can't offer any explanation or make any sense of that comment --
THE CHAIRMAN: Maybe I've missed it in the complexity of the evidence. If you can't give any evidence about that, then there's no point in pursuing it with you.
MR MILLAR: Sir, if I can perhaps assist. I think in relation to "not functioning", I think what Dr Taylor said earlier on was that when he talked about "not functioning", what he would mean by that would be not producing urine.
THE CHAIRMAN: Yes.
MR MILLAR: Mr Keane's evidence was that, in his mind, he saw a drop of urine, although he also said in his oral evidence that he wasn't being dogmatic about that. He may have been wrong, it may not have been urine, but he thought it was a drop of urine. He has never said at any stage -- and his operation note records that when he left, the kidney was perfusing reasonably well, not that the kidney was producing large volumes of urine and functioning in that sense. So there's no inconsistency between the kidney being perfused reasonably well at the end and it not functioning in the sense of producing urine. They're two totally different things, and

certainly Mr Keane has never said at any stage that at the time that he left, the kidney was producing significant volumes of urine and functioning in that sense. I don't know if that eases or is directed towards your concerns.

THE CHAIRMAN: I think Mr Keane is going to give evidence tomorrow, isn't he, so we can --

MR MILLAR: Absolutely. But it is just in terms of in ease of you, sir, struggling at the moment with that wording, I think if one treats "functioning" as "producing urine" and recognise the distinction between that form of functioning and the perfusion, the appearance of the kidney, in terms of whether it is pinky or dusky or whatever, those are two different concepts and certainly Mr Keane has never said at any stage that when he left, the kidney was producing significant volumes of urine and functioning in that sense. He did say it would perfuse reasonably well.

THE CHAIRMAN: Mr Millar, do you want to give me a preview about what Mr Keane will say about the notion that a needle was put in to the artery and no blood came out?

MR MILLAR: Absolutely. No needle was put into the artery.

THE CHAIRMAN: So in essence then, that part of the note is a mystery?

MR MILLAR: It is, sir.

THE CHAIRMAN: Sorry, that's not correct. It's not a mystery; it's just completely wrong.

MR MILLAR: It is completely wrong.

THE CHAIRMAN: So Mrs Neill has somehow recorded in this note something which either wasn't said at all or was said, but is completely false?

MR MILLAR: Well, obviously Mr Keane didn't have the benefit of either being invited to the meeting or being at the meeting, nor Mr Brown, the other surgeon. So they have no idea what was said at the meeting, so I'm not making any comment about Mrs Neill's note. That's a separate issue. But certainly just as a matter of simple fact, sir, no needle was put into the kidney. Where a needle was mentioned, who mentioned it, in what context, what Mrs Neill heard, I don't know.

THE CHAIRMAN: Okay, thank you. Ms Anyadike-Danes? Actually, it's just after 1 o'clock. I think we should be nearly finished with Dr Taylor's evidence.

MS ANYADIKE-DANES: We shouldn't be very long, but I'm conscious that there might be some questions that I ...

Mr Chairman, I wonder if this would be the way to deal with it? I don't have very much more to deal with. If we were to break now, I could make sure that I streamline that as much as possible, as well as taking on board any further queries that counsel might want me

to put that I haven't already put. That might streamline things.

THE CHAIRMAN: If we break now and start at 2. If the various parties could liaise with Ms Anyadike-Danes over lunch, we'll finish Dr Taylor as soon as we can because Dr O'Connor is here today, but we're anxious if at all possible to have her evidence finished today for a number of reasons. Thank you.

(1.03 pm)

(The Short Adjournment)

(2.00 pm)

THE CHAIRMAN: Okay, you've had discussions?

MS ANYADIKE-DANES: Yes, I have.

I wonder if we could pull up again the consultation note, 122-001-005. Can you please highlight from about halfway down:

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

There we are.

Dr Taylor, a suggestion was being put or you were being asked to consider the possibility that what this really means is that, at some stage before you started to attempt to waken Adam up, that it was appreciated that something very serious had happened to Adam and that one of the reasons why it says that the performance

of the kidney was no longer relevant at this stage was effectively because Adam had passed a point where that was one's primary concern. That was what you were being invited to consider as a construction of this before we broke for lunch.

I wonder if, in helping us to consider how one might properly interpret that, how that fits with the fact that you gave no further anaesthetic agent in the form of atracurium, which is the muscle relaxant, after 9.30. We can see that in a chart which we had before the summer break at 307-006-064.

That chart was compiled from the information in the anaesthetic record, which, just for reference purposes, is at 058-003-005, but if one looks along the bottom of that chart, one sees the periods of time when atracurium was administered. You see 7 o'clock, 8 o'clock, you see 8.30, 9.30, and then you see it's no longer being administered.

You will know, because it was being discussed, as to what might be an explanation for not administering it. The short answer was because you might not have needed it and an interpretation of no longer needing it is because something has happened that means it's no longer relevant to maintain a muscle relaxant. Okay? Do you understand the way I'm putting that?

A. Yes.
Q. So what I'm asking you is: does that not fit with an interpretation of the paragraph that the chairman was putting to you before we broke for lunch?
A. Well, you've got mixed description of atracurium. Initially, you said it's an anaesthetic agent and then you said it's a muscle relaxant.
Q. I beg your pardon. It is a muscle relaxant.
A. It's a non-depolarising muscle relaxant. So it's not an anaesthetic. It doesn't keep him asleep. The drug halothane, which was providing anaesthesia, sleep, was being administered past this time.
Q. That was my error. I beg your pardon. The characteristics of atracurium were described in a report that we have from Dr Haynes. You produced a witness statement dealing with it and the upshot of it is that it's something that you do to ensure that there is no involuntary movement and so forth. And that is obviously relevant to make sure that doesn't happen during the surgical procedure.
A. Yes.
Q. So if you'll forgive me for that error, but the issue was, and it was at the time that Dr Haynes was being invited to look at it, what might be the reasons why it wasn't administered after 9.30, and it has a certain

life, if you like, and one was because you didn't need it any more, or it was no longer required because the body wasn't responding in that way, if I might put it like that.

So the point that I'm putting to you is: bearing that in mind, does that not help to look at the interpretation that the chairman was putting on that particular paragraph?

A. The short answer is not really. Atracurium is a muscle relaxant, as you quite rightly have alluded to. It doesn't keep the patient asleep. Halothane does keep the patient asleep, and I believe it was continued up until the time of skin closure, although I would need to confirm that. So just because atracurium is no longer administered doesn't mean to say that anything untoward has happened during the anaesthetic.

Q. Could it mean that?

A. It's not related at all. In fact, when we take organs from a patient who's already brain-dead, we actually have to administer atracurium to stop the involuntary muscle of a patient who has been declared brainstem dead. So in fact, atracurium is a necessity of a patient, even though they are brainstem dead physically. There's no indication that Adam was brainstem dead at this stage. And even after admission

to intensive care, after he had his CT scan, which showed cerebral oedema, he developed seizures, so there was still some, if you like, neurological -- although abnormal, I'll accept -- there was still neurological activity in the afternoon of this day. And it wasn't until the following morning when the complete brainstem tests were done and all the anaesthetic and sedative drugs had worn off that the requirements for brainstem-death criteria could be met.

So I don't believe, and you can check this with other experts, that not needing to have another dose of atracurium would in any way reflect that a mishap has occurred during anaesthesia. In fact, you will have to administer atracurium even if the patient is brainstem dead.

Q. Yes.

A. It's an irony that you have to get an anaesthetic to a patient who's brainstem dead.

Q. The chairman will have Dr Haynes' report and how he puts that.

Then something that I should have put to you before. The statement, "The performance of the kidney was no longer relevant at this stage", is that something that you recall ever saying?

A. Sorry, could you just ...

Q. Sorry, if we can -- I beg your pardon.
MR UBEROI: [Inaudible: no microphone] give evidence on this point, but if he's going to be asked again, if it's going to be asked to be put again, could it be put on the screen?
MS ANYADIKE-DANES: That's what I was just going to get called up. There it is. So you see that final line:
"The performance of the kidney was no longer relevant at this stage."
Is that something that you recall saying at any stage?
A. No. As I've indicated earlier, not only do I not recall saying it, but I wouldn't have said it because, as I've indicated earlier, one couldn't make a decision about the hopelessness of a patient undergoing anaesthesia without (a) allowing all the sedative and anaesthetic agents to wear off and then formally doing brainstem tests, and that wasn't done until the following morning. So one can't make a decision to say that it's no longer -- that the patient's condition has reached the point of non-survival. That wouldn't be anything I would have said or practised. In fact, I would be very wrong to practice that way.
Q. And just formally, can I also ask you, do you recall saying the kidney was not working when the operation

site was closed or at the time the operation site was about to be closed, even?

A. Well, again -- sorry.

Q. Do you recall ever saying anything like, "The kidney was not working at the time when the operation site was closed"?

A. No. As I've indicated earlier, that doesn't make sense because the only way one could assess kidney performance after the skin had been closed or around the time the skin was closed is to look at the urinary output, and that wouldn't be possible.

Q. No, sorry, what I think is being sought from you is whether at the time they were just about to do that, so they haven't actually done it -- obviously if they have closed the first layer, you can't see the kidney any more. But at the time they are about to do that, do you recall ever saying that, at that stage, the kidney wasn't working?

A. No.

Q. Thank you.

THE CHAIRMAN: And your evidence in fact is that not only would you not have said that, but that you couldn't have said that?

A. I couldn't have said that when this operation was -- when the skin was closed. It wouldn't make sense to me.

THE CHAIRMAN: And before the skin was closed, you wouldn't have said, "The kidney is not working"?
A. Well, I did indicate that it wasn't -- I think in a previous statement I did say that the kidney wasn't producing continuously producing urine, so it wasn't fully working. But that doesn't mean it's not going to work in my experience.
MS ANYADIKE-DANES: Yes. Just because there is something that may be turning on this distinction between whether "working" means not being perfused or working means not producing urine --
A. Yes.
MR UBEROI: The witness has been very clear what his definition of "not working" is. It's to do with the urine. We've been over this several times now and I do respect my learned friend's position that if something is asked to be put, then she understandably makes efforts to put it, but if it has been put before then all we're doing is going round and round in circles and it's not going to help you, sir.
THE CHAIRMAN: Is there a particular point you've been asked to raise, Ms Anyadike-Danes?
MS ANYADIKE-DANES: Thank you. I was going to ask that. Your evidence earlier to the coroner, and indeed to us, was that, towards the end, you had your own concerns

about the quality of the kidney's perfusion. In fact you described the kidney as looking dusky and so forth.

A. Yes.

Q. When you were giving that evidence about what was happening, did you ever explain to the coroner that what you were meaning by "the kidney not working" is actually that it wasn't producing urine?

A. I can't remember if I indicated that to the coroner.

Q. So for example, from Mrs Neill's note at 122-044-043, when you said "the kidney wasn't working" there, which is just a few lines up from the top, "New kidney not working, consider need more fluid" --

THE CHAIRMAN: Just take your time. Is that the sixth line?

MS ANYADIKE-DANES: I think it's the sixth line. "New kidney not working". Yes.

So when you have talked about that, did you explain to the coroner that your definition of a kidney not working, it's not to do with whether it was perfused properly, but actually to do with whether it was producing urine?

A. I can't remember if I clarified that distinction between the two issues.

Q. But am I right in taking it that your evidence to the coroner was that the kidney was not perfused well and that you had a concern about that?

A. I think I've explained --
MR UBEROI: The witness' evidence to the coroner is going to be largely contained in the note.
THE CHAIRMAN: That's a question of --
MR UBEROI: I'm just a bit concerned about what are actually medical and technical terms, such as perfusion, are being bandied around in a far too broad a fashion, and I will repeat the phrase again, creating a recipe for confusion to a witness who's been asked and answered this same point several times today already.
THE CHAIRMAN: The question is, in that note, if that note is accurate, if the doctor said, "The new kidney is not working", did he mean not perfusing or not producing urine. Doctor, do you remember drawing that distinction at the inquest or do you remember anything beyond the note --
A. No.
THE CHAIRMAN: -- seeming to be accurate in that it records you as saying the new kidney was not working?
A. I don't remember what I meant by that. But if I can help, I think I've already said that I wasn't the best person to judge the colour or the perfusion of the kidney. That's something that the surgeon could be more likely to judge by the blood flow in and out of the kidney. Mine would be an observation of the colour, for

instance, of the kidney. That is a very distant and observational measure of perfusion. And that has to be borne in context. That's an observation rather than a surgical eye on that perfusion.

THE CHAIRMAN: Right.

A. But I'm more likely to assess a kidney function by its performance, by its urine output.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: So that we are clear, if we pull up 011-014-097, and if you see halfway down, the first third:

"This process was complicated by the fact that the donor kidney did not appear well perfused after an initial period of apparently good kidney perfusion."

What I'm trying to be sure that we're clear on is -- because I think that your evidence today has been the first time that you have sought to explain whatever might have been the deficiencies in the performance of the kidney as its ability to produce or its observed production of urine. Your explanation about your concerns over the kidney throughout have always been in terms of its perfusion, its colour, which has been to some extent supported by a note that was recorded by Dr O'Connor at 12.05 when she talks about the kidney looking blueish at the end. And in a different way,

although a different timing, supported by the evidence of Staff Nurse Popplestone, who said she thought she recalls people discussing concerns about the perfusion of the kidney. So this is why I'm putting it to you whether, when you say the kidney's not working, and you say it in the sense that you've now explained it to the chairman, that it wasn't producing urine or that you didn't see it producing urine, whether you ever explained that to the coroner.

A. Well, it appears that I didn't mention urinary output as a measure of kidney performance to the coroner.

Q. Thank you. Can I take you to 122-001-003? The paragraph numbered 1, the third sentence says:

"It was examined whether there was an opportunity to do the electrolytes ..."

Then if you go down to the end of that paragraph so you get the sense of it:

"... when the child was in theatre and it was confirmed that the opportunity was certainly there."

Which, of course, is something that was in Dr Savage's evidence:

"However, this procedure was planned to last 1 to 1.5 hours. A blood result taken at the start of the procedure would not have been back from the labs for perhaps 1 to 1.5 hours, so the procedure would have been

almost complete, leaving no opportunity to act on any results received."

What I want to ask you is that that, if correct, is a complete answer to why you didn't take electrolyte tests. But when you have given evidence elsewhere about electrolyte testing, you have given a variety of explanations as to why it wasn't done. For example, when you were giving your evidence to the police at -- I'm not asking for this to be pulled up unless somebody wants it -- 093-038-231, you said that it's because you knew his sodiums didn't vary.

And then you said, I believe, in your witness statement to the inquiry that if there had been less urgency in transplanting the kidney, it is likely you would have spent the necessary time in sending a blood sample.

