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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

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

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

11 Perhaps most significantly, we did not find any
12 further notes from in and around June 1996 when Adam's
13 inquest took place. You'll appreciate the significance
14 of that because, when we adjourned in June this year, it
15 was because a consultation note had emerged from
16 14 June 1996, which had information in it which appears
17 on its face to be different from some of the evidence
18 which has been given to the inquiry to date.

19 As I say, there is no further documentation from
20 around that time on any of the files which have been
21 inspected. Accordingly, the witnesses who will be
22 giving evidence today and over the next few days will
23 find that their questioning is focused on that
24 14 June 1996 document and I want to push on as quickly
25 as possible this morning with that evidence. We have

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

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

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

15 I think actually my learned junior, Mr Stewart, is going
16 to deal with that evidence. Thank you.

17 MRS HEATHER NEILL (called)

18 Questions from MR STEWART

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

25 A. Yes.

1 Q. Thank you. You have also kindly supplied the inquiry
2 with a copy of your CV, which appears at 306-093-001.

3 A. Yes.

4 Q. There's page 1. I wonder if you can go to page 2. Here
5 you set out your background, educational qualifications.
6 Of relevance to the issues we're going to be discussing
7 this morning are your level of educational attainment
8 and your proficiency in English language and matters of
9 chemistry and science.

10 I see also that you studied, at the University of
11 Oxford, jurisprudence?

12 A. Yes.

13 Q. Which college was that?

14 A. University College.

15 Q. And did you, in the course of your chemistry A level,
16 did you there gain knowledge of the sort of notational
17 symbols used for the elements in chemistry?

18 A. Yes.

19 Q. If you could go over the page, please. You'll see that
20 after university, from September 1985 to October 1986,
21 you entered training as chartered accountant. That
22 lasted only a year. Did you not like that?

23 A. Not really, no.

24 Q. And did you find more to your taste working for the
25 Director of Legal Services at the Central Services

1 Agency?

2 A. Yes.

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

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

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

11 A. Yes.

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

14 A. Yes.

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

17 A. That was George Brangam.

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

22 A. Yes.

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

1 A. It was basically the same. There would have been some
2 private cases as well, but I was still primarily
3 involved in the medical negligence cases.

4 Q. Did you find that your background training in law had
5 any relevance to your work there?

6 A. It probably helped with just the -- well, obviously in
7 dealing with cases and preparing proceedings, drafting
8 proceedings, briefing witnesses, taking statements.

9 Q. Did you work closely with Mr Brangam?

10 A. I did, yes; he was the senior partner.

11 Q. The consultation with which we are concerned occurred on
12 14 June 1996. Can I draw your attention to
13 page 122-001-006? This is the final page of that
14 consultation note and there is, beneath the place for
15 the date, a reference "HN/GMcC". Can I ask what that
16 reference is?

17 A. It's a typing reference. "HN" is myself as the creator
18 of the note and "GMcC" would have been the typist.

19 Q. Are you satisfied that this is likely to be your note of
20 a consultation?

21 A. It would appear to be.

22 Q. Was there anyone else in Brangam Bagnall's office who
23 might have shared your initials?

24 A. No.

25 Q. And on the same day, you took a note of an inspection of

1 equipment; is that correct?

2 A. Yes.

3 Q. And again, it bears the same reference and initials.

4 A. Yes.

5 Q. Do you have any recollection of an inspection of

6 equipment?

7 A. I do have a vague recollection of that meeting at the

8 Royal.

9 Q. What is that recollection?

10 A. Just very vague in relation to the fluid issues. For

11 some reason, that has stuck in my mind.

12 Q. In the course of your work with Mr Brangam, was it

13 a regular occasion that you attended consultations with

14 doctors?

15 A. Yes.

16 Q. And prior to 14 June 1996 had there ever been any

17 complaints about your note-taking or your taking of

18 statements?

19 A. No.

20 Q. And did you ever take statements or notes by yourself?

21 A. Yes.

22 Q. Would it be fair to say that Mr Brangam trusted you

23 in that regard?

24 A. I would think so, yes.

25 Q. In relation to the process that you adopted for creating

1 a typewritten note of a consultation, can you describe
2 how you initially took a note of what was said?
3 A. I would have taken handwritten notes during the
4 consultation.
5 Q. Would that have been longhand or shorthand?
6 A. Longhand.
7 Q. And then what would you do with those handwritten notes?
8 A. When I got back to the office, I would have dictated
9 a note and would have tried to bring together issues
10 because, during a consultation, you can wander from one
11 point to another, but whenever I was going through to do
12 the typewritten note, I would have tried to keep all the
13 issues together and would have scored through the
14 handwritten note as I dictated each piece.
15 Q. And your typist would have been within the office?
16 A. Once it was dictated, it would have been dictated into
17 a Dictaphone and then they would have transcribed the
18 tape.
19 Q. When the typing came back from your typist, would you
20 have at that stage proofread it?
21 A. I would have read over it, yes.
22 Q. Would it have been proofread by Mr Brangam?
23 A. No.
24 Q. What would you have done with the typed note at that
25 stage?

1 A. The notes were really just kept on file in the office.
2 They weren't a transcript; they were simply a note of
3 the consultation to be referred back to at a future
4 stage if required or, if there were future
5 consultations, they may have been brought along to
6 those.

7 Q. So they were for reference?

8 A. They were for reference, yes.

9 Q. What would you have considered the object of your
10 note-taking exercise really to have been?

11 A. To have a record of the consultation, of the main points
12 which could be referred back to at a future stage,
13 issues may be clarified later if need be.

14 Q. Can you say whether or not any comment, critical or
15 otherwise, was ever made in relation to the accuracy of
16 your work?

17 A. I don't think it was ever complained about.

18 Q. Do you have any recollection of attending any
19 consultations in respect of the Adam Strain case apart
20 from the one indicated in this note?

21 A. No.

22 Q. Did you know Dr George Murnaghan?

23 A. Yes.

24 Q. Do you have any memories of the staff of the Trust?

25 A. I knew Dr Murnaghan.

1 Q. Would you have attended consultations or meetings with
2 him before this occasion?

3 A. Yes.

4 Q. And after?

5 A. Yes.

6 Q. How often would you have gone to the hospital to take
7 notes and to attend upon meetings?

8 A. At the hospital, there would be a limited number of
9 consultations; most consultations would have taken place
10 in the Bar Library.

11 Q. Yes. Did you also take the note of the inquest into
12 Adam Strain's death?

13 A. Yes.

14 Q. And these notes start at 122-044-003; is that your
15 handwriting?

16 A. It is.

17 Q. Would you have had these notes typed up?

18 A. No.

19 Q. What was the purpose of you taking this note?

20 A. I would have taken notes at any hearing I attended.
21 Really, if any issues arose during the hearing that
22 people wanted to refer back to or discuss during the
23 course of the hearing.

24 Q. Is there any possibility that you could have invented
25 material to have been inserted into a note of

1 a consultation?

2 A. No.

3 Q. In terms of whether or not you might have correctly
4 comprehended what was being said, what comment --

5 A. It's possible that I may have misunderstood.

6 Q. In relation to the particular consultation note -- and
7 can I ask that we turn to page 122-001-005 and the sixth
8 paragraph down?

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

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

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

15 In terms of comprehension and record, how would you
16 describe that sort of information?

17 A. It would have been my understanding of what was said
18 during the consultation.

19 Q. Do you have any other recollection of Adam Strain's
20 case?

21 A. I don't, no.

22 Q. The note itself appears to, at one stage, be a series of
23 points -- 1, 2, 3 and then 4 -- starting at the top of
24 the page we're on now. Then it seems to move into
25 a general discussion between the doctors present. In

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

3 A. It would have been the theme really.

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

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

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

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

8 Mr Stewart?

9 MR STEWART: Thank you. In terms of the note on page 5,
10 005, that sixth paragraph we were looking at. You
11 gathered, you say, themes, thematic contributions
12 together. If it were to be suggested to you that
13 material might have been left out of your record, what
14 would be your response to such a suggestion?

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

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

24 A. Yes.

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

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

5 A. Yes.

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

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

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

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

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

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

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

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

5 A. Yes.

6 MR STEWART: Thank you very much indeed.

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

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

13 (The witness withdrew)

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

16 DR ROBERT TAYLOR (called)

17 Questions from MS ANYADIKE-DANES

18 MS ANYADIKE-DANES: Good morning, Dr Taylor.

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

24 A. No.

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

1 inquiry?

2 A. No. My family and my legal team.

3 Q. Have you ever seen it before it was released in June of

4 this year?

5 A. I don't believe so, no.

6 Q. Does that mean you could have seen it?

7 A. It's possible I could have seen it, but I don't remember

8 seeing it.

9 Q. I understand. Were you aware of whether there were

10 other notes of meetings which you attended?

11 A. I can't remember. I'm not aware of other notes, no.

12 Q. Did you yourself make notes of any of the meetings that

13 you attended to discuss the issues arising out of Adam's

14 death or the preparation for the inquest into his death?

15 A. I can't remember making any notes and I've checked

16 through my records and I haven't found any notes.