And in your transcript, you said on 19 April at page 72:

"The only reason why I didn't was I wanted to get the anaesthetic procedures done."

So what I'm asking you is: why is it that you have given such a variety of reasons as to why you didn't perform the electrolyte tests, whether it's by no biochemistry change and not having time due to the kidney ischaemic time or preoccupied by other events,

1 when in this consultation note you appear to have
2 a complete answer to that, which is that by the time you
3 would expect to get such a result back, you expected the
4 surgery to be over.
5 MR UBEROI: May I rise to say -- and I am sorry to rise
6 again -- I'm concerned really about potential for
7 unfairness and the plain fact that this witness is now
8 being cross-examined twice on matters that he's already
9 been questioned on. We have attempted to show a great
10 deal of latitude. Of course this is recalled evidence.
11 I entirely understand matters that are new are being
12 asked about. I have also, in my judgement, extended as
13 much latitude as I can with regard to matters where the
14 consultation note potentially sheds new light on
15 a previous matter, and those questions have been asked.
16 But this topic of the blood result, the length of
17 time it takes to come back from the lab has been asked
18 and answered before. It's pure duplication, it's two
19 for the price of one, and it risks unfairness to the
20 witness.
21 THE CHAIRMAN: But sorry, is Ms Anyadike-Danes not right in
22 saying that Dr Taylor has given us a number of
23 explanations to date on the electrolytes issue, but this
24 explanation which is set out in paragraph 1 is different
25 from the previous explanations? Is that not right?

MR UBEROI: No, I don't believe it is. I believe he said before that, effectively, the timing of the result coming back from the lab was one of the reasons why he didn't request it. He's then apologised in his clinical evidence and said he belaboured that point, it wasn't right, and he should have sent the sample and got it back.

THE CHAIRMAN: Okay. You can leave it --

MS ANYADIKE-DANES: If I may explain, Mr Chairman.

He did apologise and he said -- and we can have it in his witness statement, which is 008/6, page 3. He did apologise, and what Dr Taylor was saying is that he concentrated too much on other matters and he should have thought about that. That's not what this note is saying. It's not a matter of concentrating. This note is saying it physically wouldn't get back in time to be of any use, and that's why I'm saying if that's the actual answer, why doesn't that remain the answer? Why do we have all these other explanations?

THE CHAIRMAN: What's wrong with that, Mr Uberoi?

MR UBEROI: But my submission is it's duplication of a topic that has already been covered. My recollection is that in the oral evidence, he has gone into, in great detail, the fact that the turnaround time was something that may have contributed to his decision, but he's reflected on

it and accepts now that it shouldn't have ultimately affected his decision. That is the extract that I am hastily leafing through now that was gone through in his clinical evidence. The main point is the point of duplication.

THE CHAIRMAN: I don't doubt that there is some level of duplication, but I have to say against your client that the duplication arises from his inconsistent statements and explanations. And he says in various ways -- and we didn't try to pin down every single point in his evidence -- about what was wrong with his previous statements. But in the consultation note, and what is significant, is this is a note that was never expected to see the light of day. This is a note which is supposed to be kept confidential between the lawyers and the doctors. And what -- and it may be that I interpret that as being quite revealing because it's a frank discussion between them as opposed to, for instance, statements which were given to the inquiry.

It may be that they are franker and more revealing and more willing to make concessions between each other and discuss Adam's case more openly between each other than they are when they come to give evidence to various people or give evidence to the inquiry. And I think I will allow this question on the basis that this gives

a specific explanation -- I accept your general point that we are not going to go back over everything again. I accept the general point that we're trying to control the extent to which witnesses are being recalled and the issues they are being asked to cover. I think this is legitimate.

MS ANYADIKE-DANES: Dr Taylor?

A. Sir, can you just ...

THE CHAIRMAN: We'll go back to the consultation note if you can, please. 122-001-003.

There was a paragraph numbered 1 that you were being asked about, Dr Taylor. In that, at the consultation, you appeared to give an explanation about doing the electrolytes, which, if that was the explanation, would mean that it was something that was feasible and doable if the results would have come back in time, but because they weren't going to come back in time, there was just no point in doing them.

A. Well, I did say, after this time, that there was a delay in that time of the morning in the Belfast labs, getting a sodium result to the lab and back in a reasonable amount of time. That could make a difference to the clinical decisions that would predicate on that.

I can't explain why I then added other reasons for not doing a blood sample.

THE CHAIRMAN: Okay.
A. That I should have done and I admit that I ought to have done it, as Dr Savage suggested.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: Mr Chairman, I think I have only one or two more points to make. Could we go to 122-001-004? If you go right to the top of that page, the first paragraph there starting "it was pointed out", down to "known to have high urine output".

Firstly, who would be pointing that out? Who would be providing that kind of information? I don't mean necessarily here, but who would be the original source of information about what was and wasn't possible in relation to the measuring of the urine output?
A. I can't say.
Q. Who else other than the surgeons would know the stage at which the bladder was opened?
A. Well, Dr Gaston is an anaesthetist and he would have known that it was important to measure the urinary output, for instance.
Q. No, sorry.
A. It could have been me as well.
Q. I have not phrased the question in a way that you can understand.

Adam's bladder was opened very early on. This is

the whole point of this paragraph. Were you aware of that?

MR MILLAR: Sir, just to be clear on that point, in case it's being put to this witness as a fact, that's not accepted by Mr Keane. It sounds as though it's being put as a fact.

MS ANYADIKE-DANES: No. This is Adam, so not generally:

"However, during this procedure, the bladder was opened immediately and was opened for some two hours, so it was not possible to measure the urinary output and this child was known to have high urine output."

Were you aware during Adam's surgery of when his bladder was opened?

A. This doesn't make sense to me because I was only aware of Adam's bladder being opened at the end of the procedure.

Q. Sorry, I beg your pardon. You were only?

A. It's usual practice, and I would imagine that Adam was no different.

Q. But were you aware in Adam's surgery of when his bladder was opened?

A. No, but I'm trying to suggest that it would be usual practice to open the bladder after the anastomosis was done to allow the ureter, the transplanted ureter, to be put into the bladder. And I don't know where the

evidence came out that his bladder was opened immediately at the start. To me -- that's not my recollection of Adam, and I don't know how ... Who said it. It's certainly not practice that I have ever witnessed before at a transplant surgery.

Q. If that was something that was being suggested that could be made as a point and given as an explanation for why it was difficult to measure his urinary output and, therefore, if any potential criticism lay, why it complicated his fluid management, that's not something that you could endorse because, in your view, that's incorrect?

A. Sorry, it's incorrect to open the bladder?

Q. In your view, Adam's bladder being opened immediately and opened so it wasn't possible to measure his urinary output doesn't square as far as you're concerned?

A. No, it doesn't make sense.

Q. So that couldn't be being provided as some sort of explanation to the coroner for why there might be more difficulties in managing Adam's fluid than otherwise? That couldn't be given as an explanation.

A. I don't understand why it's there.

Q. You don't understand why it's there. If you just give me a moment. (Pause).

I wonder if we could turn to a letter from

Brangam Bagnall to Dr Murnaghan, dated 7 June. I want to turn to the second page of that letter, which is at 059-014-039. If we go down to the final paragraph, starting "finally at this stage".

I'm going to read that and see whether that resonates with you:

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

If we pause there. Firstly, are you aware of how Dr Gaston could have formed the view that you didn't have that opportunity?

A. As I say, it doesn't make sense. I have never seen the bladder opened at the start of surgery for a transplant.

Q. If this letter is accurate -- and of course we will address it with Dr Murnaghan -- if that is a source of information, can you help us with why he would think that you were in that position? Dr Gaston, that is.

A. I can't help you. I don't understand.

THE CHAIRMAN: Let me get this clear. This is a letter written on 7 June by Mr Brangam, the solicitor, to Dr Murnaghan in the hospital.

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: And he's relaying in it information, in this part, which he's received from Dr Gaston. Dr Gaston is supposed to have told Mr Brangam, or provided information, as a result of which Mr Brangam writes:

"Dr Gaston has indicated that [you] did not have an opportunity of accurately measuring urinary output because the bladder had been opened early on in the surgery."

If Mr Brangam has accurately set out the information given to him, then what Dr Gaston has told him about your lack of opportunity doesn't make any sense to you because that's not what happened to the best of your recollection?

A. No. A urinary catheter would be the usual method of measuring urinary output during an operation, and that wasn't done with that.

MS ANYADIKE-DANES: Sorry, that's the precise point that's being made. You couldn't get one in because the bladder was already opened so early. That's precisely the point that's being made. That's why I'm inviting you to comment on it.

A. I can't comment because it's nothing I -- I don't recognise the fact that the bladder was opened.

THE CHAIRMAN: Are you saying to the best of your knowledge, the information in that sentence is wrong?

A. Yes, I don't recognise how the bladder was opened at the start. It's not usual practice.

MS ANYADIKE-DANES: But can we go back to 122-001-004? And where this comes from, which is "Normally, one would be able to measure". So if this document is recording what was said, if it is, then that's something to which you would know to object to. "No, no, no, we can't present matters in that way because that just isn't correct".

A. Well, that would seem to be logical, yes.

THE CHAIRMAN: What seems odd, doctor, is that this information, which you believe is wrong, is contained in Mr Brangam's letter to Dr Murnaghan. You don't have direct control over the contents of that letter.

A. No.

THE CHAIRMAN: But the point is picked up again at a meeting at which you are present on 14 June, just a week later.

A. Yes.

THE CHAIRMAN: And it appears that you're not recorded as disagreeing with it, whereas, for instance, later in that page, halfway down the page, you and Dr Savage

are recorded as disagreeing with fluid overload. So on the same page of the same note that you and Dr Savage set out your different positions about fluid overload, that page starts with you apparently staying silent or not disagreeing with a proposition about what happened during Adam's operation, which you say is wrong. Do you understand my concern about that?

A. I do understand. Again, the bladder being opened may be something that I didn't witness or have any participation in or knowledge of. But as I said earlier, I'm not -- it would be very -- it would not be usual practice to have the bladder opened.

THE CHAIRMAN: It wouldn't be usual practice? You have never seen that procedure before. Therefore, when there's a discussion going on around you about this happening, do you not raise a voice and say, "I didn't know about that, where's that coming from?". Nor is it in the records.

A. I don't understand why it's there and why I didn't object to it.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Then quickly to follow up on the chairman's point, 059-009-027. This is a memo that Dr Murnaghan circulates to you, Dr Savage and Dr Gaston:

"Attached is a copy of a lengthy fax recently

received from George Brangam, which raises several queries and requirements which are urgent and need attention and response as soon as possible."

As I understand it from the way that we've received the documents, that fax from George Brangam of 7 June that I have just taken you to, which talks about what Dr Gaston said he got from you, is what's being attached with this cover letter. Do you recall receiving that letter from Brangam Bagnall, the 7 June letter, with this fax from Dr Murnaghan?

A. I don't recall receiving it. But I don't dispute that it was sent to me.

Q. Well, you don't disagree with it, so if you had received it, you would have seen that final paragraph at 059-014-039, which we don't have to go to, but that final paragraph which refers to what he reports Dr Gaston as attributing to your difficulty; isn't that right? You'd have seen that?

A. I would have seen that.

Q. Yes. And if you had seen that and you consider it to be incorrect in the way that you are telling the chairman, then that is something to which you should have objected?

A. Yes, that would be correct.

Q. Thank you. Then two very quick points. 122-001-005,

from Mrs Neill's note:

"Dr Taylor is to write out a document reiterating the points of what was done and why and is to fax this to Mr Brangam over the weekend."

And if I help you with that, if I can just bring up alongside of that 122-026-001. It's a bit faint, but if we go to the first (i) in a circle, "Spoke to", and you will see:

"Dr Taylor is at home. He understood that he had to prepare the summary for tomorrow's consultation."

So that is dated 17 June. This is the note of the consultation 14 June, saying that you're to write out a document reiterating the points, and this is a memo which is dated 17 June, saying that a summary is to be provided by you for tomorrow's consultation. Of course, 18 June is the beginning of Adam's inquest.

A. Yes.

Q. Did you, in fact, provide a document reiterating points of what was done and why to Mr Brangam, either by fax or by bringing it to a meeting before the inquest?

A. I can't remember, but it would be my -- I did what I was told. I normally did what I was told, and this would be an important thing for me to do so I would imagine that, yes, I did prepare a document and either send it or bring it with me.

Q. I take it that means you no longer retain a copy of it if you did it?
A. I can't find a copy and I would have expected Mr Brangam to have retained a copy in his notes.
Q. Okay. Then the final thing I wanted to take you to is, as you know from the evidence this morning, Mrs Neill actually produced three documents for us. One is the note of the consultation, another is the note of the inspection of the equipment and then the third is the note of the hearings at the inquest. If we go to the note of the inspection of the equipment, that's 122-001-007.

Then if you look at the first three paragraphs, just for context, which set out the position, describing the monitor.

Firstly, sorry, do you remember taking Dr Murnaghan and George Brangam to inspect the equipment?
A. I don't recall that, but clearly I was there so I don't dispute that I was there.
Q. Right. So then you see the monitor, it's describing the monitor, showing the heart rate, arterial pressure, percentage saturation and so forth:

"There are default alarms on the screen with the CVP alarms at 20 and minus 5. However, the alarm had been suspended in this case so it did not go off, even though

the CVP readings went above 20."

And if we can please pull up the monitor printout itself so that we can perhaps see what's being said there. 094-037-217. If we can put that alongside. Well, maybe you can't. But while it's on the screen, can you see up at the top left there is a little thing that looks like a megaphone with a cross through it.

A. Yes.

Q. Is that indicating that the alarm had been suspended?

A. It would indicate an alarm has been cancelled or suspended.

Q. Cancelled or suspended. Can we please go back to 122-001-007, the second paragraph? I wonder if you could highlight that for us. Was the alarm in fact suspended in Adam's case?

A. Well, it says it was suspended in this case for the CVP.

Q. Yes. Well, who else would be able to provide that kind of information? Or rather who would be able to provide --

A. It would be provided by me, presumably, or Dr Montague.

Q. So can you explain why the alarm would be suspended so that it wouldn't go off even if the CVP reading went above 20?

A. Well, Dr Haynes has provided --

Q. No, no, sorry: can you explain?

A. Alarms can be very disturbing to the operating staff and, as I gave evidence before, I knew that the CVP was in the wrong place and it was providing an abnormal reading, one that I ought to have paid more attention to, and I'm sorry that I didn't. But it meant that the alarm would therefore be going off quite frequently throughout the operation. As the anaesthetist stands beside and watches the monitor, then cancelling that alarm does not put the patient in any danger. Were the anaesthetist to be distracted or leave the patient for any reason, which he shouldn't do and I wouldn't do, but certainly for intensive care the alarms are an important part of the patient's safety. But I believe that when one is standing beside the monitors and one knows the reason for a nuisance alarm that continually goes off and that one is already aware of, then there is a reason for cancelling that alarm at that particular time.