17 So ...

18 Q. Did you prepare any documents for this meeting of

19 14 June?

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

21 Q. Do you recall this meeting of 14 June?

22 A. I recall there being a meeting, but I don't recall

23 what was said and the detail of the meeting.

24 Q. Do you recall what the meeting was for?

25 A. I recall there being a meeting before the inquest for

1 people to get together to prepare for the inquest.
2 I believe I recall that there was a meeting for that
3 purpose.
4 Q. What do you mean by "prepare for the inquest"?
5 A. To prepare the legal ... For the lawyers to --
6 Mr Brangam to meet with me and others to prepare for the
7 inquest and be told what -- when the inquest was about.
8 I rarely give evidence at inquests and, as a junior
9 consultant at that stage, I hadn't been to very many
10 inquests, so I believe it was to prepare me for the
11 purpose, what was expected of me. That sort of
12 preparation for an inquest. That's what my recollection
13 is.
14 Q. I understand. And did you think that part of it also
15 might be an opportunity to hear what the clinicians who
16 were primarily involved in his care had to say about
17 what actually happened?
18 A. Well, I don't remember that being the purpose of the
19 meeting, but I've read the paper and it appears that
20 that was a purpose for the meeting.
21 Q. And do you recall that that's what happened?
22 A. I don't recall the details of the meeting.
23 Q. But do you recall whether people at the meeting shared
24 their thoughts about what had happened to Adam and why
25 it might have happened?

1 A. I don't remember that detail of the meeting.

2 THE CHAIRMAN: Does reading the note suggest to you that
3 that's what did happen?

4 A. Reading the note suggests that that's what happened,
5 yes.

6 MS ANYADIKE-DANES: Before we go into that point, can I ask
7 you about something that you said before? You said that
8 you had not discussed the note or the issues that arise
9 out of it with anyone apart from your family and your
10 lawyers. Why is that?

11 A. I don't understand.

12 Q. Why haven't you discussed it with anybody?

13 A. With other colleagues?

14 Q. Yes.

15 A. I didn't.

16 Q. I know you said you didn't; I'm asking you why you
17 haven't.

18 A. It's not the sort of thing I would discuss.

19 Q. Well, given that you don't recall it very well yourself,
20 why didn't you seek to see what others made of it?

21 A. I don't know.

22 Q. You said that now that you've read it, you see that one
23 of the things that did happen in the course of it, at
24 least one of the things that is recorded as happening
25 in the course of it, is that those present, certainly

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

3 A. I accept that.

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

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

8 Q. And your views about it, yes.

9 A. It appears to be, yes.

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

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

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

14 A. I don't remember it.

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

17 THE CHAIRMAN: This is Dr Taylor's evidence?

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

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

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

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

4 If you see the bit in the middle:

5 "It does seem sensible to me."

6 Then the chairman picks it up at line 25:

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

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

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

25 And your answer to that at line 21 is:

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

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

13 THE CHAIRMAN: Is that right?

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

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

19 A. Yes.

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

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

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

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

3 A. I think that's not correct.

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

7 A. Yes.

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

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

14 THE CHAIRMAN: Okay.

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

17 THE CHAIRMAN: Well --

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

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

23 A. Yes.

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

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

5 A. Yes.

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

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

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

19 I think what was intended would be "either
20 10 per cent dextrose or saline".

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

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

1 believe it was available at that time.

2 THE CHAIRMAN: Okay.

3 A. So that seems to be, possibly, a transcription error.

4 THE CHAIRMAN: Yes.

5 A. Dr Gaston could answer that better.

6 THE CHAIRMAN: In other words, whether it's a typographical
7 error or whether Mrs Neill didn't quite pick it up
8 exactly, the gist of what she's recorded is accurate.
9 I mean, as I understand what you're saying, that
10 sentence should be there in the note --

11 A. The sentence should be there.

12 THE CHAIRMAN: -- but there's a word in it which changes its
13 meaning and makes it incorrect?

14 A. Correct. And if you look again at it, it says, "The
15 other options". So that suggests there's more than one
16 other option. So to me, it reflects that there should
17 be two types of fluid that were alternatives rather than
18 one bag of fluid that contained dextrose and saline.

19 THE CHAIRMAN: Okay. Thank you. But beyond that error?

20 A. The other bit that I feel is problematic from my memory
21 and doesn't make sense to me is the bit that obviously
22 you're coming to, which is the bit about the needle
23 in the artery and the reason to -- it didn't matter
24 anyway. In 05, I think it's halfway down.

25 THE CHAIRMAN: It is in 05 and we'll come to that. Before

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

10 A. Yes.

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

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

17 "The other options being ..."

18 And I think you were saying that lends support to
19 the fact that actually what should have been there is
20 "10 per cent dextrose or saline", that constituting two
21 options?

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

23 Q. So it looks like -- anyway.

24 A. Dr Haynes actually is more confused by that, and he says
25 "10 per cent dextrose in saline", which clearly is yet

1 again a different representation of the same --

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

3 A. Yes.

4 Q. Thank you. So what I was asking you really is: if this

5 happened in this way and you were faced with Dr Savage's

6 view, which is different from yours -- and we'll come to

7 that in a minute -- why are you not able to remember

8 this?

9 A. Well, it was a long time ago and I've said I can

10 remember there being a meeting, but I can't remember the

11 details of the meeting and what was discussed.

12 Q. I appreciate that.

13 A. I do remember there was a meeting.

14 Q. I appreciate that, Dr Taylor. It's not really even the

15 details that I'm talking about. As the chairman

16 indicated, what his thought was in the transcript that

17 I took you to, this would have been a difficult thing.

18 Dr Savage is a man that you respected, you've talked

19 about that in your evidence before, how you relied on

20 him in certain respects because you knew he was there

21 and you could contact him and that was a very important

22 element for you in going into this surgery. So after

23 the event and, unfortunately, the child has died, there

24 is Dr Savage in a meeting, if this is correct, saying

25 that he fundamentally disagrees with you in relation to

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

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

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

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

17 THE CHAIRMAN: You say that there isn't that sort of direct
18 confrontation which I was positing with the witness on
19 21 June at this hearing?

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

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

1 says:

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

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

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

16 A. That's apparently so, sir.

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

25 A. I accept that.

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

9 A. It appears to be.

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

12 A. Sorry, how?

13 Q. Why don't you remember that?

14 A. I can't explain that.

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

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

1 the dilutional hyponatraemia element.

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

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

6 Then it says:

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

9 How did that come about?

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

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

15 A. I don't know.

16 Q. Sorry?

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

18 Q. No, but did you have any argument?

19 A. I can't remember.

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

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

10 A. That would be correct.

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

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

23 A. I think so.

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

25 A. I think so, yes.

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

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

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

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

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

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

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

1 A. I think so, yes.

2 Q. Yes. So if that's the case, then that would mean your
3 management of Adam's fluids because you're the person
4 who's administering the fluids.

5 A. That would be right.

6 Q. Yes. So if there's going to be a common agreement that
7 the term is not used, isn't that actually a way of
8 shielding the coroner from the position that, actually,
9 we all appreciate and acknowledge that Adam died because
10 too much fluid was given him, it's most regrettable, but
11 that's what happened?

12 A. Sorry ...

13 Q. If you leave out the reference to fluid overload, if
14 nobody talks about fluid overload, you can maintain an
15 argument that whilst it was hyponatraemia, it wasn't
16 dilutional hyponatraemia, then you maintain an argument
17 that he might not have developed his hyponatraemia and
18 his cerebral oedema and died because of anything to do
19 with the quantity and type of fluid that was given to
20 him.

21 MR UBEROI: Sorry, I am confused, I have to say, and
22 I wouldn't blame the witness for being confused. The
23 witness's point of view is in this note. Those are the
24 arguments he was putting forward at the time and we've
25 gone into them in great detail in the past. To the

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

14 THE CHAIRMAN: Let me tease that out with you, Mr Uberoi.

15 The position which is set out by Dr Taylor in this
16 note is different from the position which he has now
17 adopted in the inquiry; isn't that right?

18 MR UBEROI: In many respects, yes.

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

24 MR UBEROI: Yes, sir.

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

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

4 MR UBEROI: Yes, sir.

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

8 MR UBEROI: Yes.

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

12 MR UBEROI: Yes.

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

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

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

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

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

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

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

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

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

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

23 MR UBEROI: Yes.

24 THE CHAIRMAN: Okay.

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

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

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

13 THE CHAIRMAN: Mr Fortune?

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

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

1 leading to Adam's death.

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

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

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

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

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

20 MR FORTUNE: Well, if that's --

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

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

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

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

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

22 THE CHAIRMAN: I will.

23 Can we move on?

24 MS ANYADIKE-DANES: Yes, we can indeed.

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

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

9 A. Sorry, what's ...

10 Q. Did you inform the coroner that--

11 THE CHAIRMAN: Professor Savage --

12 MR UBEROI: Professor Savage gave evidence at the inquest.

13 THE CHAIRMAN: He gave evidence at the inquest --

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

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

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

24 A. Okay.

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

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

17 THE CHAIRMAN: Thank you.

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

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

24 Highlight that:

25 "A query was also raised about whether the new

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

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

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

18 Q. Then:

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

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

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

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

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

8 A. Thank you.

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

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

14 A. Yes.

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

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

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

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

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

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

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

18 Q. Well --

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

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

25 "The kidney was not working and it was felt that

1 more fluids were required"?

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

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

9 THE CHAIRMAN: Let's be careful to be fair to you, doctor.
10 It could have been you, but it is virtually certain that
11 before this meeting took place with the lawyers that the
12 lawyers had also met Mr Keane and Mr Brown and that
13 there must have been various discussions going on
14 between the various doctors who were involved. So while
15 it may have been that you did say at that meeting on
16 14 June that the kidney was not working and it was felt
17 that more fluids were required, the first part of that
18 may actually have come from notes of an earlier meeting,
19 which are simply unavailable to us.

20 A. I see.

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

25 A. Right.

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

5 A. I understand. Thank you.

6 MS ANYADIKE-DANES: There may be a bit of help from the
7 inquest note. Mrs Neill also attended the inquest and
8 she made a note of the evidence that was being given,
9 which is obviously fuller than what the coroner took
10 down. If one looks at 122-044-043, it's handwritten, so
11 it might be a bit difficult to fathom. You can see just
12 at the top there's Mrs Higgins who's asking questions.
13 And then you see a "Dr T". Unfortunately, there's
14 a hole there, but that is "Dr T". You're starting off
15 talking about the CVP increasing. Then you see:
16 "New kidney not working."
17 Do you see that? Four lines down:
18 "New kidney not working. Consider that need more
19 fluid. It became pink, but then paled. Fluids
20 reassessed."
21 What I'm putting to you, or at least what I'm
22 inviting you to help us with, is it seems in that
23 consultation note you had linked together the new kidney
24 not working with a concern that you needed to provide
25 more fluid.

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

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

19 MS ANYADIKE-DANES: Yes.

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

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

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

1 says:

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

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

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

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

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

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

24 THE CHAIRMAN: Let's double-check that.

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

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

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

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

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

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

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

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

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

17 A. Yes, correct.

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

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

1 THE CHAIRMAN: But sorry, unless this note is wrong, that's
2 what's written because that's what you told
3 the coroner --
4 A. Yes.
5 THE CHAIRMAN: -- in 1996.
6 A. That's correct.
7 THE CHAIRMAN: I'm asking you this question based on what
8 you told the coroner 16 years ago, at a time much closer
9 to Adam's operation and death.
10 A. Yes, that's correct.
11 THE CHAIRMAN: And in 1996, can I assume that your memory
12 would have been clearer than it is 16 years later?
13 A. That would be a reasonable assumption, yes.
14 THE CHAIRMAN: Right, thank you.
15 MS ANYADIKE-DANES: Two points out of that, and I'm thankful
16 to the chairman. Firstly, you are aware that Mr Keane's
17 evidence is that the kidney, the new kidney, did produce
18 a few drops of urine?
19 A. Yes.
20 Q. Secondly, when you were answering the chairman, you also
21 used the expression "perfusion". Just so that we're
22 clear, in your view, is part of the kidney functioning
23 or not functioning whether it perfuses, or is your
24 reference to functioning solely confined to whether it
25 produces urine?

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

8 Q. But --

9 A. -- in the operating room.

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

12 A. I think that's correct, yes.

13 Q. Yes.

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

21 Q. And from --

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

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

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

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

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

11 A. Yes.

12 Q. Thank you. I just want to, again, slightly out of order
13 in the way that I was going to take it, but now that you
14 mention the timing -- I think you referenced when the
15 anastomosis could have happened. It was another part of
16 this note that I wanted to take you to, to have your
17 explanation, and that is 122-001-003. If we go to the
18 top of that page, the second, if you would, sentence:
19 "In this case, the kidney was in at around 9.30 am.
20 The vein was in and the arteries were being finished."
21 What does that mean so far as you understand it?

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

24 Q. Yes.

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

1 Q. Yes.

2 A. And the other anastomosis, the arteries were being
3 finished. So I think that's what the note suggests,
4 that all happened at around 9.30.

5 Q. So then you, I think, have referred to the ... Let's
6 pick that up again and I'll come back to where I think
7 you were taking us to in the medical notes. If we go
8 back to the inquest note where we were at 122-044-048.
9 You'll see, "9.32, the clamps removed". That's
10 Mr Brangam putting that to you at that stage. As this
11 note records it, I should say in fairness:
12 "9.32 clamps removed, critical rime."
13 And you respond "yes".
14 And:
15 "The team took the view that this op would be over
16 shortly."
17 And you thought that was a reasonable view. You'd
18 been involved in many kidney transplants.
19 So why I put that to you is that that seems, on the
20 face of it, to fit with what the consultation note says
21 when it says that the kidney was in around 9.30 and the
22 vein was in and the arteries were being finished.
23 Then what I'm going to ask you about is the note
24 that Dr O'Connor makes as to when the anastomosis was
25 complete in Adam's medical notes and records. She says

1 that happened at about 10.30.

2 A. Yes.

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

9 A. Mm-hm.

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

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

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

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

3 A. It is, yes.

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

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

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

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

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

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

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

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

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

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

16 A. I have, yes.

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

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

25 THE CHAIRMAN: I think we have to give the stenographer

1 a break, so I'll come back out at a quarter to --
2 MS ANYADIKE-DANES: Mr Chairman, could I just ask one
3 question just to follow on from that?

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

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

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

10 (11.35 am)

11 (A short break)

12 (11.50 am)

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

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

21 And then you see:

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

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

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

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

6 Do you see those there, Dr Taylor?

7 A. Yes.

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

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

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

1 problematic, apparently?

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

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

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

15 Next:

16 "List of tests done: sugar and electrolytes."

17 That's what you're going to do:

18 "Once happy blood et cetera normal."

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

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

1 actually happened at 11 o'clock. But you have been
2 talking here of things coming to a relatively speedy
3 close in or around 9.30, 9.32, and this is the point
4 that the chairman was asking about just before the
5 break. That's what you were expecting. In fact, in the
6 048 page, that's what the team was expecting:

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

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

11 A. Yes.

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

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

21 Q. Yes.

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

1 time of the operation.

2 Q. Yes.

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

4 released.

5 Q. Exactly.

6 A. I don't know whether that was a venous clamp or an

7 arterial clamp. It appears to be in my documentation

8 that it was an important time of the operation.

9 Q. I understand.

10 A. The other doctors have said it was 10.35 when the clamps

11 were finally released and the kidney was finally

12 anastomosed. I was busy, presumably at that time,

13 erecting blood, checking blood against the patient's arm

14 band, going through quite a lot of anaesthetic tasks.

15 That's what happened in my side of things between those

16 two times, and I'm unable to comment or nothing became

17 clear to any about -- that I documented that happened on

18 the surgical side of the --

19 Q. As you know, we're going to come to a paragraph that

20 deals precisely with that. You say in the 048 page that

21 you've been involved in many kidney transplants. When

22 you then describe that you were doing, the 9.32 is

23 important for you, the haematocrit was low, you were

24 addressing that point and so on. From your experience,

25 is that the kind of thing that would have stopped the

1 operation from concluding?

2 A. The anaesthetic? Putting up --

3 Q. No, no, what you say that you were doing. You say 9.32

4 is important for you.

5 A. Yes.

6 Q. You took certain steps at that stage because you noted

7 his haematocrit was low and in other evidence you have

8 said as far as you were concerned, you appropriately and

9 adequately addressed those things.

10 A. Yes.

11 Q. So the question that I'm putting to you is: is that the

12 kind of thing that in your experience would have delayed

13 the operation? Could that have constituted, "later

14 proved not the case", or the other expression that you

15 use with this "things changed somewhat"?

16 A. Well, I'm trying to understand. Are you trying to ...

17 THE CHAIRMAN: Let me ask what I think is the question in

18 a slightly different way. The things that you were

19 doing at 9.32, are those the things which you would do

20 if you understood that the operation was coming to an

21 end shortly?

22 A. No. The things I would do if the operation was coming

23 to an end shortly was to start getting my anaesthetic

24 drugs ready to wake the child up.