Q. And that's your explanation?

A. That's my explanation.

Q. How audible is the alarm if it goes off?

A. This monitor is no longer used. The modern monitors, you can change the level of the alarm.

Q. Sorry, how audible was the alarm that was on the equipment used during Adam's procedure?

A. I can't remember how loud this alarm was.

Q. If it went off, would people around it be able to hear it?
A. Yes.
Q. Would the nurses and the surgeons be able to hear it if it went off?
A. Yes.
MS ANYADIKE-DANES: Thank you. Mr Chairman, I don't have any further questions.
THE CHAIRMAN: Thank you. Any questions from the floor?

Okay. Mr Hunter, I think Mrs Slavin might be looking for you behind you.

Doctor, just while we are waiting for him to come back, I want to explore just one other point with you. One of the apparently strange pieces of evidence which we heard before was from Eleanor Boyce, who was the transplant coordinator. She gave her evidence on 27 April. She said she came over to the hospital, not to go into the theatre at all, but only to see Adam's mum. And in effect, she only wanted to say to her, "When this is over, would you write a letter to the donor's family because they can get consolation from the death that they've suffered if there has been a successful use of one of the donor's organs which helps another child?". But she says she was told as she arrived that things had gone badly wrong, as a result of

which, she went into the operating theatre and saw you and Mr Keane and she said everybody was working away. She had been told that Adam was brainstem dead and she wondered to herself when she saw all this going on, "Why is this operation still going ahead when he's dead?".

The lady who gave that information, the nurse who gave that information, Joanne Sharratt, said, "That's not right, I didn't have that conversation with her"; okay?

A. Right.

THE CHAIRMAN: So I was left in a curious position, two witnesses doing the best they could, had quite different recollections. But whether Eleanor Boyce heard from Joanne Sharratt or how she heard, if I take her evidence, her evidence is that she wasn't supposed to go into the operating theatre at all, she only went in because she was somehow alerted to the fact that things were going seriously wrong, and when she went in, after being told outside that things were going seriously wrong, everybody was still working away with Adam. And she was wondering, "What are they doing?".

That evidence is something I have to consider, but you'll understand how, on one interpretation, the consultation note at page 5 seems to add some credibility to it.

A. Yes.
THE CHAIRMAN: And in essence, what she's saying is, "I wasn't part of this procedure, I wasn't part of the operation, I wasn't meant to go into the theatre at all, but I did for the reasons I've given, and when I did, everybody was working away with a patient who'd -- word had already reached outside the theatre that Adam was dead". Do you confirm in your evidence that you don't accept that that can be right?
A. As I've said before, the first time I knew that Adam was having a problem, was potentially brain-dead, was the fact that he didn't start breathing at the end of the skin closure when I tried to wake him up. That would have been around 11 o'clock. But that cannot be confirmed until the CT scan, again, indicated that he'd suffered cerebral oedema, and then the following morning when the brainstem tests were done. So it doesn't seem to make sense to me that if she had been in the operating theatre before 11 o'clock that there would have been an indication that Adam could have suffered an irreversible brain injury.
THE CHAIRMAN: Right. So you think the earliest time it could have been was around 11?
A. There was an indication at that time that Adam had suffered -- I think I've written down that he had fixed

dilated pupils at that time.

THE CHAIRMAN: So let's suppose that word of this awful development spreads very quickly outside the theatre and let's suppose that Eleanor Boyce comes along and finds that out. When she comes into the theatre for the first time, what do you say she would see when she came into the theatre in terms of doctors working on Adam and what you were doing and what she says Mr Keane was doing? You would still have been working on Adam, would you?

A. Well, at that time when I was trying to wake Adam up, I would be doing tests on his nerves and muscles to check that the neuromuscular blocking drug had worn off. I would be checking to see if his blood sugar and other things that could have explained the fact that he wasn't breathing. Certainly, the surgery would have been finished by that time. I wouldn't have attempted to switch off the anaesthetic and wake him up or try to wake him up until the surgeons had stopped operating.

THE CHAIRMAN: She says she saw a surgeon there. In fact, she says she saw Mr Keane there. That's a matter of dispute, but let's say for a moment that a surgeon had been recalled. Was there anything for a surgeon to do?

A. After the skin is closed and the bladder catheter -- I think it was a suprapubic catheter -- was put in around that time and I was trying to wake him up.

I can't imagine I was trying to wake up Adam before all the surgical procedures had been completed. One doesn't do that.

THE CHAIRMAN: If you were trying desperately as best you could to find out what had gone wrong and reverse it or improve it, was there anything for a surgeon to be doing at that time?

A. No.

THE CHAIRMAN: Do you remember a surgeon being there at that time, or do you not remember --

A. Perhaps writing a note or doing some other post-procedure thing, but certainly there would be no further operation.

THE CHAIRMAN: So in effect then, when efforts are being made to save Adam at that point, it's some time from about 11 o'clock, it was you on your own?

A. Yes, well, the surgeon wouldn't have been operating. He may have been present writing his notes or doing something but a surgeon wouldn't have been operating at that time. I can't see how a surgeon would have been operating at the time when I was waking Adam up.

THE CHAIRMAN: Sorry, just to make it clear. You're trying to wake Adam up, you find you can't, you then start to do a number of things to see if you can or see what more can be done. At that point, would you call for help?

A. Yes, I think Dr Campbell came in from the next theatre, Dr Rosalie Campbell.

THE CHAIRMAN: Even if a surgeon wasn't able to do anything on Adam, would a surgeon stay and help and maybe make suggestions or even be there to show concern?

A. That's possible, yes.

THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: Two points that I omitted. In fact, you're right there. What I think hadn't been explained is exactly what was ... You say that if the skin closure -- and that is what's recorded in the note at 122-044-045 -- happened at 11, what was happening actually in the operating theatre between 11 and 12 when Adam is sent off to paediatric intensive care? What's happening in that hour?

A. I can't remember, but --

Q. Well, what would be happening in the hour if skin closure has happened?

A. The dressing would be put on the patient and I would be switching off the gas, the anaesthetic gas, the halothane, giving oxygen, giving a reversal drug, the neostigmine glycopyrrolate and giving some time to allow the patient to recover his respiratory status. I would be completing my chart and possibly measuring -- tallying up the blood loss that was on the nurse's ...

So I would be completing my record, waiting for Adam to start breathing, which he didn't, and then preparing for his transfer into intensive care.

Q. And that takes an hour to do?

A. Well, normally it wouldn't take an hour, but with Adam there was a prolonged period of failed recovery. In other words, there was a period of waiting for him to commence breathing, which didn't happen.

Q. Yes. If I can refer you to Dr Haynes' most recent expert report, 204-016-002. The paragraph which starts "spontaneous breathing". If we can start with:

"Following a major operation, such as a renal transplant, I would expect spontaneous breathing within five minutes or so following cessation of ventilation. But full protective airway reflexes may not be present for a further five to ten minutes."

Leaving aside how long it might take a patient to actually wake sufficiently up to have a conversation with you, am I right in interpreting this as meaning that within about ten minutes, you would know whether you had a difficulty? Do you accept that?

A. Ten or 15 minutes, one would expect the patient to return to spontaneous breathing.

Q. What happens for the rest of the 45 minutes?

A. I think his arrival time in PICU was 11.40.

Q. No, it was 12.05.
A. I can't explain where the time went, but there was obviously time spent working out problems and trying to find out what was going on. I can't account for where the time went.
Q. Why doesn't he get rushed immediately to PICU? If you can't wake him up within the 15 minutes when you think he should be doing that, maybe you spend a few more minutes having another go, nothing is successful. Why don't you get him immediately to paediatric intensive care?
A. Rushing to PICU doesn't make you better. The patient is already on a ventilator, he's on a monitor. He has a consultant anaesthetist standing beside him. I would argue he's in a better state than being rushing to PICU, as you describe, and being left with a PICU nurse by his side. There's no magic about rushing a patient to PICU.

In fact, very often -- and I don't remember if this happened in Adam's case -- the delay in taking a patient to PICU is to wait for the nurses and the doctors in PICU to prepare a bed for the arrival of that patient. So there may have been nothing sinister, perhaps as you suggest, in his delay. It may have been that the nurses and doctors in PICU have merely said, "Can you hold him in theatre for a few more minutes while we prepare

a bed?". I can't remember.

Q. Well, can we go to witness statement 014/2, page 6? That is the witness statement, I think, of Dr O'Connor. If you see right down at the bottom:

"At the end of the anaesthetic, when trying to wake Adam up, Dr Taylor discovered that he had fixed dilated pupils. I think this was about 12 midday and he was moved immediately to intensive care and I recorded a note there at 12.05 pm."

And it gives the reference for that note.

So then I'm asking what's happening between about 10 to 15 minutes from 11 o'clock at skin closure to that time, to Adam?

A. Well, I can't remember. There would have been a period when I was waiting for Adam to regain his protective reflexes and start breathing. That clearly didn't happen in 10, 15 minutes. I then spent another period of time investigating why he wasn't breathing and then I presumably was waiting for the clearance to move him into intensive care.

Q. When he's in that stage, so you know after 10 to 15 minutes that spontaneous breathing isn't happening, you can't produce it, is that not the time to contact, apart from Dr Campbell, his nephrologist?

A. I can't remember if I tried to contact the nephrologist,

but this was a job for the anaesthetist to work out why a patient doesn't breathe immediately following an operation. There may be a period required longer than the usual 15 minutes with a long operation. I simply can't remember why it took an hour to get him to intensive care. But I don't believe he suffered any difficulties by remaining in theatre for that time.

Q. That's a slightly different issue. We're trying to work out the timings of things. It's true that Adam was expected in intensive care. So it wasn't that you had to book a place because something untoward had happened in the theatre; he was actually expected to go from the theatre to intensive care.

A. A bed was booked in intensive care. That doesn't always say a bed is immediately ready when a bed is booked in intensive care. They may have had another admission just at that time and they may say, "Your patient's fine, he's on a monitor, he's being ventilated, he's in theatre. We'll admit the child with meningitis first and then, when the nurses are free, we'll let your patient come in". So there can be other explanations even though a bed is booked on a particular day. It's not always immediately available and there's no great benefit or magic about admitting a patient to intensive care suddenly.

Q. I understand. In any event, you have no real explanation of what was being done with Adam for a large part of that period from, let's say, about 11.15 to about noon?
A. That's right.
Q. And just because I was asked to, the other period of time that there seems to be a little bit of gap to try and explain, if I can put it that way, is when you were giving your evidence in answer to some questions from the chairman, and I think, although we're only dealing with the provisional text, it appears at page 69 of this transcript. I think after a bit of trying to work out matters, you had agreed with the chairman that it would be about 45 minutes after you were noting 9.30, if you like, that you thought that everything would be finished and the operation would, to all intents and purposes, be over. And what is being asked of you is, that takes you to about 10.15, as I think the chairman said. What is the explanation for what's happening between 10.15 and 11 o'clock when skin closure is recorded?
A. Well, I think I already indicated --
Q. I apologise if you did. There was some lack of clarity as to what was actually happening.
THE CHAIRMAN: And I think there is a lack of clarity and I've explored it and you've explored it. I think we'll

let Dr Taylor go without another explanation.

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

Questions from MS WOODS

MS WOODS: I wonder if I could remind you of some of the evidence Dr Taylor gave in the clinical section? A few minutes ago, Dr Taylor was asked some questions about who may or may not have been present in the theatre with him at the time he was trying to wake Adam up and we got more of the -- no criticism to Dr Taylor -- "That's possible" type answers. When this was addressed on 20 April, these questions were asked of him:

"Who was with you at the end of the surgery when you were trying to wake Adam up?"

Just so we're absolutely clear his answers at that point were:

"I have no memory who was with me at that stage".

The reference is on page 127 of the transcript for that day.

THE CHAIRMAN: Thank you.

Okay. Can we let Dr Taylor go?

Doctor, thank you very much again.

(The witness withdrew)

THE CHAIRMAN: Can we start with Dr O'Connor?

DR MARY O'CONNOR (called)

Questions from MR STEWART

MR STEWART: Dr O'Connor, good afternoon. Have you had a chance over the summer to see the consultation note that we're discussing?

A. Yes.

Q. Have you over the course of the summer had the opportunity to discuss the content of this with any of the other witnesses to this inquiry?

A. I understood, and maybe I was wrong, that that wasn't appropriate behaviour. So I did not discuss the contents with any other witnesses. I did ask a question of our current transplant surgeon, not quoting the document, but I asked him a question about the practice of putting needles into renal arteries because the whole document puzzled me. So I did have a conversation with Mr Connelly, our current transplant surgeon, but not relating directly to the evidence in front of me, just asking him some questions about practice.

Q. Okay. What was his name again?

A. Mr John Connelly, the current senior transplant surgeon.

Q. I see. Having studied the note, can you identify any inaccuracies within it?

A. I was not at this meeting. In fact, I was in Corsica when this meeting took place, having checked my diary. So I find it difficult to be asked about the content of a meeting that I wasn't present at.

Q. Yes.
THE CHAIRMAN: Can I just pick up one point you mentioned a moment ago? Am I right in saying that you said a moment ago the whole note puzzled you? Or was it just ...
A. Much of it puzzled me, yes. A lot of it didn't make medical sense to me.
THE CHAIRMAN: Okay.
MR STEWART: A lot of it didn't make medical sense to you?
A. Yes.
Q. Was there anything in it that you found particularly surprising or new?
A. I was surprised by many things. It might be easier if I had a copy. Am I allowed to have a copy of it in front of me?
Q. Absolutely. 122-001-001.
THE CHAIRMAN: If the witness has a hard copy in front of her, that does no harm.
MR STEWART: No.
A. This is my copy here. I've highlighted one or two sections.
THE CHAIRMAN: That's okay. The question you were being asked was: was there anything in the note which you found particularly surprising or new?
A. Um ...

THE CHAIRMAN: Take your time. Take a few minutes.
A. There were a number of things. First of all, I find it hard to follow because it wasn't written in the form of a transcript and, as it was some sort of amalgamated note, it was hard for me to know who was meant to have had what opinion expressed in it.
THE CHAIRMAN: Yes. You now know it's not supposed to be a transcript.
A. Yes. Secondly, I found the table very confusing. In this table, I couldn't figure out where some of these figures come from myself. I was particularly surprised at somebody writing down 60 ml per hour for metabolism. We have referred in this inquiry before to the fact that a child has what we call insensible losses. And that's usually the sort of fluid that's probably described here as for metabolism. It's not a phrase that I would use. But there's a very clear calculation for working that out and, in Adam's case, it was 9 ml per hour and I don't think that's ever been disputed. So the fact that somebody would write 60 ml an hour, it's such a blatant error that I just ... That didn't make any sense to me.
MR STEWART: Do you attach any significance to the fact that that is underlined as though to draw attention or emphasis to it?