25 THE CHAIRMAN: Right. So at 9.32, let's look at the note on

1 page 048. Mr Brangam says to you:
2 "9.32, clamps being removed, critical time."
3 And you said:
4 "Yes. Team took the view that this op would be over
5 shortly."
6 A. Yes.
7 THE CHAIRMAN: So whatever you were doing at 9.32 would be
8 part of the work being done by different doctors on
9 Adam, which you expected to result in the operation
10 ending shortly?
11 A. Yes.
12 THE CHAIRMAN: And let's try to put some time on "shortly".
13 By "shortly", do you mean 15, 20 minutes, something like
14 that? Is that right?
15 A. That's right.
16 THE CHAIRMAN: So the work that you were doing at 9.32,
17 allied to the work which is being done by the surgeon at
18 about 9.32, should mean that Adam's operation is
19 complete and he's removed from the theatre before
20 10 o'clock.
21 A. Okay.
22 THE CHAIRMAN: Right. We're not sure at this point if in
23 fact Mr Keane was there at 9.32. I think you thought
24 that he was the team, though if he leaves it's not
25 entirely clear when he leaves, he said he did the first

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

2 A. Yes.

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

6 A. Yes.

7 THE CHAIRMAN: For some reason, something changes.

8 A. Right.

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

13 A. No, he's not.

14 THE CHAIRMAN: He's eased off it?

15 A. He's not woken up until the skin is closed, which is at
16 11 o'clock.

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

24 A. That's correct.

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

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

4 A. Yes.

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

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

15 THE CHAIRMAN: Yes.

16 A. So from my experience of that, once the vascular
17 anastomoses are done, then the bladder's opened and the
18 ureter is implanted into the bladder, and that can take
19 15 or 20 minutes if it's straightforward. And once the
20 bladder and all -- that's the third anastomosis, if you
21 like. The vein goes in first, I believe. The artery
22 goes in second. That's when the clamps are released.
23 Then there's a period of time needed to open the bladder
24 and put the ureter, in a special surgical procedure,
25 into the bladder. And then the surgeons recheck all the

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

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

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

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

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

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

25 THE CHAIRMAN: Okay.

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

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

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

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

15 A. Yes.

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

19 A. Yes.

20 THE CHAIRMAN: So what happened for the worse over the next
21 40 or 45 minutes?

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

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

1 after about 9.32?

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

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

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

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

21 A. Yes.

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

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

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

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

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

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

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

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

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

21 A. Apparently, yes.

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

25 A. That was my evidence, yes.

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

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

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

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

1 administration?

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

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

5 A. That would appear to be possible, yes.

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

15 A. Yes.

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

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

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

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

1 That's being discussed on 18 June. I know that
2 you have given evidence of the error that you believe
3 you made at the time. Sorry, I beg your pardon. On
4 14 June, this note seems to be recording that his urine
5 output, Adam's, was assumed to be fixed, so there's no
6 difficulty there. People assume that he has got fixed
7 urine output and you'll have heard the evidence that
8 that's part of the reason of polyuria. But more to the
9 point, his urinary output is, or at least what's
10 required to compensate for it, is considered to be
11 100 ml per hour.

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

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

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

1 a position where the evidence you're giving is that you
2 based your calculations, made your error, in terms of
3 200 ml with his urine output not being fixed?

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

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

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

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

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

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

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

6 Sorry.

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

11 A. Yes.

12 THE CHAIRMAN: On page 2 you are recorded -- unless you say
13 this isn't your contribution, but it appears to be your
14 contribution -- that Adam's output was perhaps up to
15 100 ml per hour. You've accepted to the inquiry when
16 you were giving evidence in the spring that when you
17 calculated Adam's fluid output in 1995, you got it
18 wrong. This note from June 1996 seems to suggest that
19 at that time, in June 1996, you may have realised that
20 you'd got it wrong. And that's what the calculations in
21 this box suggest. Do you understand that?

22 A. My problem is I don't know if I came up with this table.

23 I'm not sure if this is my calculations or somebody
24 else's.

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

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

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

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

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

9 THE CHAIRMAN: Because one possible reading of it, which
10 I want you to respond to, is that at that consultation
11 you were not making the case that Adam had unlimited
12 fluid output but rather you were accepting, either
13 because this calculation came from you or else because
14 you didn't challenge it, that Adam's fluid output was
15 100 ml per hour. What's your response to that?

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

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

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

22 I have got that point, Mr Uberoi.

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

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

5 A. Yes.

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

10 A. I don't know.

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

15 A. I think so yes.

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

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

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

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

9 A. I can't explain that.

10 THE CHAIRMAN: Shall we go on to page 5?

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

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

15 And can you highlight the entire paragraph?

16 Thank you.

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

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

23 And then about halfway down, it says:

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

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

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

9 Q. Sorry. You said you'd heard?

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

11 Q. But you didn't see that?

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

13 Q. Sorry, carry on.

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

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

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

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

16 A. Yes.

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

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

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

21 A. Yes.

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

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

1 second sentence.

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

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

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

19 A. It would appear to be.

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

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

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

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

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

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

17 Q. Thank you. So we've got after the clamps are released.
18 Then the sentence goes on to say:
19 "A needle was put into the artery and no blood came
20 out and clearly the kidney was not working when the
21 operation site was closed."
22 And we'll leave the "however" for a moment. Let's
23 deal with the kidney [sic] being put into the artery and
24 no blood coming out. Firstly, are you aware of such
25 a procedure?

1 A. I am aware that a needle is put into an artery, but it's
2 the purpose of that ...

3 Q. That's what I'm going to ask you. Do you know why it's
4 done?

5 A. The purpose of that is usually to inject a drug to stop
6 the spasm, potential spasm. I'm not an expert in this
7 area; I observe surgeons doing this procedure. I'm not
8 trained or skilled in doing this procedure personally.
9 So I'm talking about my view, my observation of several
10 kidney transplants.

11 Q. Yes. Well, have you seen that happen often?

12 A. A needle put into the artery?

13 Q. Yes.

14 A. Yes, to inject drugs.

15 Q. At a time when a kidney is failing?

16 A. At a time when the surgeon is concerned about the
17 arterial spasm or the arterial blood supply to the
18 kidney.

19 Q. Yes. Sorry, at a time when the surgeon is concerned
20 about the arterial blood supply?

21 A. Well, I may be confusing here because it's not an
22 anaesthetic job. I'm not doing this, so I'm giving my
23 observation of several surgeons who I've watched. So
24 I'm really not an expert --

25 Q. I understand --

1 A. -- in this area --

2 Q. But you had helped us a little bit --

3 A. -- so I could be wrong in my observations.

4 Q. I understand that. You had helped us a little bit by

5 saying part of your function was making sure that there

6 is an adequate blood supply, if you like, so that when

7 the anastomosis was complete and the clamps were

8 released, there wasn't some negative effect of that

9 because a kidney, possibly even a large kidney, will

10 absorb quite a bit of blood and you don't want to have

11 an adverse reaction to that. And part of your role

12 in the management of fluids is also to manage the

13 provision of blood and make sure the pressure is at an

14 adequate level and so forth. You've already given that

15 evidence.

16 A. Yes.

17 Q. So when you say that when there's a concern about the

18 blood -- I think you said the arterial ...

19 A. The renal artery, the new artery is maybe not getting

20 sufficient pressure, sufficient blood, then the surgeon

21 can inject a drug called papaveritan(?) to overcome any

22 potential spasm, I believe. I believe.

23 Q. I understand.

24 A. I'm not familiar with that drug. I don't know its side

25 effects.

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

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

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

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

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

16 A. Yes, that's my observation.

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

21 A. Yes.

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

25 A. Yes, that's what it says.

1 Q. And then it says:
2 "And clearly, the kidney was not working when the
3 operation site was closed."
4 A. Well, that's another bit I don't understand because
5 if -- the reference now is to when closure of the wound
6 has occurred.
7 Q. Yes.
8 A. So when the operation site is closed, the skin is
9 closed, so the kidney's ... Sorry, the kidney's in
10 place and the ureter is inside the bladder so the only
11 way one could confirm if the kidney was working when the
12 operation site is closed is to measure the urine output
13 produced. But presumably, the urine would be going into
14 the void of a bladder, and I don't know how one could
15 make that statement. I don't know how one could make
16 that statement at that time.
17 Q. Might it mean something as simple as there's a concern
18 about the perfusion of the kidney? A needle's put in,
19 when the needle is removed, no blood comes out, so there
20 is no blood flowing into that kidney, the kidney's not
21 working and the operation site is closed? So by the
22 time the operation site is closed, the kidney's clearly
23 not working. Is that not an interpretation?
24 A. One couldn't observe the kidney when the skin is closed.
25 Q. No, before then. One interpretation -- I'm asking you

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

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

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

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

9 Q. When I asked you about the kidney not working in the way
10 that you had coined it, which is not producing urine --
11 A. Not continuing to produce urine.

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

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

22 Q. Did you see a needle being used?

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

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

1 just didn't see it?

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

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

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

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

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

25 THE CHAIRMAN: But on the other few operations where

1 you have seen a needle being used to inject a drug,
2 is that because you have seen it or because you've been
3 told about it?
4 A. I've been told about it, sir.
5 THE CHAIRMAN: So --
6 A. I would be in an unlikely position to observe either
7 needle being placed in an artery.
8 THE CHAIRMAN: But even if you were to be in a position to
9 observe, you may not actually see it because you're
10 doing something else?
11 A. That's another option, sir.
12 THE CHAIRMAN: So if a needle was put into Adam's kidney,
13 it's not really surprising if you did not see it?
14 A. I would be more surprised if I did see it.
15 THE CHAIRMAN: Right. But would you be surprised if you
16 didn't know at the time that that was happening?
17 A. No. I wouldn't be surprised. It could have happened
18 without my knowledge or without --
19 THE CHAIRMAN: We're talking about the team in the theatre
20 at this stage, and you thought the -- the team at this
21 point might still include the nephrologist, but it would
22 certainly include the surgeon.
23 A. The surgeon, yes. The surgeon would be doing it. He
24 may have consulted me, he may not. I can't remember in
25 this case. It wouldn't be a common item for discussion,

1 I don't think. It's very much a surgical procedure.

2 MS ANYADIKE-DANES: If this is being prompted by a concern
3 over perfusion and you have said even in the experience
4 you've had of it being done, it is still being prompted
5 by concerns over perfusion because it is a drug that is
6 being administered to improve that. One other way of
7 interpreting this is it's being done to check and see
8 whether the blood supply's getting to the kidney.
9 Either way, it arises out of a concern with perfusion.
10 If there was that kind of concern, is that not something
11 that would be being discussed?

12 A. It probably would be being discussed.

13 Q. And if a drug --

14 A. Sorry, it probably would have been discussed between the
15 surgeon and the nephrologist. It may not have included
16 me because it was related to the graft, it was related
17 to the ... My impact would be to make sure there's
18 enough fluid and blood pressure to supply the kidney.

19 THE CHAIRMAN: I don't quite get this at the moment.
20 Because earlier this morning, before the break, there
21 was discussion about a note and the note was to the
22 effect that the team discussed it. And you confirmed
23 that the team was you and the surgeon, which you
24 probably I think is Mr Keane, and probably Dr O'Connor.
25 And what you were discussing was that the kidney was not

1 working in the sense of not producing urine.

2 A. Yes.

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

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

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

16 A. I may.

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

19 A. Yes.

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

22 A. Yes.

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

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

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

9 A. Yes.

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

11 A. Yes.

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

14 A. Yes.

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

19 A. That's correct.

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

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

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

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

11 A. Yes.

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

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

16 Q. But it would be recorded somewhere?

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

18 THE CHAIRMAN: It should be recorded?

19 A. Yes, it should be recorded.

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

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

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

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

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

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

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

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

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

19 THE CHAIRMAN: I accept that.

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

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

25 A. I have to say no.

1 Q. No?

2 A. Usually the surgeon checks pulsation in the artery with
3 his fingers. That's the usual test of blood flow to --

4 Q. Sorry, I'm asking you a different question.

5 A. I'm not aware of a needle being used to check for blood
6 flow.

7 Q. No, no. Were you aware before what is recorded here in
8 this consultation note of a needle being used in Adam's
9 operation in the way this is described here?

10 A. No.

11 Q. Is that because you don't remember or you positively
12 know that that was never told to you?

13 A. Well, my memory is not good for 17 years ago, and all
14 the events that happened, but ...

15 Q. So could it have been mentioned before?

16 A. It's possible it could have been mentioned before.

17 Q. If it had been mentioned, who is the person who is in
18 a position to be able to provide that information?

19 A. Well, I was at the operation. I don't think I would
20 have provided the information about the needle to this
21 meeting because it's not procedure that I would have
22 visualised or seen or had any memory of, in particular.

23 THE CHAIRMAN: And for the record, if a needle was put into
24 Adam's kidney, it was not put into Adam's kidney by you?

25 A. That's absolutely correct.

1 THE CHAIRMAN: Right.

2 MS ANYADIKE-DANES: Thank you.

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

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

7 A. Well, yes, I've read and re-read this quite a lot, and
8 it doesn't make sense. If it's, as the first part of
9 the sentence says, during the surgery it's no longer
10 relevant, it doesn't make sense because the timing of
11 the performance of the kidney and the relevance of Adam
12 not surviving the operation are completely different
13 events. So I did not know Adam had suffered
14 irreversible brain damage until his CT scan was done at
15 1 o'clock and that showed a serious cerebral oedema. So
16 to say that the performance of the kidney wasn't
17 relevant during the operation doesn't seem to make sense
18 in the timing of the surgery.

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

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

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

13 A. That would be the definitive test.

14 THE CHAIRMAN: The CT scan.

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

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

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

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

1 such a question to a witness, in my submission.

2 Anything is possible and it's not a helpful way to try

3 and elicit factual evidence on such an important point.

4 THE CHAIRMAN: Okay, well, let's rephrase it because I think

5 it is right to say -- and the witness has said a number

6 of times -- that things are possible without that taking

7 me very much further this morning. Let's put it this

8 way: this note goes on for six pages; right? This note

9 that we're looking at here.

10 A. Yes.

11 THE CHAIRMAN: You have confirmed this morning that -- and

12 let's ignore this paragraph at the moment. Apart from

13 this paragraph, this note is very, very detailed and

14 seems to be consistently accurate and reliable.

15 A. Yes. With a couple of ...

16 THE CHAIRMAN: Yes, a couple of bits and pieces, but it's

17 not --

18 A. Overall.

19 THE CHAIRMAN: It's not perfect, but it is consistently

20 accurate and reliable.

21 A. I agree.

22 THE CHAIRMAN: It's also, we now know, written by a very

23 well-educated lady.

24 A. Yes.

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

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

6 A. I know.

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

15 A. I understand.

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

19 A. I do, sir.

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

25 A. I can try.

1 THE CHAIRMAN: Please do.

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

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

17 THE CHAIRMAN: Yes.

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

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

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

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

13 THE CHAIRMAN: For the inquest?

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

20 THE CHAIRMAN: Okay.

21 A. Perhaps.

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

1 A. I believe that's their interpretation.

2 THE CHAIRMAN: Let's lend your interpretation to the final
3 bit of the last sentence and interpret that to mean that
4 Mr Brangam or somebody's saying the performance of the
5 kidney is no longer relevant at this stage, ie the stage
6 at which the inquest is about to be heard; okay?

7 A. Yes.

8 THE CHAIRMAN: So even if we take that interpretation, how
9 do I interpret the previous part of that sentence, which
10 says, "Clearly, the kidney was not working when the
11 operation site was closed"? Because all of the evidence
12 which I've heard suggests that the kidney was working
13 when the operation site was closed, and in fact the
14 operation site would not have been closed if the kidney
15 was not working. I understand how there might be some
16 ambiguity about "at this stage", but I don't understand
17 how the rest of the sentence can be made to reconcile
18 with the evidence to the coroner or to the inquiry.

19 For instance, Mr Keane's statement to the inquiry
20 says the surgery was a success and he explained here
21 that that meant that the transplant worked; right? This
22 paragraph says, "Clearly, the kidney was not working
23 when the operation site was closed". Can you help me
24 understand that?

25 A. Well, I do, sir, and I am merely coming up with

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

12 THE CHAIRMAN: Yes.

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

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

23 A. Yes.

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

1 was not working when the operation site was closed"?

2 MR UBEROI: Sir, I'm sorry to rise. I do think Dr Taylor

3 had answered that earlier when he said he can't offer

4 any explanation or make any sense of that comment --

5 THE CHAIRMAN: Maybe I've missed it in the complexity of the

6 evidence. If you can't give any evidence about that,

7 then there's no point in pursuing it with you.

8 MR MILLAR: Sir, if I can perhaps assist. I think

9 in relation to "not functioning", I think what Dr Taylor

10 said earlier on was that when he talked about "not

11 functioning", what he would mean by that would be not

12 producing urine.

13 THE CHAIRMAN: Yes.

14 MR MILLAR: Mr Keane's evidence was that, in his mind, he

15 saw a drop of urine, although he also said in his oral

16 evidence that he wasn't being dogmatic about that. He

17 may have been wrong, it may not have been urine, but he

18 thought it was a drop of urine. He has never said at

19 any stage -- and his operation note records that when he

20 left, the kidney was perfusing reasonably well, not that

21 the kidney was producing large volumes of urine and

22 functioning in that sense. So there's no inconsistency

23 between the kidney being perfused reasonably well at the

24 end and it not functioning in the sense of producing

25 urine. They're two totally different things, and

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

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

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

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

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

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

25 MR MILLAR: It is, sir.

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

3 MR MILLAR: It is completely wrong.

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

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

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

19 MS ANYADIKE-DANES: We shouldn't be very long, but I'm
20 conscious that there might be some questions that I ...
21 Mr Chairman, I wonder if this would be the way to
22 deal with it? I don't have very much more to deal with.
23 If we were to break now, I could make sure that
24 I streamline that as much as possible, as well as taking
25 on board any further queries that counsel might want me

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

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

9 (1.03 pm)

10 (The Short Adjournment)

11 (2.00 pm)

12 THE CHAIRMAN: Okay, you've had discussions?

13 MS ANYADIKE-DANES: Yes, I have.

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

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

19 There we are.

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

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

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

12 That chart was compiled from the information in the
13 anaesthetic record, which, just for reference purposes,
14 is at 058-003-005, but if one looks along the bottom of
15 that chart, one sees the periods of time when atracurium
16 was administered. You see 7 o'clock, 8 o'clock, you see
17 8.30, 9.30, and then you see it's no longer being
18 administered.

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

1 A. Yes.

2 Q. So what I'm asking you is: does that not fit with an
3 interpretation of the paragraph that the chairman was
4 putting to you before we broke for lunch?

5 A. Well, you've got mixed description of atracurium.
6 Initially, you said it's an anaesthetic agent and then
7 you said it's a muscle relaxant.

8 Q. I beg your pardon. It is a muscle relaxant.

9 A. It's a non-depolarising muscle relaxant. So it's not an
10 anaesthetic. It doesn't keep him asleep. The drug
11 halothane, which was providing anaesthesia, sleep, was
12 being administered past this time.