A. I didn't do the underlining, so I can't pass comment, but it doesn't make medical sense.

MR FORTUNE: The third line. It's the addition --

MR STEWART: Thank you for that. Mr Fortune's quite correct, this is an addition, that is not an emphasis. I'm sorry.

Carry on, please.

THE CHAIRMAN: Just before you go on from that, you've heard Dr Taylor give his evidence.

A. Yes.

THE CHAIRMAN: This appears to be details of the fluid calculation. That, you would expect, to be part of a consultation in which Dr Taylor's particularly involved.

A. I don't know where these figures came from. It doesn't tally with --

THE CHAIRMAN: Dr Taylor's already been asked a number of times today, is there anything specifically inaccurate, significantly inaccurate, which you can point out in this document. And I think we were at pages 4 and 5, and his -- he did not say that the table on page 2 was wrong.

A. It doesn't make any sense to me. Even the comment about "less 10 to 20 ml per hour urinary output of a normal child". The urinary output of any other chid is of no

relevance to Adam. We have an idea that his urine output was about 1,500 ml per day. But the fact that ... No normal ... The average urine output is about 1 ml per kilo per hour. So your urine output depends on your weight.

MR STEWART: Do you disagree with Dr Taylor's calculations?

A. I don't know whose calculations these are, but the table doesn't make sense to me.

Q. Okay. Yes?

A. The next page, the comment, "The kidney was in at around 9.30 am". I suppose it depends what you mean by "in".

Q. I think it's described here precisely. The vein was in and the arteries were being finished. So it looks as though vascular anastomosis was well progressed.

A. That's absolutely not true.

Q. Can I just stop you there. "That's absolutely not true." On what basis do you say it's absolutely not true?

A. On three bases. One, the note I made to say that the vascular anastomosis was at 10.30, and that note is in the chart.

Q. Perhaps we'll take that first.

A. It's a very important thing to record. It's usually the responsibility of the transplant surgeon to record the times out of ice and the times of the anastomosis. But

if you're in theatre -- the reason I wrote the note in the margin was so it wouldn't be forgotten.

Q. Thank you. Page 058-035-134.

A. That was an aide-memoire for when the proper note was to be written. But that was because that's an important time to know.

Q. Yes. Can I ask you a question or two about that? It's obviously been entered into the record as it appears, an afterthought? It's not part of the record, it's written in the margin.

A. It's written as an aide-memoire for when the more detailed note would be written.

Q. Yes.

A. It's something that has to be recorded in the documentation that goes back to UK Transplant. And as I understand, on that form, it was recorded at 10.30.

Q. Yes. My question was: was it entered as an afterthought? I didn't ask whether it was there to remind you as an aide-memoire, but if it was entered non-contemporaneously. It was not put in at 10.30, was it?

A. It was put in in the midst of me writing a summary note that was going to be part of my record later on.

Q. What time did you enter it?

A. Um ... I cannot be entirely sure if I physically wrote

the note at 10.30, but the time is recorded usually on the whiteboard in theatre.

Q. Could you have written the note at 10.30?

A. Yes, I could have.

Q. Could you have written the note at 12 o'clock?

A. No, because at 12 o'clock I was writing several pages hence.

Q. Could we go please to page WS014/2, page 8. We see here at (d) in the middle of the page:

"If so, state when was the vascular anastomosis entry made."

These are your replies:

"This entry were made some time between 10.30 am and 12.05 pm on 27 November."

So do I take it that that entry there is correct or is your evidence today correct?

A. The next timed note that I personally wrote was 12.05, which is probably why I phrased that in that way.

Q. Can I ask you then, at 12.05, why you didn't include this note, this aide-memoire "vascular anastomosis 10.30", within your 12.05 pm entry?

A. I probably would like to see that entry.

Q. The next page, 058-035-135.

A. My main concern at 12.05 was the serious state of Adam's neurology.

Q. At 12.05, it's in a different sort of pen, this looks like a felt tip pen:

"Returned to ITU post transplant surgery."

Is that post-operatively?

A. Yes.

Q. Why did you not choose, if you were writing at 12.05, to include this vital piece of information within the body of that entry?

A. My concern at that time was that we had a very sick child who wasn't breathing, and the content of the note seems to follow a thought process of what's going on here in terms of why he's not breathing.

Q. Can I suggest to you that it doesn't seem likely it was entered at 10.30 itself?

A. I can't tell you exactly what time I wrote that note. I can tell you some other evidence to say --

Q. May I stop you? The question was, before we get deflected from the question: it's unlikely that you made the entry at 10.30.

A. I cannot tell you precisely at what time I made the entry. It may have been 10.30 or it may have been another time.

Q. If it was at 10.30, it would mean, would it not, that you were present in theatre for anastomosis?

A. I may have been. I have written on a drug kardex, which

my barrister has the reference for, I prescribed a drug, azathioprine, at 10.20. All the immunosuppression drugs for transplant must be given before the clamps are released and we have evidence from the anaesthetic record that the methylprednisolone was given at 10 am and the azathioprine on the anaesthetic record is signed for between 10.00 and 10.15 but I actually signed it and prescribed it on a drug kardex at 10.20.

MR BRADLY: Sir, can I give you the reference for that, please? It's 057-021-033.

THE CHAIRMAN: Thank you. If we can bring it up, that might help. It's the final entry, doctor, is it?

A. Yes.

THE CHAIRMAN: 27 November.

MR STEWART: What time is that, 10.20?

A. Yes.

Q. Can I give you a reference, 508-003-005? This is another chart. You see at the top left-hand corner there is a series of drugs.

A. I have just made reference to this chart, which shows that prednisolone, which actually was methylprednisolone, was given dead on the line of 10 o'clock. Do you see the "200" straddles the line at 10 o'clock?

Q. That's right. And the next one which you have just

referred to --

A. The next one is written in between 10.00 and 10.15.

Q. Yes, not 10.20.

A. I prescribed it at 10.20. It was the time that I --

Q. Why is it entered here between 10.00 and 10.15?

A. This isn't my record, but I suppose we're talking about a time of five minutes.

Q. All right. Just to get back to the anastomosis note and when it was entered. If you'd been in theatre at 10.30 and witnessed the anastomosis, you would then presumably have been able to write it down?

A. My practice would be, and still would be, to write a note, a summary note when the child goes to intensive care, which I admit I sometimes start in theatre if I'm there and nothing else is happening, and to write a chronological account, the history of the child, what's known about the transplant kidney. I usually record the time out of ice, the time that the clamps are off. I work out cold ischaemic time, warm ischaemic time. I then go on to record drugs and fluids given in theatre, and then to write a post-operative note.

Something very catastrophic happened to Adam and when I started to write notes again at 12.05, this is a very sick child who's not breathing and my focus was less directed towards the transplant rather than he's

a sick child, what's wrong with his brain? I did not forget about the transplant because the drugs I prescribed, as you'll see from the fluid balance chart in theatre -- sorry, in intensive care, include ciclosporin, which is an anti-rejection drug, and the other anti-rejection drugs were written up on the drug kardex from intensive care.

So the appropriate drugs were given for the maintenance of a kidney transplant, but our concern was, is this child going to live? Our concern at that time in the post-operative period in a child with fixed dilated pupils was not firstly about the kidney.

Q. To summarise your evidence, this entry was made between 10.30 and 12.05. You don't know when and you don't know if it was entered at 10.30 or not?

A. No, but the -- I am confident that the time of 10.30 is accurate because that would have been recorded on the whiteboard in theatre.

THE CHAIRMAN: Sorry, let's pause a minute, to be fair, because Mr Stewart quite properly explored that particular point with you. You said a few minutes ago and I want to make sure we get this piece of your evidence. You said it was absolutely not true that the anastomosis was at around 9.30.

A. Yes.

THE CHAIRMAN: It was at 10.30 and you said there were three reasons for that. Now --

A. The first reason --

THE CHAIRMAN: We'll go into the details of the reasons. Let me get a note of what the three reasons are.

A. The first reason is my note in the margin saying 10.30. The second reason is that all anti-rejection drugs always must be -- always are -- given before the clamps come off. It's a principle of transplantation. Often, they're given half an hour beforehand. But they must be given before the clamps come off. And we do have a record on the anaesthetic chart of drugs being given at 10 o'clock and between 10.15 as recorded here, and my own record of 10.20 for the azathioprine.

THE CHAIRMAN: Okay. And can you remember what your third reason was?

A. I think I was referring to the three notes -- the drug kardex, the anaesthetic sheet and the "10.30" in the margin.

THE CHAIRMAN: Okay.

MR STEWART: Are you surprised, therefore, that Dr Taylor should have taken the view that it happened at 9.30?

A. I'm astounded.

Q. And that he should have given evidence to that effect to the coroner?

A. I would need to be reminded of his evidence to the coroner. I don't know what time, but I wasn't at the inquest.
Q. Does that surprise you, that he should have felt it was wholly consistent with his note and his reading of the notes that it should have happened at 9.30?
A. I'm quite clear that it didn't happen at 9.30.
Q. Well, his evidence to the coroner is at 011-014-105. I will take you to it.
A. I'm not sure how fair this is to ask me to comment on his evidence to the coroner because I wasn't there.
MR UBEROI: Perhaps I might rise on that point just to ask my learned friend to clarify what he means by "consistent with his note". Perhaps if we can bring that up and, as the witness is encouraging, if she can always be taken to a document when she is being asked to comment on it as opposed to being asked to comment on it in the abstract. But particularly on that question about the consistency of the note, I'd be grateful for the reference.
MR STEWART: Dr Taylor did not say this morning that he found anything about the idea of a 9.30 anastomosis to be contrary to his reading of the record.
MR UBEROI: I certainly don't intend to engage in debate across the floor now, but as a general principle

it would be uncontroversial if a reference for that is being made and a mention to something is being shoehorned into a question, then I'd be grateful if the note could be pulled up on screen.

THE CHAIRMAN: Okay.

MR STEWART: You have here a note of the evidence, a signed deposition that he gave at the inquest, and it is about ten lines down:

"The new kidney did not work, leading to a reassessment of the fluids given. This made us think we had underestimated fluid and we gave fluid bolus at 9.32."

That's an example of Dr Taylor finding a consistent entry in his note with a 9.30.

MR BRADLY: Sir, I haven't risen until now, but it seems to me now that this witness is really being asked to comment on the quality or content of somebody else's evidence given a long time ago in 1996. I don't know if my learned friend could explain the basis for these questions and why the answers are going to help.

THE CHAIRMAN: I think you might take it, Mr Bradly, that Dr O'Connor is saying: I'm astounded Dr Taylor said anastomosis was at 9.30.

A. Yes.

MR UBEROI: And I will close off my objection -- I'm sure it

was unintentional -- but the suggestion that Dr Taylor had made a medical note of that anastomosis being at 9.30, I don't believe that is supported in the evidence.

MR STEWART: I didn't suggest for one instant that he had made a note of it; what I did say was that he didn't see anything that was inconsistent with his note or his reading of the note.

THE CHAIRMAN: To be fair, what Dr Taylor's done today is reinterpret his earlier position because he originally thought it was 9.30 and he's now saying, actually, in light of the other notes, I think that's wrong. But something significant happened at 9.30, the anastomosis must have been later, it must have been about 10.30, because that's what the others are saying. But he's saying that's not what he understood it to be. It's very, very curious. I won't put it beyond that, but it's very curious.

MR STEWART: Dr O'Connor, that is one of the things we have to explore. The differing accounts given of what happened on that morning of surgery.

A. Can I reiterate that one must give the anti-rejection drugs before releasing the clamps?

Q. Yes.

A. It's like one and one equals two. It's as straightforward as that.

Q. And it's for that reason alone that you feel clear that it's a 10.30 anastomosis.
A. Plus I've written "10.30". I didn't write that for ...
THE CHAIRMAN: For any other reason than you thought it was 10.30?
A. This was going to be part of my record and accurate.
MR STEWART: You were keenly following to a point what was happening in theatre that morning?
A. I was in and out, and this has been explored in my evidence before. I cannot give you precise timings of when I was in and out. I know that I must have been there at 10.20 because I prescribed that drug. I have said in my evidence before, I have no recollection of any concern at the time the clamps were released. I cannot say for certain that I was there when the clamps were released because I don't remember anything untoward. I think it's very likely I was there when the clamps were released if I was there prescribing drugs beforehand.
Q. When was the first you were aware of anything untoward?
A. In terms of Adam --
Q. In terms of Adam and his condition, the condition of the kidney, anything about Adam. When was the first you were aware of anything untoward?
A. At some stage towards the end of the operation before

he was woken up, as you know I have recorded this comment that the kidney was said to be blueish. I cannot remember who made that remark. I don't recall witnessing, seeing a blue kidney. So that has made me think I heard this remark. But the first time I have serious concern about Adam is when I was beeped back to theatre after he was attempted to be woken up and Dr Taylor discovered he had fixed dilated pupils. That was the first significant concern.

THE CHAIRMAN: So the comment you heard about the kidney being blueish, that wasn't in the same league of seriousness as being bleeped back?

A. Oh, no, no, no, no. It was also a comment later on, it wasn't to do with the time of the vascular anastomosis.

MR STEWART: So you don't know when the kidney was observed to be blueish?

A. In the later part of the procedure, but I don't recall myself observing that. It was a comment that someone made.

Q. Do you know what time skin closure was achieved?

A. I don't know for sure, but the anaesthetic record goes on to 11 o'clock and I'm not sure if it goes beyond. But if the anastomosis was 10.30 -- and I believe quite definitely that it was 10.30 -- the ... At that point, and maybe these questions are best asked of a surgeon,

but in the operating field, the blood vessels are in one place and the bladder's in another place. So the surgeon then has to move his place of operating, if you like. And I do have a memory that it seemed to be the bladder that seemed to be difficult. He'd had previous surgery in and around his bladder, and that, in my opinion, as a non-surgeon, would have made the anastomosis of the ureter to the bladder perhaps more time-consuming than normal.

Currently, when we go to theatre for a transplant, normally I would speak to the parents after the vascular anastomosis. I would often leave theatre and go and tell them the kidney is plumbed in now, it looks okay, but we won't be seeing you in intensive care for two or three hours. That's my standard comment to parents.

Q. Did you go and speak to Adam's mother and tell her that anastomosis had occurred?

A. I spoke to Adam's mother some time in or around 10 o'clock I think. Some time ... I wonder if it is when I went to the ward to get some drugs because the drug azathioprine wouldn't be carried in theatre. I don't think the anastomosis -- if anastomosis has happened, I would say so to the parents. I think I spoke to her before the anastomosis. Of course, my habits in theatre and what I say to parents have very

much been influenced by Adam's case. Because as I've said in my evidence before, it was not routine practice for nephrologists to go to theatre. In very many of the UK units, they don't go to theatre at all, and my practice of going to theatre and leaving theatre to go to speak to parents has been extensively influenced by Adam's case.