13 Q. That was my error. I beg your pardon. The
14 characteristics of atracurium were described in a report
15 that we have from Dr Haynes. You produced a witness
16 statement dealing with it and the upshot of it is that
17 it's something that you do to ensure that there is no
18 involuntary movement and so forth. And that is
19 obviously relevant to make sure that doesn't happen
20 during the surgical procedure.

21 A. Yes.

22 Q. So if you'll forgive me for that error, but the issue
23 was, and it was at the time that Dr Haynes was being
24 invited to look at it, what might be the reasons why it
25 wasn't administered after 9.30, and it has a certain

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

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

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

17 Q. Could it mean that?

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

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

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

16 Q. Yes.

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

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

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

25 A. Sorry, could you just ...

1 Q. Sorry, if we can -- I beg your pardon.

2 MR UBEROI: [Inaudible: no microphone] give evidence on this
3 point, but if he's going to be asked again, if it's
4 going to be asked to be put again, could it be put on
5 the screen?

6 MS ANYADIKE-DANES: That's what I was just going to get
7 called up. There it is. So you see that final line:
8 "The performance of the kidney was no longer
9 relevant at this stage."

10 Is that something that you recall saying at any
11 stage?

12 A. No. As I've indicated earlier, not only do I not recall
13 saying it, but I wouldn't have said it because, as I've
14 indicated earlier, one couldn't make a decision about
15 the hopelessness of a patient undergoing anaesthesia
16 without (a) allowing all the sedative and anaesthetic
17 agents to wear off and then formally doing brainstem
18 tests, and that wasn't done until the following morning.
19 So one can't make a decision to say that it's no
20 longer -- that the patient's condition has reached the
21 point of non-survival. That wouldn't be anything
22 I would have said or practised. In fact, I would be
23 very wrong to practice that way.

24 Q. And just formally, can I also ask you, do you recall
25 saying the kidney was not working when the operation

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

3 A. Well, again -- sorry.

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

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

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

19 A. No.

20 Q. Thank you.

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

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

1 THE CHAIRMAN: And before the skin was closed, you wouldn't
2 have said, "The kidney is not working"?

3 A. Well, I did indicate that it wasn't -- I think in
4 a previous statement I did say that the kidney wasn't
5 producing continuously producing urine, so it wasn't
6 fully working. But that doesn't mean it's not going to
7 work in my experience.

8 MS ANYADIKE-DANES: Yes. Just because there is something
9 that may be turning on this distinction between whether
10 "working" means not being perfused or working means not
11 producing urine --

12 A. Yes.

13 MR UBEROI: The witness has been very clear what his
14 definition of "not working" is. It's to do with the
15 urine. We've been over this several times now and I do
16 respect my learned friend's position that if something
17 is asked to be put, then she understandably makes
18 efforts to put it, but if it has been put before then
19 all we're doing is going round and round in circles and
20 it's not going to help you, sir.

21 THE CHAIRMAN: Is there a particular point you've been asked
22 to raise, Ms Anyadike-Danes?

23 MS ANYADIKE-DANES: Thank you. I was going to ask that.
24 Your evidence earlier to the coroner, and indeed to us,
25 was that, towards the end, you had your own concerns

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

3 A. Yes.

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

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

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

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

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

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

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

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

1 A. I think I've explained --

2 MR UBEROI: The witness' evidence to the coroner is going to
3 be largely contained in the note.

4 THE CHAIRMAN: That's a question of --

5 MR UBEROI: I'm just a bit concerned about what are actually
6 medical and technical terms, such as perfusion, are
7 being bandied around in a far too broad a fashion, and I
8 will repeat the phrase again, creating a recipe for
9 confusion to a witness who's been asked and answered
10 this same point several times today already.

11 THE CHAIRMAN: The question is, in that note, if that note
12 is accurate, if the doctor said, "The new kidney is not
13 working", did he mean not perfusing or not producing
14 urine. Doctor, do you remember drawing that distinction
15 at the inquest or do you remember anything beyond the
16 note --

17 A. No.

18 THE CHAIRMAN: -- seeming to be accurate in that it records
19 you as saying the new kidney was not working?

20 A. I don't remember what I meant by that. But if I can
21 help, I think I've already said that I wasn't the best
22 person to judge the colour or the perfusion of the
23 kidney. That's something that the surgeon could be more
24 likely to judge by the blood flow in and out of the
25 kidney. Mine would be an observation of the colour, for

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

5 THE CHAIRMAN: Right.

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

8 THE CHAIRMAN: Right.

9 MS ANYADIKE-DANES: So that we are clear, if we pull up
10 011-014-097, and if you see halfway down, the first
11 third:

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

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

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

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

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

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

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

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

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

22 "However, this procedure was planned to last 1 to
23 1.5 hours. A blood result taken at the start of the
24 procedure would not have been back from the labs for
25 perhaps 1 to 1.5 hours, so the procedure would have been

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

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

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

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

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

21 So what I'm asking you is: why is it that you have
22 given such a variety of reasons as to why you didn't
23 perform the electrolyte tests, whether it's by no
24 biochemistry change and not having time due to the
25 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?

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

8 THE CHAIRMAN: Okay. You can leave it --

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

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

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

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

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

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

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

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

7 MS ANYADIKE-DANES: Dr Taylor?

8 A. Sir, can you just ...

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

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

19 A. Well, I did say, after this time, that there was a delay
20 in that time of the morning in the Belfast labs, getting
21 a sodium result to the lab and back in a reasonable
22 amount of time. That could make a difference to the
23 clinical decisions that would predicate on that.
24 I can't explain why I then added other reasons for not
25 doing a blood sample.

1 THE CHAIRMAN: Okay.

2 A. That I should have done and I admit that I ought to have
3 done it, as Dr Savage suggested.

4 THE CHAIRMAN: Thank you.

5 MS ANYADIKE-DANES: Mr Chairman, I think I have only one or
6 two more points to make. Could we go to 122-001-004?
7 If you go right to the top of that page, the first
8 paragraph there starting "it was pointed out", down to
9 "known to have high urine output".

10 Firstly, who would be pointing that out? Who would
11 be providing that kind of information? I don't mean
12 necessarily here, but who would be the original source
13 of information about what was and wasn't possible
14 in relation to the measuring of the urine output?

15 A. I can't say.

16 Q. Who else other than the surgeons would know the stage at
17 which the bladder was opened?

18 A. Well, Dr Gaston is an anaesthetist and he would have
19 known that it was important to measure the urinary
20 output, for instance.

21 Q. No, sorry.

22 A. It could have been me as well.

23 Q. I have not phrased the question in a way that you can
24 understand.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 A. No, it doesn't make sense.

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

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

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

25 I wonder if we could turn to a letter from

1 Brangam Bagnall to Dr Murnaghan, dated 7 June. I want
2 to turn to the second page of that letter, which is at
3 059-014-039. If we go down to the final paragraph,
4 starting "finally at this stage".

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

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

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

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

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

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

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

4 MS ANYADIKE-DANES: Yes.

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

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

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

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

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

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

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

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

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

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

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

19 A. No.

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

22 A. Yes.

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

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

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

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

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

21 THE CHAIRMAN: Okay.

22 MS ANYADIKE-DANES: Then quickly to follow up on the
23 chairman's point, 059-009-027. This is a memo that
24 Dr Murnaghan circulates to you, Dr Savage and Dr Gaston:
25 "Attached is a copy of a lengthy fax recently

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

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

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

13 Q. Well, you don't disagree with it, so if you had received
14 it, you would have seen that final paragraph at
15 059-014-039, which we don't have to go to, but that
16 final paragraph which refers to what he reports
17 Dr Gaston as attributing to your difficulty; isn't that
18 right? You'd have seen that?

19 A. I would have seen that.

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

24 A. Yes, that would be correct.

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

1 from Mrs Neill's note:

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

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

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

11 So that is dated 17 June. This is the note of the
12 consultation 14 June, saying that you're to write out
13 a document reiterating the points, and this is a memo
14 which is dated 17 June, saying that a summary is to be
15 provided by you for tomorrow's consultation. Of course,
16 18 June is the beginning of Adam's inquest.

17 A. Yes.

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

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

1 Q. I take it that means you no longer retain a copy of it
2 if you did it?

3 A. I can't find a copy and I would have expected Mr Brangam
4 to have retained a copy in his notes.

5 Q. Okay. Then the final thing I wanted to take you to is,
6 as you know from the evidence this morning, Mrs Neill
7 actually produced three documents for us. One is the
8 note of the consultation, another is the note of the
9 inspection of the equipment and then the third is the
10 note of the hearings at the inquest. If we go to the
11 note of the inspection of the equipment, that's
12 122-001-007.

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

16 Firstly, sorry, do you remember taking Dr Murnaghan
17 and George Brangam to inspect the equipment?

18 A. I don't recall that, but clearly I was there so I don't
19 dispute that I was there.

20 Q. Right. So then you see the monitor, it's describing the
21 monitor, showing the heart rate, arterial pressure,
22 percentage saturation and so forth:

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

1 the CVP readings went above 20."