THE CHAIRMAN: I want to bring you back to the note because it's the note that we're focusing on.

A. Okay.

THE CHAIRMAN: Mr Stewart was asking you about what you regarded as mistakes in the note. I think we'd got to the top of page 3 where it says, in this case, the kidney was in around 9.30 and you have explained why you think that is absolutely not correct.

A. Yes.

THE CHAIRMAN: Can you now take us on to what you regard as the next significant mistake in the note?

A. Well, I think there's already been an awful lot of discussion in my evidence about CVP. I don't think I have anything different to add to the comments I've made in my deposition about CVP.

THE CHAIRMAN: Yes.

A. I think that the next significant comment I would make would be at the top of page 4, when I absolutely cannot

understand anybody to make the comment that you would open a bladder early on in the transplant procedure. There's a certain stage in transplantation, you expose the operating area -- and again a surgeon is more qualified to answer this question -- but the first thing is to anastomose the kidney, the artery and the vein. And when the surgeon's happy with that and happy that there's no leak of blood, he then moves on to the less onerous task of anastomosing the ureter. So you don't go near the bladder until the kidney's plumbed in. It doesn't make any sense at all.

THE CHAIRMAN: Okay.

A. And we've had 69 transplants of Belfast children since Adam, and I was involved in 13 transplants, I think, before Adam. I've never, ever heard of a bladder being opened before the kidney is anastomosed.

MR STEWART: We discussed that earlier this afternoon. I think a trail of that comment may go back to Dr Taylor.

THE CHAIRMAN: Maybe we can --

MR UBEROI: Are we still on the "bladder being opened" point? It's not right.

THE CHAIRMAN: Sorry, no. I think you're at cross-purposes with Mr Stewart. I think what is really being said is that you heard what Dr Taylor said this afternoon

about the bladder being open.

A. Yes, but you asked me did I disagree with this document --

THE CHAIRMAN: Sorry, I understand you disagree with it. I understand it's entirely outside all your experience.

A. Yes.

THE CHAIRMAN: But Dr Taylor explained why he thought that that was so unlikely to have happened and do you agree with that part of the evidence which he gave?

A. I wholeheartedly agree. I would adamantly not understand how it could have been opened early on.

THE CHAIRMAN: Is that your point, Mr Uberoi, that it's not -- okay. Your next -- this isn't a failing in the note perhaps as much as maybe in a discussion -- it's for me to decide later, I suppose.

What's the next medical error that you have identified?

A. Hypernatraemia, rather than hyponatraemia. I think it's a typing error.

THE CHAIRMAN: Right.

A. I suppose going on down, the 10 per cent dextrose is mentioned.

THE CHAIRMAN: That's on page 5.

A. No, 004. In my experience, one would never give plain 10 per cent dextrose to a child of this age. It's

sometimes given to neonates because they have low blood sugars, but you don't ever give 10 per cent plain dextrose unless you're treating hypoglycaemia, when you give a small amount of it. So that doesn't make sense to me, 10 per cent dextrose on its own. You don't give 10 per cent dextrose to children generally over 4 weeks old, unless there's particular metabolic reason with low blood sugar, so that doesn't make any medical sense to me.

THE CHAIRMAN: Okay.

A. Further on that page, I don't understand comment "the bladder disadvantage". That's not a medical term, that's not quoting a doctor.

THE CHAIRMAN: Unfortunately, it's quoting a lawyer, which might make it more difficult.

A. Going on to the next page, I suppose the paragraph we've mostly concentrated on, about the needle in the artery. I was sent this document I think probably on the last -- around about the last day of the inquiry. I was at work and I got telephoned and e-mailed. I just couldn't understand this. And I had reason to speak to Mr Connelly, the transplant surgeon, about another child that I was dealing with that day. When I was on the phone, I didn't quote this to him -- I felt that I've understood that we're not to discuss actual evidence

from the inquiry. But I asked him, in his practice, had he ever known a needle to be inserted into a renal artery to check blood flow because, in the 13 transplants before Adam and in the 69 transplants we've done since, it is not something I've witnessed. I did ask him did he think there could have been some confusion. Someone describing the not uncommon practice of injecting a drug called papaverine, which is sometimes given if a kidney is poorly perfused.

That drug is given not if there's a blockage in the main big renal artery blood vessel, but if there is spasm in the vessels inside the kidney, the little ones that we don't see to the naked eye. And Mr Connelly confirmed to me that on the occasions when he gives that drug, he would never give it directly into the renal artery because of the risk of causing an aneurysm in that artery later on and that he would always give it in the more peripheral vessel of the iliac artery. When that drug is given, it is given with a tiny insulin needle because the surgeon doesn't want to make any large puncture in a blood vessel. And with that tiny needle, it wouldn't, as far as I know, be practice to withdraw back to look for blood. So I wondered with him was there any misunderstanding of if that had been done. But I have no recollection of that being done on that

day and I would expect: (a) to have been told about it; (b) to have probably witnessed it; and (c) it would definitely have been written in the surgeon's note. I've often seen it done in other transplants but I have no knowledge of that drug being given in Adam's case on that day. The drug is kept in a cupboard, the nurses would have to go and get it out. There would be some discussion of getting it out and so on. So I think there would be evidence if it was given.

MR STEWART: You concluded if there was no drug given, you concluded there was no drug given because it's not in the surgeon's record and it's not in the drug record?

A. Yes.

Q. And you therefore conclude it wasn't given?

A. I have no recollection of it being given.

Q. Okay.

THE CHAIRMAN: Well, there's no record of the drug being given. What Mr Connelly says is that even if you were giving that drug, you would not give it in that way.

A. No, you would give it in the iliac artery and it's always given with a tiny, tiny -- most people have met some diabetics. You've seen the little needles they use to give insulin. It's given with that little insulin needle.

THE CHAIRMAN: But if it wasn't given for the drug, and that

does appear not to be the case that the drug was not administered, then in effect are you relaying to us that Mr Connelly says you just would never ever ever put a needle into an artery to see if it was perfusing?

A. Mr Connelly has been our transplant surgeon since the end of 1996, I think, and obviously he trained in Manchester before that. He told me that he has never put a needle into a renal artery to check for blood flow during a transplant. I have witnessed Mr Connelly be concerned about the blood flow into an artery during a transplant and his practice, which would be a good practice, would be to take down the anastomosis and check for clots and so on if he was sufficiently concerned.

That can be difficult if the kidney is already perfused with blood. Sometimes you have to actually take the kidney away and put the clear perfusion fluid through it again and cool the kidney down again. It's very complex, it's probably going to put the kidney at big risk. It's possibly best commented on by Mr Keane, whose knowledge would be much more than mine of surgical practice. But I have witnessed Mr Connelly take down the anastomosis on occasions when he has been concerned there might have been a problem with blood flow.

MR STEWART: And in other words, have a second anastomosis

having cleared it?
A. Yes, but it's not without -- you are probably decreasing the chance of a successful transplant if you're trying to do that kind of thing, although I have seen it done successfully.
Q. It would only be done if there was a real reason and a real concern?
A. Yes.
THE CHAIRMAN: Can I just ask you this -- sorry to interrupt again, Mr Stewart. It might be very, very bad practice -- and I'm getting the very strong impression that it would be really, really bad practice -- but would putting a needle into an artery tell you if blood was flowing if you took the needle out and there was no blood with it? Would it be a terrible way of doing something of which there are a number of good ways of doing?
A. It's probably best to ask a surgeon about surgical practice, but I think the fact that Mr Connelly in all his years of transplantation told me that he has never done it ... We often put needles into arteries, the usual time is if you want to measure blood pressure and you put needles into the arteries here (indicating). As soon as you put a needle into an artery, usually the blood spurts out because there's a pressure in the

artery, so it kind of spurts like that (indicating). So you would usually expect, if you put a needle in, if the needle was sufficiently wide bore, that blood would spurt out. But if a currently practising transplant surgeon has never done it, I would not surmise that it would be good practice.

MR STEWART: But it could have happened?

A. I have no knowledge of it happening. I didn't see it happen and nobody told me it happened, so I'm very sceptical about the fact that it happened. I don't understand why it would have happened.

Q. But you fairly concede it might have happened?

A. I have no knowledge of it happening and I can't understand why it might have happened.

MR STEWART: Sir, the stenographers would be grateful for a short break.

THE CHAIRMAN: I suppose we need to keep it short to get Dr O'Connor finished. Can we do ten minutes and back at 3.55?

(3.45 pm)

(A short break)

(3.55 pm)

MR STEWART: If I might ask you to comment on some views expressed by Messrs Forsythe and Rigg at page 203-011-004. They were asked to comment at 4(b)

about the entry relating to needle being put into the artery. The question was posed of Messrs Forsythe and Rigg:

"What was the purpose of putting a needle into the artery? The purpose of putting a needle into the artery is to determine if there is a blood flow into the kidney. If blood flow comes out of the needle, then the surgeon is reassured that there is blood getting to the kidney. But if there is no blood and the surgeon is happy the needle is in the lumen of the artery, then this means that there is no inflow of blood to the kidney."

Secondly:

"Is this commonly done in transplant surgeries? In our experience this is very uncommon and is only done when there is concern about whether there is blood flow in the artery when no pulse in the artery can be felt."

Would you agree with that?

A. Because this is in the realm of the experience of a transplant surgeon, it's why, having never witnessed this practice or seen this practice, I asked Mr Connelly for his opinion because he was the surgeon to whom I had access. His results in transplant surgery, if one looks on the UK Transplant website, equal the best in the country. And the fact that he has never done this

practice, he actually told me that if you put -- if you were to do such a thing, you run the risk of causing an aneurysm in the renal artery, which could then cause problems later on.

So what I have spoken of is really -- I have never seen it and the expert that I have access to has never done it. And obviously --

THE CHAIRMAN: They're saying it's very uncommon.

A. Yes.

THE CHAIRMAN: If you are relying on what Mr Connelly says to you, he's maybe going a bit further than saying it's very uncommon.

A. He's actually saying he has never done it and he would consider it bad practice.

MR STEWART: Just for the sake of completeness, Messrs Forsythe and Rigg also comment on the bladder being opened at page 203-011-007. There at 7(a)(b)(i):

"Please explain what 'the bladder was open' means and why it was not possible to measure the urinary output?"

And they respond:

"The description of the bladder being open means that during the initial incision and exposure that the bladder was opened by cutting into it. It is likely that this was done inadvertently and not deliberately."

Does that, in a sense, answer the query you had that it would be strange to do it deliberately?

A. I have certainly never seen it done deliberately. I have also never seen it done inadvertently either.

Q. But this, at least, would provide an explanation for your query.

A. I don't know that we have any evidence that the bladder was open. I haven't seen any convincing evidence that convinces me.

Q. Very well. Can I ask you: you were, once Professor Savage left at about 9.30 that morning, part of the team, the team conducting the renal transplant operation.

A. I wasn't conducting the operation, but I was in and out of theatre and I was part of the nephrology team --

Q. Part of the team engaged with Adam.

A. I was the nephrologist responsible for his care in that time, but he was having an operation, being looked after by the surgeon and anaesthetist primarily at that time. I was obviously very interested in what was happening.

Q. I think you told the inquiry before that, in fact, Adam's case was given priority by you that morning.

A. I didn't have clinical responsibility for a patient who was anaesthetised and having an operation. A physician would never have the clinical responsibility for

a patient who was anaesthetised and having an operation. But I had huge interest in what was happening and obviously my primary task, as I saw it, was to ensure that it was clear about what immunosuppression was to be given, because we had made changes, and in fact I believe we had a further discussion that morning, which is why I prescribed azathioprine.

Q. Was that because you changed from the Bristol protocol to the Belfast one?

A. Bristol didn't use azathioprine, Belfast did. Bristol did use methylprednisolone and I used ciclosporin and we were kind of doing a bit of both. So I surmised we had a conversation about that and decided to use the azathioprine and that's why I prescribed it when Professor Savage hadn't already written it in the notes.

Q. Is it because of that change in the prescription that you were intent on being there to ensure that it was properly administered?

A. To ensure that it had been prescribed and Dr Taylor was clear what drugs they wanted, yes.

Q. And the initial prescriptions were given by Dr Savage?

A. For methylprednisolone. I can't remember if he prescribed anything else to be given. Mannitol -- Augmentin is an antibiotic and mannitol is to cause a diuresis. So the only immunosuppression that I think

had already been prescribed was the methylprednisolone. The azathioprine was additional and the ciclosporin was then given by infusion once we entered the intensive care unit.

MR FORTUNE: Can I help, sir? There are two references. You can have either 058-035-133 or 059-006-011. It's Professor Savage's note in the middle of the page, "In theatre to have". And then he sets out four drugs: methylprednisolone, Augmentin, a reference to a double or triple lumen line for the drugs, and dopamine.

A. Only one of those is immunosuppression, the methylprednisolone. I think we must have had had a discussion, I surmise, and added azathioprine to that.

MR FORTUNE: He made it quite clear that the methylprednisolone was to be administered before the clamps were released.

A. Yes.

MR STEWART: So your role was to liaise with the anaesthetist to ensure that the immunosuppression was given appropriately.

A. Yes, and it's why I had prescribed, in written form on a drug kardex, the additional drug which I wanted him to give.

Q. And that was one reason why you'd be going in and out of theatre to liaise with the anaesthetist. Another was to

be able to report back to Adam's mother the progress of the operation.

A. I suppose at that time if you like, that was a by-product of my going in and out of theatre. I've made it clear that since Adam's transplant I try very hard to communicate with everybody -- surgeon, anaesthetist, parents -- as best I can. But I didn't have a routine or a habit at that stage. I did anticipate that my primary task for the nephrologist was to look after the fluids immediately post transplant, and that would have been my practice in Bristol. And the practice of many of my colleagues throughout the country is that they meet the patient in the recovery room because the common situation -- it obviously wasn't the case with Adam, but the common situation post transplant is that lots of urine is being passed early on and if one does not keep up an appropriate amount of fluid going in and there's lots going out, then the kidney will clot and you will lose the kidney, and that is not an uncommon scenario. It's why the nephrologist would always be immediately present in the post-operative period.

Q. So you are very keen to know what the anaesthetist does and you are very keen to know what you might have to do post-operatively.

A. My main role is post-operatively. As I have said in Bristol, I didn't go to theatre except for one transplant --
Q. And, obviously, post-operatively, you are worried about clotting of the vascular anastomosis.
A. You're worried about very many things, but if the patient becomes dehydrated, there is a huge risk of clotting of the vascular anastomosis.
Q. So you want to be --
A. I sit at the bedside for many hours post-operatively -- this is what I do, I watch the in and the out and the CVP and the blood pressure. The fluids are calculated on an hourly basis in the post-operative period.
Q. So your critical focus is on that post-operative period?
A. Yes.
Q. Because that's when you come into your own, that's when you do your specialty?
A. Yes.
Q. In other words, you are waiting for the operation to come to an end so that your role can begin?
A. Yes, in the intensive care unit.
Q. So you're not distancing yourself very far from theatre, you're staying there or thereabouts and going in and out to see what happens?
A. Well, the ward is perhaps -- as it was then, was maybe,

I didn't measure it, maybe 100, 150 yards from theatre, so I wasn't any further away from the ward.

Q. So the longer surgery took, I would take it the more interested you become as to when exactly it was going to end so that you could start?

THE CHAIRMAN: Or while it's going on?

A. I certainly would have wanted to be in intensive care immediately on the patient's arrival.

THE CHAIRMAN: But if the surgery's going on longer than expected, you would want to know why because that might have some knock on effect on the complexity of the job which you're going to take over in intensive care?

Let's take a silly example. Let's suppose surgery's supposed to last for two hours and it lasts for five. You'll want to know what's going on because this shouldn't be happening and you must wonder, when I come to look after this child, am I going to find more problems than I expected?

A. I suppose I find it hard to answer in that my practice is always to be in and around theatre nowadays. While the child is in theatre, the giving of the fluids -- the normal thing is that the fluids are given and I appreciate here we didn't have an accurate CVP, but they're given to order, if you like, according to the blood pressure and the CVP. And while the child is

anaesthetised, that's the anaesthetist's job to do that.
THE CHAIRMAN: Let's make sure we've got the 1995 picture right. Because you had just come from Bristol, where it wasn't your practice to be in theatre at all.
A. No, you met the child in the -- in Bristol they didn't go to intensive care, they came to the ward where we had CVP monitors. So --
THE CHAIRMAN: So you were moving from a practice of being out of the theatre --
A. Yes and most nephrologists don't go to theatre. I was curious enough to ask my colleagues this.
THE CHAIRMAN: -- and to a practice whereby you're beginning to spend more time in the theatre than you had ever done before?
A. I think in my return to Belfast, the first case -- and the Trust have still never got me the notes for the case on 17 November. It happened in the middle of the night. I wouldn't have had other jobs to do and I would have been interested to be about and to observe. And in Adam's case, I obviously wasn't very far away, but my practice has entirely been coloured since then so I find it hard to say. I didn't have a norm by the time the second case came up in Belfast.
THE CHAIRMAN: Okay.
MR STEWART: Your witness statement, WS014/2, page 5 at (b):

"Explain what you meant by 'made myself available'. I was on site in the hospital, ready to supervise the post-operative transplant care. I went into theatre on several occasions as I was keen to know how quickly the operation was progressing and when I would be needed in intensive care at the end of surgery."

It seems to express the suggestion I was putting to you that you would have been keen to know about the progress.

A. Yes, I wasn't very far away. I said I was never further away than the ward.

Q. And the longer the operation went on, the keener you'd become to know when exactly it was going to conclude.

A. Well, can I say that nowadays if we have a vascular anastomosis done at a certain time, I often nowadays go and speak to the parents and say, "The kidney's plumbed in, it looks pink" -- that is maybe some reassurance at this stage -- "but you won't see your child for another two or three hours until we're into ICU and established with all our monitors". So it's not necessarily a very quick thing to come from the point of the anastomosis to being in ICU and to have anastomosis at 10.30 and be in ICU at 12 o'clock, I could go and look at notes for the last number of transplants and try and get figures for that. It's only an hour and a half, it's not a long

time between vascular anastomosis and being in intensive care.

THE CHAIRMAN: Are you saying from 10.30 to 12 is not an unusually long time for that process?

A. No, normally a lot of our transplants these days are live donors, so we do kind of have a time frame we're kind of used to because the parent goes to theatre at 8 o'clock or so in the City, the surgeon arrives over carrying his bag with the kidney about 11.45. The child goes down to theatre to have lines and things put in. We get a phone call from the City first, the child often goes down about 11.30. The surgeon will often start the surgery for the transplant about 12.30. And one of the things we now always do is do an ultrasound scan once the skin's closed. And I suppose I see my job as a facilitator trying to make everything work, and one of the difficulties I have is we're usually looking for that ultrasound scan and skin closure after 5 o'clock when the consultant radiologists have gone home. So currently, my job -- if we have a transplant, I'm usually up in theatre that morning, negotiating with the consultant radiologists, please will you stay after 5 o'clock. I'm going to need an ultrasound scan about 5.10, 5.15, please don't get in your car and go home, I'm going to need you then. So I don't see an hour and

a half after vascular anastomosis as a long time between then and getting into ICU.

MR STEWART: [Inaudible: no microphone] you have expressed -- we heard this morning from Dr Taylor about his indicative times. Forsythe and Rigg at 203-011-033, they've given their suggested times.

THE CHAIRMAN: Was Forsythe and Rigg not up on the screen a few moments ago?

MR MILLAR: Sir, is it the most recent report, part of that that you're looking for? It's 203-011, and part of it is --

MR STEWART: Try 203-011-003.

THE CHAIRMAN: Thank you.

MR STEWART: Yes. At the top of this page, second line:

"Indicative times for the different stages of the operation are as follows."

The one we're interested in is after anastomosis, which is the third and fourth bullet points:

"Time to check for bleeding and uretic anastomosis, 15 to 30 minutes. Closure of the wound, 10 to 20 minutes."

So it ranges there from 25 to 50 minutes from anastomosis to being ready to pack up and move on to the intensive care. That might take a further 10 minutes. So at most 50, 60 minutes?

A. I haven't had a stopwatch to time this. But between the point that the surgeon is finished and we get into intensive care, first of all the child has to be woken up. Dressings have to be secured to make sure lines aren't pulled out. Monitors changed because the child is monitored en route to the intensive care unit. I wouldn't expect to be in intensive care 10 minutes after the wound's closed.

Q. What would be your estimate for reversing the anaesthetic and generally preparing the patient for transfer to PICU? Would these be done simultaneously?

A. When the surgery's over and the child's awake, it still takes a time to make sure the monitors are in place and even to move the child from the operating table to the bed, we've got lines here (indicating), a tube here to be secured, an arterial line in the wrist to be secured, we perhaps have a drain in the abdomen to be secured. We've usually got an epidural anaesthetic to be secured, and I've been in situations when children are moved quickly on to the bed and the central line's pulled out. So generally, the team take care that all these lines are secured.

Q. Would that take an hour? Would it take an hour and a half?

A. Well, in Adam's case obviously there was a catastrophic

event that he had fixed dilated pupils and ... That caused consternation to everybody and there would have been a lot of --

Q. May I just put to you the timings suggested this morning from Haynes' report. It's 204-016-002, "Times of surgery: Comment", asking first of all about the time span for reversal of the anaesthetic, which for the purpose of this discussion is taken to mean the return of spontaneous breathing. Further on down, second paragraph:

"I would expect spontaneous breathing within five minutes or so following cessation of ventilation. Full protective airway reflexes, a further five or ten minutes."

That's ten to 15 minutes to come round. Then (b):

"Preparation of patient for transfer to PICU. No more than 10 minutes."

So in all, at most, about 25 minutes according to this expert.

A. I can't comment on anaesthetic drugs and waking up; that's out of my experience. But I can say that we are generally more concerned about all the lines and things being secured than the actual timing of how many minutes it takes to transfer to ICU because the child is at all times accompanied by an anaesthetist and it doesn't,

in that respect, really matter whether they're in theatre or ICU, as long as they're being looked after.

Q. Can I take you to WS014/2, pages 6 and 7? At the bottom of page 6 you were asked:

"State when and where Dr Taylor discovered Adam had fixed dilated pupils."

You respond:

"At the end of the anaesthetic, when trying to wake Adam up, Dr Taylor discovered he had fixed and dilated pupils. I think this was about midday as he was moved immediately to intensive care and I recorded a note there at 12.05 pm".

That does suggest that, in fact, the waking up process was really at or about midday.

A. Maybe I've misled with the word "immediately". He certainly was moved immediately from the time that I was called back and informed of this because I -- in my memory, I think when I arrived that he was on the journey from theatre to intensive care. I can't be entirely clear, but I have a horrendous memory of seeing him come through a doorway and being told that his pupils were fixed and dilated. I am not sure. I'm not sure if my memory's totally correct, when I was in the theatre or just saw him coming through a doorway. But my note there at 12.05. That's the time I wrote that

note. It would have taken me some time to try and find some facts to examine the patient. I think at that 12.05 I've recorded an examination as far as I remember, if you wanted to show me the note. It would have taken some time to do that. It probably would have taken me some time to ... I would have been shocked at this news. It probably would have taken me some time to gather my thoughts together to write a note. But the 12.05 is the time I wrote the note. Before that note, I have examined him and so on.

Q. The words "immediately moved to intensive care" is yours and suggests really the fixed dilated pupils were not discovered until the waking up process, which is about midday.

A. The fixed dilated pupils were certainly not discovered until the waking up process.

Q. And it would seem to suggest from your note that it was midday. Skin closure is 11 o'clock. Why does it take an hour to get to waking up stage?

THE CHAIRMAN: Let's be fair. The witness has asked to be referred back to her note, which started at 12.05. Is that 058-035-134?

MR STEWART: It's over the page.

THE CHAIRMAN: Yes. Give us 135, please.

So what you're saying, doctor, just to get it clear,

for you to write this note at 12.05 -- the 12.05 means that that's the time you start to write?

A. That's the time I wrote this note and I had obviously gone through some thought processes and I don't know what the next page says exactly, but I think I examined the patient.

THE CHAIRMAN: Can you give us 136 as well as 135, please, the two together?

A. Yes, so I had examined the patient. I had looked at his pupils, I'd done the examination of the back of his eyes, I'd examined him neurologically in terms of his reflexes, I'd examined his abdomen. I had looked at the fluid balance chart and recorded these numbers. That all would have taken me some time to have looked at that information.

THE CHAIRMAN: Right. Okay.

MR STEWART: Could I establish when you actually did go into theatre as best we can? Because you've told us that you don't remember --

A. I don't have timings, no. I do know that I wrote that drug kardex at 10.20 am.

Q. But that doesn't mean to say you were in theatre at 10.20 does it?

A. Yes it does because the kardex was in theatre, yes.

Q. Very well. So that's one fixed point, 10.20.

THE CHAIRMAN: Does that mean for you to write that at 10.20, that you were there before that and you've been -- or does it mean that you've been there before that and you've been discussing what's going on with the anaesthetist and the surgeon as best you can put things together?

A. As best I can put things together. I think I went to the ward to get the azathioprine, and that might have coincided with the time that I spoke to Adam's mother. The fact that I prescribed that drug at 10.20 confirms that to me because I wouldn't give a drug after the anastomosis, that that was before the anastomosis. The comments that I've made previously about looking at the CVP and discussing with Dr Taylor that it was 30 and that alarmed me. The time anyone is most interested in the CVP is immediately prior to clamp release. It would make sense to me that I would have looked at the CVP reading immediately prior to clamp release. So I think I would have had discussions about the CVP at that time.

MR STEWART: The first time I can track you into theatre is about 9 or before 9 o'clock.

A. I think I came to work at 9 o'clock, so I have been questioned extensively before about what time exactly I first went into theatre, and I wasn't able to clarify

a precise time for you.

Q. Mine was a separate point and it is the point that in one of your witness statements you say that you saw Dr Montague in theatre, and Dr Montague --

A. Yes.

Q. -- has given evidence to the inquiry that he left at the end of his shift, the end of his duty came at 9 o'clock.

A. I can only give my own evidence.

Q. But you did see him?

A. My recollection is very clear that I saw him.

Q. So that places you probably in theatre at or about 9 o'clock?

A. I came to work at 9 o'clock and some time shortly thereafter I went to theatre.

Q. And at 10 o'clock, it seems that you looked at a CVP monitor and saw that it was giving an elevated reading.

A. I'm not sure if I can time that as precisely as 10 o'clock. I would expect that I looked at the CVP monitor before the clamps were released, but I don't have a written note that I said, "This is the time I looked at the CVP monitor".

Q. If I could draw your attention to your transcript of 25 April 2012 at page 121. Five lines from the bottom, line 21, at that point you're being taken through evidence about the CVP monitor giving a reading of 30.

The question is:

"Question: Okay, just so we're clear, you saw the 30?

"Answer: I did.

"Question: That means you saw it on the monitor; is that right?

"Answer: Yes."

A. Mm-hm.

Q. And it seems that the inquiry can track by the trace, the reading of 30 to 10 am.

A. Could I see the trace just to remind me? Would that be okay?

Q. I will let you have that in due course.

MR BRADLY: Sir, I think "I'll let you have it in due course" is not an entirely fair way -- the witness has asked for it.

A. My question is there could be many moments in time that the CVP was 30. It could have been at 10 am, it could also have been at 10.30.

MR STEWART: Of course. I will do my best to get that for you, Dr O'Connor.

THE CHAIRMAN: Let's see if we can find that reference now for the witness. I think we looked at this earlier today, didn't we, about the alarm being off? Was it at the end of Dr Taylor's evidence? (Pause).

MR McALINDEN: Mr Chairman, it's 094-037-217.

THE CHAIRMAN: Thank you.

A. Okay. Looking at this, it goes from 0 to 60. It's the bottom line. And the CVP -- so 30 is the dotted line in the middle. And the CVP is over a value of 30 from about 9 am until 11 am, it doesn't go under the value of 30 except very brief blip. So my saying that I saw a reading of 30, I don't see any evidence that tells me what precise time, according to this trace, I saw a reading of 30. But I know that the time that I would have been interested in knowing the CVP would have been prior to clamp release. There's no time on that trace that it's under 30 from -- there's that sort of 9 ... It goes up at about 9 am. In fact, it goes up about 8.30 and there's a very slight blip around about 9.30 where it goes to maybe 28. And the whole of the rest of the time from 8.30 through to well after 11, it's above 30. So I think that's consistent with my memory.

We also see here that the monitor -- at the time this monitor stops, it would seem to make sense to me that that's the time that the child was moved. Now we take the same monitor into ICU, but I don't remember whether in those days that was possible or not. But this monitor trace for the blood pressure seems to go to about 11.40 or so.