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

8 A. Yes.

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

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

12 Q. Cancelled or suspended. Can we please go back to
13 122-001-007, the second paragraph? I wonder if you
14 could highlight that for us. Was the alarm in fact
15 suspended in Adam's case?

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

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

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

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

24 A. Well, Dr Haynes has provided --

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

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

18 Q. And that's your explanation?

19 A. That's my explanation.

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

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

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

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

1 Q. If it went off, would people around it be able to hear
2 it?

3 A. Yes.

4 Q. Would the nurses and the surgeons be able to hear it if
5 it went off?

6 A. Yes.

7 MS ANYADIKE-DANES: Thank you. Mr Chairman, I don't have
8 any further questions.

9 THE CHAIRMAN: Thank you. Any questions from the floor?
10 Okay. Mr Hunter, I think Mrs Slavin might be
11 looking for you behind you.

12 Doctor, just while we are waiting for him to come
13 back, I want to explore just one other point with you.
14 One of the apparently strange pieces of evidence which
15 we heard before was from Eleanor Boyce, who was the
16 transplant coordinator. She gave her evidence on
17 27 April. She said she came over to the hospital, not
18 to go into the theatre at all, but only to see Adam's
19 mum. And in effect, she only wanted to say to her,
20 "When this is over, would you write a letter to the
21 donor's family because they can get consolation from the
22 death that they've suffered if there has been
23 a successful use of one of the donor's organs which
24 helps another child?". But she says she was told as she
25 arrived that things had gone badly wrong, as a result of

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

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

10 A. Right.

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

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

1 A. Yes.

2 THE CHAIRMAN: And in essence, what she's saying is,
3 "I wasn't part of this procedure, I wasn't part of the
4 operation, I wasn't meant to go into the theatre at all,
5 but I did for the reasons I've given, and when I did,
6 everybody was working away with a patient who'd -- word
7 had already reached outside the theatre that Adam was
8 dead". Do you confirm in your evidence that you don't
9 accept that that can be right?

10 A. As I've said before, the first time I knew that Adam was
11 having a problem, was potentially brain-dead, was the
12 fact that he didn't start breathing at the end of the
13 skin closure when I tried to wake him up. That would
14 have been around 11 o'clock. But that cannot be
15 confirmed until the CT scan, again, indicated that he'd
16 suffered cerebral oedema, and then the following morning
17 when the brainstem tests were done. So it doesn't seem
18 to make sense to me that if she had been in the
19 operating theatre before 11 o'clock that there would
20 have been an indication that Adam could have suffered an
21 irreversible brain injury.

22 THE CHAIRMAN: Right. So you think the earliest time it
23 could have been was around 11?

24 A. There was an indication at that time that Adam had
25 suffered -- I think I've written down that he had fixed

1 dilated pupils at that time.

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

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

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

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

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

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

8 A. No.

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

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

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

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

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

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

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

6 A. That's possible, yes.

7 THE CHAIRMAN: Okay, thank you.

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

16 A. I can't remember, but --

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

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

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

4 Q. And that takes an hour to do?

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

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

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

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

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

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

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

1 Q. No, it was 12.05.

2 A. I can't explain where the time went, but there was
3 obviously time spent working out problems and trying to
4 find out what was going on. I can't account for where
5 the time went.

6 Q. Why doesn't he get rushed immediately to PICU? If you
7 can't wake him up within the 15 minutes when you think
8 he should be doing that, maybe you spend a few more
9 minutes having another go, nothing is successful. Why
10 don't you get him immediately to paediatric intensive
11 care?

12 A. Rushing to PICU doesn't make you better. The patient is
13 already on a ventilator, he's on a monitor. He has
14 a consultant anaesthetist standing beside him. I would
15 argue he's in a better state than being rushing to PICU,
16 as you describe, and being left with a PICU nurse by his
17 side. There's no magic about rushing a patient to PICU.

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

1 a bed?". I can't remember.

2 Q. Well, can we go to witness statement 014/2, page 6?

3 That is the witness statement, I think, of Dr O'Connor.

4 If you see right down at the bottom:

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

10 And it gives the reference for that note.

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

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

21 Q. When he's in that stage, so you know after 10 to
22 15 minutes that spontaneous breathing isn't happening,
23 you can't produce it, is that not the time to contact,
24 apart from Dr Campbell, his nephrologist?

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

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

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

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

1 Q. I understand. In any event, you have no real
2 explanation of what was being done with Adam for a large
3 part of that period from, let's say, about 11.15 to
4 about noon?

5 A. That's right.

6 Q. And just because I was asked to, the other period of
7 time that there seems to be a little bit of gap to try
8 and explain, if I can put it that way, is when you were
9 giving your evidence in answer to some questions from
10 the chairman, and I think, although we're only dealing
11 with the provisional text, it appears at page 69 of this
12 transcript. I think after a bit of trying to work out
13 matters, you had agreed with the chairman that it would
14 be about 45 minutes after you were noting 9.30, if you
15 like, that you thought that everything would be finished
16 and the operation would, to all intents and purposes, be
17 over. And what is being asked of you is, that takes you
18 to about 10.15, as I think the chairman said. What is
19 the explanation for what's happening between 10.15 and
20 11 o'clock when skin closure is recorded?

21 A. Well, I think I already indicated --

22 Q. I apologise if you did. There was some lack of clarity
23 as to what was actually happening.

24 THE CHAIRMAN: And I think there is a lack of clarity and
25 I've explored it and you've explored it. I think we'll

1 let Dr Taylor go without another explanation.

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

3 Questions from MS WOODS

4 MS WOODS: I wonder if I could remind you of some of the
5 evidence Dr Taylor gave in the clinical section? A few
6 minutes ago, Dr Taylor was asked some questions about
7 who may or may not have been present in the theatre with
8 him at the time he was trying to wake Adam up and we got
9 more of the -- no criticism to Dr Taylor -- "That's
10 possible" type answers. When this was addressed on
11 20 April, these questions were asked of him:

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

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

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

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

19 THE CHAIRMAN: Thank you.

20 Okay. Can we let Dr Taylor go?

21 Doctor, thank you very much again.

22 (The witness withdrew)

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

24 DR MARY O'CONNOR (called)

25 Questions from MR STEWART

1 MR STEWART: Dr O'Connor, good afternoon. Have you had
2 a chance over the summer to see the consultation note
3 that we're discussing?
4 A. Yes.
5 Q. Have you over the course of the summer had the
6 opportunity to discuss the content of this with any of
7 the other witnesses to this inquiry?
8 A. I understood, and maybe I was wrong, that that wasn't
9 appropriate behaviour. So I did not discuss the
10 contents with any other witnesses. I did ask a question
11 of our current transplant surgeon, not quoting the
12 document, but I asked him a question about the practice
13 of putting needles into renal arteries because the whole
14 document puzzled me. So I did have a conversation with
15 Mr Connelly, our current transplant surgeon, but not
16 relating directly to the evidence in front of me, just
17 asking him some questions about practice.
18 Q. Okay. What was his name again?
19 A. Mr John Connelly, the current senior transplant surgeon.
20 Q. I see. Having studied the note, can you identify any
21 inaccuracies within it?
22 A. I was not at this meeting. In fact, I was in Corsica
23 when this meeting took place, having checked my diary.
24 So I find it difficult to be asked about the content of
25 a meeting that I wasn't present at.

1 Q. Yes.

2 THE CHAIRMAN: Can I just pick up one point you mentioned
3 a moment ago? Am I right in saying that you said
4 a moment ago the whole note puzzled you? Or was it
5 just ...

6 A. Much of it puzzled me, yes. A lot of it didn't make
7 medical sense to me.

8 THE CHAIRMAN: Okay.

9 MR STEWART: A lot of it didn't make medical sense to you?

10 A. Yes.

11 Q. Was there anything in it that you found particularly
12 surprising or new?

13 A. I was surprised by many things. It might be easier if
14 I had a copy. Am I allowed to have a copy of it in
15 front of me?

16 Q. Absolutely. 122-001-001.

17 THE CHAIRMAN: If the witness has a hard copy in front of
18 her, that does no harm.

19 MR STEWART: No.

20 A. This is my copy here. I've highlighted one or two
21 sections.

22 THE CHAIRMAN: That's okay. The question you were being
23 asked was: was there anything in the note which you
24 found particularly surprising or new?

25 A. Um ...

1 THE CHAIRMAN: Take your time. Take a few minutes.

2 A. There were a number of things. First of all, I find it
3 hard to follow because it wasn't written in the form of
4 a transcript and, as it was some sort of amalgamated
5 note, it was hard for me to know who was meant to have
6 had what opinion expressed in it.

7 THE CHAIRMAN: Yes. You now know it's not supposed to be
8 a transcript.

9 A. Yes. Secondly, I found the table very confusing. In
10 this table, I couldn't figure out where some of these
11 figures come from myself. I was particularly surprised
12 at somebody writing down 60 ml per hour for metabolism.
13 We have referred in this inquiry before to the fact that
14 a child has what we call insensible losses. And that's
15 usually the sort of fluid that's probably described here
16 as for metabolism. It's not a phrase that I would use.
17 But there's a very clear calculation for working that
18 out and, in Adam's case, it was 9 ml per hour and
19 I don't think that's ever been disputed. So the fact
20 that somebody would write 60 ml an hour, it's such
21 a blatant error that I just ... That didn't make any
22 sense to me.