THE CHAIRMAN: No, it's short of 11.30, surely.
A. Do you see the middle one, the blood pressure? It goes past the halfway mark there, so it's about 11.40. And that would suggest to me that that was the time of the physical move.
MR STEWART: Can I take you to the top of that little chart. Do you see the number 40? 60 and then 40.
A. Yes.
Q. Could that top dotted line not refer to 40 and the mid-line, PAM, be actually 20?
A. Not on my interpretation of it because usually with a graph the scale goes up the side.
Q. What does 40 mean?
A. I don't know.
Q. Can I suggest to you that it does mean the upper end of that scale, in which case 10 o'clock is exactly at 30?
A. But the scale for everything else is on the left-hand side and, in normal practice, the scale for things are always on the left-hand side. It's the method we learned in mathematics at school.
Q. But somebody's put 40 there for a very good reason. Can you suggest what that might be?
A. I don't use anaesthetic monitors personally. I wouldn't -- I don't understand why the 40's there.
Q. What would the mid-dotted line be, marked PAM, at the

end?

A. Sorry, I do not know what PAM means.

THE CHAIRMAN: Between 0 and 60 there's mmHg, PAS, PAM --

A. I don't know what the abbreviation means.

MR STEWART: We learned this morning that the alarm would go off on the CVP monitor at 20 if it was not disconnected. That seems to be conveniently the midline if 40 is the top line.

A. My interpretation is that the trace is all along the side and it's nought to 60, but you would be better speaking to -- I think you probably have spoken to technicians and people about this.

THE CHAIRMAN: But your other point is all of these traces end at about 11.40 or so.

A. Yes.

THE CHAIRMAN: And you suggest that that is consistent with these readings being disconnected and, at about that time, Adam's moved to PICU.

A. And that would fit with the fact that I took some time to examine him before writing the note at 12.05.

MR STEWART: Yes. Thank you. So you may or may not be in theatre at 10 o'clock. But on one reading, you might be?

A. I think Adam's mum has said at what time I spoke to her. She had a record of it more accurately than myself.

Q. She has told the inquiry that at some time after 10 o'clock you spoke with her --
A. Yes, I think --
Q. -- to say that the operation was taking a little longer than you thought --
A. Yes.
Q. -- due to adhesions?
A. Yes.
Q. Is that right?
A. That's my recollection. I don't have a time on it, and in my experience and practice of telling parents as much information as I have, if the vascular anastomosis had been carried out at the time I was speaking to mum, I would have told her that because it's a very crucial, very important thing.
Q. So the fact that she doesn't recall you telling her about anastomosis would suggest that --
A. It hasn't happened at that stage.
Q. It was before 10.30?
A. Yes.
Q. So then you're in theatre at 10.20. You have prescribed your drug and it's marked on the sheet.
A. Yes.
Q. And I think when you told the inquiry before that if you were there at 10.30, it's likely that you would have

stayed on for anastomosis because it was such an exciting, near-miraculous moment where you see the kidney pink --

A. Yes.

Q. -- and you want to stay there and watch it?

A. I always watch it if I'm in theatre, yes. It's a very -- what I describe as a modern day miracle, yes.

Q. But you can't remember it?

A. I can't have a specific memory here, no. I think my memory would be more likely to be clear if something wrong happened, if it didn't pink up, because um ... I don't remember any transplants that I've been at where the kidney didn't pink up. I remember one transplant where the kidney went blue afterwards and had to be removed because of kinking in the blood vessel every time the skin was closed, and that kidney was removed at the time. But otherwise, the reasons why a kidney doesn't pink up could either be hyperacute rejection, which is extremely rare -- less than 1 per cent -- or a clot in the blood vessels, which a surgeon would be best placed to answer questions about. But usually, it might take a little bit of time to develop. Our practice nowadays is always to do an ultrasound of the kidney once the skin is closed to confirm the blood flow immediately on skin closure, to make sure the blood

vessels haven't been kinked in the skin closure.
I don't think it was our practice then.
Q. If you were there, would you not have taken a note of the timing at that time?
A. Yes, I did. 10.30.
Q. Are you now saying that you made that note at 10.30?
A. Um ... I don't have a recollection of when I wrote that down.
Q. Dr Taylor gave evidence that the kidney paled after it was initially perfused.
A. Yes. I don't have any recollection of seeing that, but I do have a recollection later in the procedure of somebody using the term "blueish". I cannot be more precise as to what conversation that was.
Q. He's also described how there would have been discussion amongst the team as to what to do in the event of something like that happening.
A. I have no recollection of any discussion about poor perfusion of the kidney at the time of the vascular anastomosis, none whatsoever.
Q. So you have no recollection of any want of perfusion, you don't remember being there at the time of anastomosis, you don't remember it being --
A. I think it's likely that I was there at that time because I was there at 10.20. I cannot tell you that

I actually remember, but I think it would be very unlikely that I would go away between 10.20 and 10.30.

Q. Is it likely that you'd be there for that and not go outside and tell Adam's mother that it's okay, it's good, it's --

A. I didn't ... I didn't speak to Adam's mother.

Q. Yes. Why not?

A. It wasn't -- it's now my practice, but as I said before, I didn't. I came from a practice where I didn't go to theatre at all, so ... I just didn't -- it's not ... If you ask most units in the country, "Does the nephrologist go and speak to the parent immediately on the vascular anastomosis?", I think you'll find that it is not normal practice anywhere except Belfast. We have been totally influenced in our practice by the case of Adam and the tragic case of Adam. But most nephrologists won't be present at all to relay information to parents.

Q. One of the purposes you are there for is to relay information about progress.

A. It's one of the purposes now that I have continued to see as important, but I didn't have a practice of such. As I said, in Bristol, where I came from, the nephrologists didn't go to theatre at all so there was no relaying of information about progress until the

child came to the recovery ward. That was normal in Bristol where I came from.

THE CHAIRMAN: Because there was nobody to come in and out to keep the parent informed?

A. Yes. It's --

THE CHAIRMAN: Because the surgeon and the anaesthetist can't leave, so if the nephrologist isn't there --

A. It is not normal for people to come up and down from an operation to speak to parents. I think I've made an exception because of the tragedy and we've been influenced by it.

THE CHAIRMAN: Okay.

MR STEWART: Can I suggest that it's odd if you saw this great miraculous event and one of the reasons you were there was to keep Mrs Strain up-to-date with what was happening to her son that you didn't go out and speak to her?

A. I don't think it was odd that I hadn't developed any habit of going to speak to parents after anastomosis at that time. I now have developed that habit.

MR BRADLY: Sir, forgive me for rising again, I don't wish to prolong things. I wonder if my learned friend could explain the basis of his suggestion that the purpose of her being there was to provide parents with the information [inaudible].

MR STEWART: 093-020-059. Halfway down:

"I can state it is my normal practice during transplant surgery, if I am able to be present, to relay to parents information from theatre, informing them as to the stage of the operation and generally how matters are progressing."

MR BRADLY: Sir, the [inaudible: no microphone] Police Service of Northern Ireland.

A. In 2005, at which time I had developed normal practice, and I suppose my statement would have been influenced by that.

THE CHAIRMAN: "I cannot recall a specific conversation with Adam's mother, but it would have been my normal practice to have had such."

Anyway. Okay.

A. I think I've said in my evidence before, and could I say again, I find this part of the statement difficult because Detective Cross, what he did, he had the written part of my statement for the inquiry, then he spoke to me, and I have the handwritten copy. He hand wrote at the end as I was speaking to him. So if you like, it was his words. We were having a conversation and he was writing down the record of that conversation. But it wasn't -- I suppose I wasn't having time to ... The nuances of language -- I didn't have time to think about

the nuances of what he was writing in his language of our conversation.

THE CHAIRMAN: To an extent, we are going back over ground which was covered. You gave evidence in April, so we can move on, I think.

MR STEWART: I was going to bring you to an example of your own words, which was your transcript of 25 April 2012, page 169. At the top:

"I was aware that Adam had gone to theatre some time before 7 and I might have expected everything to be finished after sort of 3.5, 4 hours, and we weren't at the point of being near finished here. So I think I was aware she was anxious. I was trying to give whatever information I had. It was probably fairly meaningless information, but I was trying to be reassuring that I had no evidence of any cause for concern at that point in time. That is what I will have been trying to convey to an anxious mother."

This is what you might have said at some time after 10 about the adhesions and so forth. But the same, I would suggest holds true, that you were trying to give whatever information you have and that you realise that she is anxious for information.

A. Could I clarify that word "meaningless"? I think that was ill-chosen by me. What I meant by that was there

was no information of substance yet because the vascular anastomosis hadn't happened. So anything that I had to say about how it's taking a bit longer -- I had no useful information to give her about the progress of the transplant before 10.30 because nothing important had happened.

THE CHAIRMAN: Okay.

MR STEWART: After 10.30, there's no further evidence we have to show that you were in theatre. You haven't taken any notes. Can you trace any notes for us?

A. I wouldn't normally write a note until -- I sometimes start the note in theatre to be my post-operative note, but my main time of writing notes is on arrival in the intensive care unit. So the records in theatre are those of the surgeon and the anaesthetist. The nephrologist doesn't have a record-keeping role in theatre.

Q. I see. So that is a shame because you don't remember the key moments of this surgery, you weren't witness to them and you weren't brought in to discuss them. For example --

A. I don't remember any witnessing of or description of any difficulty around the time of the vascular anastomosis. I think the contrary is that if there had been a problem, that would have stood in my mind. Most

kidneys do turn pink.

Q. Do you remember Mr Keane --

A. Yes.

Q. -- leaving the theatre?

A. Um ... I don't have a clear recollection that I was there when he left the theatre. I do have a recollection later on in the day of being anxious that he was contacted because he didn't and wouldn't have known that something devastating had happened. I don't remember which of us contacted him, but I remember being anxious about having to ... I don't know, was it myself or Dr Savage having to give him that information because I knew he'd be shocked.

Q. Is there any note of that obligation or duty in the record?

A. I don't think so, but I think it's in his evidence that he was contacted by somebody from the Children's Hospital.

Q. Do you remember another anaesthetist coming into theatre?

A. I don't, no.

Q. Dr Campbell?

A. I don't.

Q. You don't remember the moment when the eyes were found to be fixed and dilated?

A. I wasn't there at that time. I was called back to theatre after that had happened.
Q. You're quite sure about that?
A. I'm quite sure of that.
Q. Page 148 of your transcript of 25 April, starting at the top:
"17 years later, I find it hard to be entirely sure if I was called back into theatre or met them on the way to intensive care."
A. Yes.
Q. "I don't have any recollection of being there at the moment --
A. I have already alluded to that. I have this image of him being wheeled through a doorway rather than being static in the theatre. I think he was en route to intensive care by the time I was called, but I can't give you any more information about that than I think I remember him being wheeled through a doorway.
Q. Do you have any recollection that we can pin to the period of 10.30 to midday?
A. I recollect that someone used the word "blueish" in terms of how the kidney --
THE CHAIRMAN: Sorry, doctor, I think the point of the question is this -- and you may have picked up from earlier evidence today that what we're concerned about

is timings.

A. Yes.

THE CHAIRMAN: And times seeming to be missing.

A. Yes.

THE CHAIRMAN: And it's that confusion, I have to say, that is to some degree caused by inconsistent evidence that we've received from the people who were involved at the time.

A. Mm-hm.

THE CHAIRMAN: So Mr Stewart isn't accusing you of anything at all, we're just probing to see how the hours passed.

A. The vascular anastomosis was 10.30.

THE CHAIRMAN: Right.

A. And to plumb into the bladder, I would have thought -- and I'm not a surgeon, but it was a difficult job to plumb into the bladder. I would have thought that would have taken until about 11.15. Then there's skin to sew up and muscle layers to sew up and catheters to be sorted and tubes to be sorted. And the anaesthetic trace that you showed me suggests that Adam left theatre about 11.40, so ...

THE CHAIRMAN: That's the best timeline you can put together?

A. Yes. I don't -- it doesn't give me the impression that there's missing time there from 10.30 to leave theatre

at 11.40.

THE CHAIRMAN: But it's partly because you have a very strong assertion that it was 10.30?

A. Yes.

THE CHAIRMAN: The evidence has not always pointed that way from Dr Taylor and it doesn't point that way from the consultation note. That's the --

A. I don't understand the consultation note.

THE CHAIRMAN: You think that's definitely wrong?

A. Absolutely.

THE CHAIRMAN: Okay, thank you.

MR STEWART: I was asking, is there anything else that you can point to to show that you might have been in theatre from 10.30 to midday? And I take it that there is nothing that you can point to that says, "That shows that I was there".

A. No.

THE CHAIRMAN: Do you remember seeing Eleanor Donaghy, now Boyce?

A. Um ...

THE CHAIRMAN: You know who she is?

A. Yes, I know her very well, and normally, in those early days, Eleanor actually used to bring the kidney over and it often would have been her who recorded the timings of out of ice and so on. I do remember seeing her,

I think, early on that day. She normally -- when I came first, she used to be in theatre for the whole time of transplants, but she obviously had other jobs to do.

THE CHAIRMAN: For paediatric transplants?

A. Yes, uh-huh.

THE CHAIRMAN: Because her evidence here was that she wasn't intending to go into the theatre at all.

A. She often was the one who brought the kidney over.

THE CHAIRMAN: In this case -- let me just clarify it -- she didn't know that Adam's transplant was taking place until she arrived in work on the Monday and was told about it. That means by definition she could not have brought the kidney over. Her evidence was, she came over to the Royal only to speak to Adam's mum to ask her to, when it was over, contact the donor's family. So that's why she was there and she didn't intend to go into the theatre, but it was only when she heard everything had gone terribly wrong that she did change and go into the theatre and she described what she found there.

A. It doesn't fit with my recollection. I don't have a clear recollection, but I -- and, of course, she was there for so many cases, I could be mixing up ...

THE CHAIRMAN: Maybe things changed as time went on in the way that your own practice changed as time went on, but

she was quite clear about not expecting to be in the theatre with Adam and why she went into the theatre with Adam.

A. I think she filled in the times. You know the form that goes back to UK Transplant?

THE CHAIRMAN: Yes.

A. Normally, that's a job that she carried out, and she took those forms back with her to the City Hospital. So in the early days of transplantation, when I came back, I was used that she -- I think she was the only coordinator then. I was used that she would often be about for a lot of the theatre. I can't give times for sure.

THE CHAIRMAN: That turns out to be another problem because the timings on the form, which was returned to the transplant agency, are different again.

A. Okay.

THE CHAIRMAN: But that's for me to sort out; you can't really comment on that. But we have had quite a lot of evidence about that before the summer.

A. Okay.

MR STEWART: Anyway, you think you remember seeing her?

A. I think I do.

Q. And, of course, you arrived at 9 that morning.

A. Yes.

Q. So it would have had to be after 9 o'clock?
A. Yes.
Q. Did you see her in theatre?
A. I think I saw her in theatre, yes. I can't give a time precisely, but I think I saw her in theatre. I cannot make any sense of the evidence that has been quoted, but that's been gone into in some length, that Staff Nurse Clinghan, who's now Nurse Sharratt, wouldn't have known anything about Adam's fixed dilated pupils until the point in time when Dr Taylor was waking him up and the surgeons had gone.
Q. If information was leaking from the theatre so that Nurse Sharratt knew about it outside --
A. Nurse Sharratt was doing haemodialysis on a child called [redacted] and she was in the haemodialysis room in Musgrave Ward and could not leave the room. Part of my job as the consultant that morning would have also been being responsible for the child on dialysis, so I would have had reason to be in the dialysis room during that morning as well. I wasn't -- I didn't just have the one patient, there were other patients to be looked after.
Q. And why do you remember her being there at that time?
A. Because she was very close to Adam's mother, she was very good to the patients on home dialysis, she did a lot of home visits, and I remember her devastation.

She came up to visit Adam's mum after Adam's mum had been brought up to be with Adam, and I just remember the grave upset. But she wouldn't have been free to leave the child on haemodialysis until the session had completed, and children usually came for dialysis at 9 or 9.30 and their sessions were for three hours. You can't leave a child who's having dialysis treatment, you can't leave the room.

Q. Do you find it odd that you should remember that Nurse Sharratt was there with dialysis when you can't remember seeing the kidney pink, you can't remember it being blueish, you don't remember whether or not you were there for the eyes being found to be dilated and fixed?

A. I wasn't in the room when the eyes were noted to be dilated and fixed. I have never said otherwise. I was called back when Dr Taylor discovered that. I remember Nurse Sharratt's reaction because she was very close to Adam, she had known him since he was born. She was very upset; she cried. We were all very upset, but Joanne was particularly close to this little boy.

Q. So I take it that you are saying that Eleanor Donaghy is --

A. I don't understand the sequence of what she said; it doesn't make any sense to me, is what I'm saying.

Q. Is it pure invention?

A. I'm just saying I can't make any sense of it.
THE CHAIRMAN: It's not pure invention. There are a number of possibilities. One is that she may have found this out, but she may be wrong in recollecting that it was Nurse Sharratt who told her; she may have got that information from somebody else, but she describes being in the operating theatre.
A. At the time when Dr Taylor was waking the child up, my understanding is that the surgeons were gone at that stage. So it doesn't make sense.
THE CHAIRMAN: That's part of the issues that I have to decide on. She says the word was outside the theatre that Adam was in effect dead but that -- not medically dead and brainstem tested dead, but in effect dead. But the word was already outside the theatre and she went into the theatre, not intending to be there, and saw Dr Taylor and Mr Keane.
A. But Mr Keane left before the skin was closed and there was no concern about Adam in terms of his survival until he was woken up and the pupils were fixed and dilated.
THE CHAIRMAN: Okay.
A. Absolutely.
MR STEWART: Are you telling the inquiry that you remember Mr Keane leaving?
A. I don't know that I was there when he left, but he was

not there when I was called back because of the fixed dilated pupils. And I do remember the anxiety of somebody having to tell the surgeon who'd done the operation that the child was effectively dead. I remember thinking that was a difficult thing to have --

Q. All you can say of your own knowledge is that he wasn't there at midday approximately?

A. Yes.

Q. Yes. Nothing else? Did you tell Adam's mother that the surgery was over at ten to twelve?

A. Once I was called and Adam's pupils were fixed and dilated, I felt that my responsibility was to the sick child, and I would not have left the child. Important as it was that somebody spoke to the parents, my responsibility was to the sick child to try and find out what had gone on, to organise investigations. I phoned Dr Savage, who knew the patient's family very well, and he was in a position to come and speak to them. But I would have felt that my duty of care was to be at the patient's side when the patient was so sick. I wouldn't have left at that time to walk down to the ward.

Q. Well, can I ask the question again. Did you tell Adam's mother that the surgery was over at ten to twelve?

A. I have no recollection of doing so, no.

Q. Well, she says that you did, and I will just take you to a reference; it's in a letter that she wrote. 011-049-182, halfway down the main paragraph:

"Another thing is that I was told by Dr O'Connor, who was keeping me in touch with what was happening with Adam in theatre that morning, that surgery ended at 11.50 am, not 11 am, as Dr Sumner said in his report. This may only be a small point, but I can't help wondering at exactly what time surgery ended."

A. I only recollect speaking to her once and I know we were over this point the last time I gave evidence, and I think the transcript shows that Adam's mum -- apparently this was discussed with her, and in the transcript it has been said that she had said that she didn't remember speaking to me a second time. There's a point in the transcript where that's said by Ms Anyadike-Danes.

THE CHAIRMAN: If we look at witness statement 001/2 at page 12, maybe it's the next -- question 76, so it may be the ... If you could put up the next page with it. Question 76:

"Who informed you that Adam was out of surgery? I am not certain."

So --

A. I think it's also covered. There is a bit in the

transcript where Ms Anyadike-Danes said to me -- there was a break and I came back to the witness stand, and she said that mum had confirmed that she wasn't clear that I had told her that surgery was over. But maybe you might want to look at that.

THE CHAIRMAN: That's where I got the reference from, thank you.

MR STEWART: There may be a difference between telling her that surgery was over and telling her that the eyes were fixed and dilated. Could it be that you went as a matter of a progress report to inform her that surgery was now complete?

A. I could have done, but I don't have a recollection of that conversation. But once I knew that there was a problem with Adam and his pupils were fixed and dilated, I did not leave his side. When there were two of us there, I sent for Dr Savage, who knew the family better. Obviously someone needed to speak to the family, but the immediate priority was to look after the patient.

Q. In your transcript of 25 April 2012 at page 133, the second line:

"I am afraid I don't recall my conversations with Adam's mum, but I'm aware that she has said that I told her the surgery had finished about 10.50."

A. Yes, that was from some of the documents I read on the website.
Q. Well, it seems that this document shows that she says it was 11.50.
A. Okay.
Q. "It could be that I'd gone to tell her that the surgery was at an end, but then I got called back. I certainly did not leave Adam once I knew that he had fixed dilated pupils."

Can you point to where she is said to have recorded you speaking to her and telling her that surgery was over at 10.50 as opposed to 11.50?
A. I think it was on one of the documents that I had read on the website. I can't point it out, but I obviously didn't think it was accurate from my recollection.
Q. Well, neither is accurate. Neither 10.50 nor 11.50 is accurate for surgery being over.
A. We know that the monitoring -- looking at the CVP trace, the monitoring finished about 11.40, the child was possibly moved at that time. I haven't seen any dated and timed records of exactly when the skin closure was. I don't have evidence that that was 11 o'clock; I haven't seen that anywhere.
THE CHAIRMAN: In a way, that's part of the problem. You would expect there to be notes of that, wouldn't you?

A. No, not -- I mean, a surgeon writes a note afterwards to describe exactly what happened. He doesn't put "skin closure 11.50". The times you record for a transplant are the kidney out of ice and the times that the clamps are taken off. Those times are recorded, but it's not routine to record other times. The monitors obviously give some indication of the progress with times attached and the anaesthetic record is timed because the anaesthetist is making a very close record and we've seen that the drugs have been timed in that record.

MR STEWART: This brings us back to your note because we don't know therefore what time skin closure was, we don't know then at what time the kidney looked blueish at the end of theatre, do we?

A. It would have obviously been before skin closure, yes, uh-huh.

Q. But we don't know when that was?

A. No.

Q. And can I ask you about the consistency of that note that it looked blueish with Mr Keane's note that "the kidney perfused reasonably at end". Isn't there an inconsistency? It's either perfused reasonably or it's blueish, but it's not both?

A. I have been questioned in my written evidence about this and I have made comment that I didn't really understand

his use of the word "reasonably" because I would have thought it's either well perfused or there's a problem, and the word "reasonably" didn't make sense to me, but I think it's best to question Mr Keane about his evidence than me.

Q. Well, just one final question if I may. It's going back to that vexed question of the CVP graph. I'm asked to go to the transcript of 24 April 2012 at pages 174 and 175. This is an exchange between Ms Anyadike-Danes and Mr Millar at line 22. My learned senior says:

"No, the dotted line is the 20 mark. The maximum is 40. The 60 is measuring something else."

Mr Millar:

"Sorry, it looked kind of halfway to me."

Ms Anyadike-Danes:

"I understand that the 40 is the top line for CVP. I beg your pardon. So that puts the middle mark at 20 and therefore that highest point is roughly 30."

Mr Millar:

"Absolutely right."

So Mr Millar seems to be conceding --

A. I don't know that Ms Anyadike-Danes or Mr Millar would be the expert, but I think you have had experts.

THE CHAIRMAN: Neither of them would pretend to be experts, but Mr Millar is acting on behalf of Mr Keane.

Ms Anyadike-Danes has access to the inquiry's experts, and that exchange between them was not challenged at the time or subsequently by any other witness until now.

A. I would be interested to know what the expert technician -- you probably have evidence from him.

THE CHAIRMAN: If need be, we can follow it up again.

MR STEWART: Thank you.

THE CHAIRMAN: Thank you.

MR HUNTER: Sir, I wonder if you could give me a couple of minutes. There's one issue I would like to explore.

THE CHAIRMAN: I will sit here, Mr Hunter, to wait for you to take instructions on that issue. (Pause).

MR HUNTER: Thank you, sir. There's just one issue if I could put it to the witness.

THE CHAIRMAN: Let's hear what the issue is, please.

Questions from MR HUNTER

MR HUNTER: It says that there are two times when one would make recordings during a transplant, and that is when the kidney is taken out of ice and when the clamps are removed; is that correct?

A. Mm-hm.

Q. But you have recorded the time of anastomosis --

A. That's the equivalent of clamps being released. It's just a use of language. It's the same thing.

Q. Okay. Can I just ask you about -- I think I'm correct

in saying that you weren't aware that there was actually a transplant taking place until you arrived in the hospital that morning.

A. That's quite correct.

Q. It would have been Professor Savage who had laid out the immunosuppressant drugs to be given in the original prescription?

A. The original note which we looked at today, and he has written "methylprednisolone to be given", yes.

Q. Can I ask you, did you have a conversation with Professor Savage before you prescribed the additional immunosuppressants?

A. Yes, most certainly. I don't have a record of that, but the azathioprine came from his protocol and the methylprednisolone came from my protocol. I was concerned that in the overlap -- and we didn't have a new written protocol -- that something could have been missed out. The one child who'd been done before, I think I just gave things in the manner I was doing in Bristol, but azathioprine was a drug that he was used to using, so definitely we had a conversation as to what would be best.

MR HUNTER: Okay, thank you.

THE CHAIRMAN: Thank you.

Mr Bradly, you'll be last if anyone else has

anything.

MR BRADLY: Sir, I'm grateful. Might I please just ask that the doctor confirm that she's finished dealing with the conference note of 14 June? We got as far as --

THE CHAIRMAN: Halfway down page 5.

MR BRADLY: She may have finished, I know not.

THE CHAIRMAN: Doctor, Mr Bradly is reminding me that you had been pointing out what you regarded as significant mistakes or inexplicable statements through the document. We had got to the middle of page 5. Is there anything beyond that?

A. There were two other sentences that I found strange because they weren't, if you like, in doctor speak. There's a sentence here:

"Mr Brangam pointed out that Dr Sumner's conclusion is that, on the balance of probabilities, that oedema was caused by hypernatraemia [which I presume is hyponatreamia] and does not put the case any more strongly than this."

I was surprised to see that Mr Brangam was commenting on medical evidence. I just -- that confused me.

THE CHAIRMAN: Right.

A. And then on the last page, again I think towards the very end, the wording shows that it's written by -- you

know, without full understanding of what someone's describing. It does say:

"Again, it was pointed out that for some reason this child had higher sodium levels in the brain than elsewhere in the body."

And so on.

The natural medical understanding is, the sodium levels in the brain and the blood are generally the same, but if there's a sudden change in the blood sodium, it takes the brain longer to equilibrate with that change. So this kind of reads as if there was something wrong with the amount of sodium in Adam's brain; there wasn't, it would have been equal to his blood sodium initially before the administration of the fluids. So it's just the way it's worded, it's worded by someone who doesn't have the medical understanding of what they're writing.

THE CHAIRMAN: That could be for a number of reasons. That could be because, for instance, the notetaker is trying to record as accurately as she can what is being discussed, but she's not a medic.

A. Yes.

THE CHAIRMAN: But also part of it is because -- and from some of your earlier criticisms, some of it may be because the people who were there, the medics who were

there, were inaccurately stating what had been happening.

A. It's just not medical type language. That's all.

THE CHAIRMAN: But it's more than the language; in some cases, it's the substance of what they said. The one that you highlighted very vigorously at the top of page 3, that the kidney was in at around 9.30. That, in all the evidence, does not seem to be Mrs Neill's mistake; that seems to be a mistake which has been made by Dr Taylor.

A. Well, the kidney actually would have been taken, I suspect, out of the ice and put into the wound at 9.30. So it's an interpretation of what the word "in" means.

THE CHAIRMAN: Yes, but if you read it in conjunction with the next sentence, the vein was in and the arteries were being finished.

A. Yes, that doesn't make sense.

THE CHAIRMAN: You say that isn't right.

A. It's definitely not right.

THE CHAIRMAN: Doctor, thank you very much indeed. You're free to go.

Ladies and gentlemen, we resume tomorrow morning. We've got Mr Brown and Mr Keane tomorrow. Mr Keane was unable to be with us when we were here in June doing

governance evidence, so apart from any issues arising from his consultation note which are raised with him, he will also be asked some issues about governance, which he couldn't deal with last time, Mr Millar, because he wasn't here.

MR MILLAR: That's news to me, sir.

THE CHAIRMAN: Well, I'm surprised, because you knew that we wanted him as a governance witness. He wasn't able to be here, for reasons which I accepted. He is now available to be here. I'm surprised that you think that we might just ask him questions about the consultation note and not ask him anything about the evidence which he would have been asked to give in June.

MR MILLAR: I say it's news to me, it is news to me. The other thing, sir, is that I think other witnesses on governance were given notification of lines of questioning and things of that sort, and certainly I've had nothing to indicate lines of questioning for Mr Keane on governance. If there's to be questioning, it would be helpful to have what the other witnesses had.

THE CHAIRMAN: What I think we should do is we should start -- Mr Brown has already given his evidence and Mr Brown was inconvenienced a number of times earlier on in the inquiry's hearings by being here and then not

being reached. What I propose to do is to start with Mr Brown tomorrow. His evidence will certainly finish almost certainly tomorrow morning. We'll then start with Mr Keane's evidence and we have in the timetable, as you know, allowed for the possibility of Mr Keane running into Monday, and then Professor Savage giving evidence. So we'll run on that basis.

I understand, Mr Fortune, that you had suggested that maybe we start at 9.30 to get through both witnesses, but I'm not going to do that because the timetable that we have allows for both witnesses not to be finished tomorrow and we have also had a very long day today.

We'll start at 10 o'clock tomorrow with Mr Brown and we'll continue with Mr Keane. Thank you.

(5.15 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X