23 MR STEWART: Do you attach any significance to the fact that
24 that is underlined as though to draw attention or
25 emphasis to it?

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

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

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

7 Carry on, please.

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

10 A. Yes.

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

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

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

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

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

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

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

9 Q. Okay. Yes?

10 A. The next page, the comment, "The kidney was in at around
11 9.30 am". I suppose it depends what you mean by "in".

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

15 A. That's absolutely not true.

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

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

22 Q. Perhaps we'll take that first.

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

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

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

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

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

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

13 Q. Yes.

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

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

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

24 Q. What time did you enter it?

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

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

3 Q. Could you have written the note at 10.30?

4 A. Yes, I could have.

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

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

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

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

12 These are your replies:

13 "This entry were made some time between 10.30 am and
14 12.05 pm on 27 November."

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

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

19 Q. Can I ask you then, at 12.05, why you didn't include
20 this note, this aide-memoire "vascular anastomosis
21 10.30", within your 12.05 pm entry?

22 A. I probably would like to see that entry.

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

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

1 Q. At 12.05, it's in a different sort of pen, this looks
2 like a felt tip pen:
3 "Returned to ITU post transplant surgery."
4 Is that post-operatively?
5 A. Yes.
6 Q. Why did you not choose, if you were writing at 12.05, to
7 include this vital piece of information within the body
8 of that entry?
9 A. My concern at that time was that we had a very sick
10 child who wasn't breathing, and the content of the note
11 seems to follow a thought process of what's going on
12 here in terms of why he's not breathing.
13 Q. Can I suggest to you that it doesn't seem likely it was
14 entered at 10.30 itself?
15 A. I can't tell you exactly what time I wrote that note.
16 I can tell you some other evidence to say --
17 Q. May I stop you? The question was, before we get
18 deflected from the question: it's unlikely that you made
19 the entry at 10.30.
20 A. I cannot tell you precisely at what time I made the
21 entry. It may have been 10.30 or it may have been
22 another time.
23 Q. If it was at 10.30, it would mean, would it not, that
24 you were present in theatre for anastomosis?
25 A. I may have been. I have written on a drug kardex, which

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

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

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

13 A. Yes.

14 THE CHAIRMAN: 27 November.

15 MR STEWART: What time is that, 10.20?

16 A. Yes.

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

20 A. I have just made reference to this chart, which shows
21 that prednisolone, which actually was
22 methylprednisolone, was given dead on the line of
23 10 o'clock. Do you see the "200" straddles the line at
24 10 o'clock?

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

1 referred to --

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

3 Q. Yes, not 10.20.

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

5 Q. Why is it entered here between 10.00 and 10.15?

6 A. This isn't my record, but I suppose we're talking about

7 a time of five minutes.

8 Q. All right. Just to get back to the anastomosis note and

9 when it was entered. If you'd been in theatre at 10.30

10 and witnessed the anastomosis, you would then presumably

11 have been able to write it down?

12 A. My practice would be, and still would be, to write

13 a note, a summary note when the child goes to intensive

14 care, which I admit I sometimes start in theatre if I'm

15 there and nothing else is happening, and to write

16 a chronological account, the history of the child,

17 what's known about the transplant kidney. I usually

18 record the time out of ice, the time that the clamps are

19 off. I work out cold ischaemic time, warm ischaemic

20 time. I then go on to record drugs and fluids given in

21 theatre, and then to write a post-operative note.

22 Something very catastrophic happened to Adam and

23 when I started to write notes again at 12.05, this is

24 a very sick child who's not breathing and my focus was

25 less directed towards the transplant rather than he's

1 a sick child, what's wrong with his brain? I did not
2 forget about the transplant because the drugs
3 I prescribed, as you'll see from the fluid balance chart
4 in theatre -- sorry, in intensive care, include
5 ciclosporin, which is an anti-rejection drug, and the
6 other anti-rejection drugs were written up on the drug
7 kardex from intensive care.

8 So the appropriate drugs were given for the
9 maintenance of a kidney transplant, but our concern was,
10 is this child going to live? Our concern at that time
11 in the post-operative period in a child with fixed
12 dilated pupils was not firstly about the kidney.

13 Q. To summarise your evidence, this entry was made between
14 10.30 and 12.05. You don't know when and you don't know
15 if it was entered at 10.30 or not?

16 A. No, but the -- I am confident that the time of 10.30 is
17 accurate because that would have been recorded on the
18 whiteboard in theatre.

19 THE CHAIRMAN: Sorry, let's pause a minute, to be fair,
20 because Mr Stewart quite properly explored that
21 particular point with you. You said a few minutes ago
22 and I want to make sure we get this piece of your
23 evidence. You said it was absolutely not true that the
24 anastomosis was at around 9.30.

25 A. Yes.

1 THE CHAIRMAN: It was at 10.30 and you said there were three
2 reasons for that. Now --

3 A. The first reason --

4 THE CHAIRMAN: We'll go into the details of the reasons.
5 Let me get a note of what the three reasons are.

6 A. The first reason is my note in the margin saying 10.30.
7 The second reason is that all anti-rejection drugs
8 always must be -- always are -- given before the clamps
9 come off. It's a principle of transplantation. Often,
10 they're given half an hour beforehand. But they must be
11 given before the clamps come off. And we do have
12 a record on the anaesthetic chart of drugs being given
13 at 10 o'clock and between 10.15 as recorded here, and my
14 own record of 10.20 for the azathioprine.

15 THE CHAIRMAN: Okay. And can you remember what your third
16 reason was?

17 A. I think I was referring to the three notes -- the drug
18 kardex, the anaesthetic sheet and the "10.30" in the
19 margin.

20 THE CHAIRMAN: Okay.

21 MR STEWART: Are you surprised, therefore, that Dr Taylor
22 should have taken the view that it happened at 9.30?

23 A. I'm astounded.

24 Q. And that he should have given evidence to that effect to
25 the coroner?

1 A. I would need to be reminded of his evidence to the
2 coroner. I don't know what time, but I wasn't at the
3 inquest.

4 Q. Does that surprise you, that he should have felt it was
5 wholly consistent with his note and his reading of the
6 notes that it should have happened at 9.30?

7 A. I'm quite clear that it didn't happen at 9.30.

8 Q. Well, his evidence to the coroner is at 011-014-105.
9 I will take you to it.

10 A. I'm not sure how fair this is to ask me to comment on
11 his evidence to the coroner because I wasn't there.

12 MR UBEROI: Perhaps I might rise on that point just to ask
13 my learned friend to clarify what he means by
14 "consistent with his note". Perhaps if we can bring
15 that up and, as the witness is encouraging, if she can
16 always be taken to a document when she is being asked to
17 comment on it as opposed to being asked to comment on it
18 in the abstract. But particularly on that question
19 about the consistency of the note, I'd be grateful for
20 the reference.

21 MR STEWART: Dr Taylor did not say this morning that he
22 found anything about the idea of a 9.30 anastomosis to
23 be contrary to his reading of the record.

24 MR UBEROI: I certainly don't intend to engage in debate
25 across the floor now, but as a general principle

1 it would be uncontroversial if a reference for that is
2 being made and a mention to something is being
3 shoehorned into a question, then I'd be grateful if the
4 note could be pulled up on screen.

5 THE CHAIRMAN: Okay.

6 MR STEWART: You have here a note of the evidence, a signed
7 deposition that he gave at the inquest, and it is about
8 ten lines down:

9 "The new kidney did not work, leading to
10 a reassessment of the fluids given. This made us think
11 we had underestimated fluid and we gave fluid bolus at
12 9.32."

13 That's an example of Dr Taylor finding a consistent
14 entry in his note with a 9.30.

15 MR BRADLY: Sir, I haven't risen until now, but it seems to
16 me now that this witness is really being asked to
17 comment on the quality or content of somebody else's
18 evidence given a long time ago in 1996. I don't know if
19 my learned friend could explain the basis for these
20 questions and why the answers are going to help.

21 THE CHAIRMAN: I think you might take it, Mr Bradley, that
22 Dr O'Connor is saying: I'm astounded Dr Taylor said
23 anastomosis was at 9.30.

24 A. Yes.

25 MR UBEROI: And I will close off my objection -- I'm sure it

1 was unintentional -- but the suggestion that Dr Taylor
2 had made a medical note of that anastomosis being at
3 9.30, I don't believe that is supported in the evidence.

4 MR STEWART: I didn't suggest for one instant that he had
5 made a note of it; what I did say was that he didn't see
6 anything that was inconsistent with his note or his
7 reading of the note.

8 THE CHAIRMAN: To be fair, what Dr Taylor's done today is
9 reinterpret his earlier position because he originally
10 thought it was 9.30 and he's now saying, actually, in
11 light of the other notes, I think that's wrong. But
12 something significant happened at 9.30, the anastomosis
13 must have been later, it must have been about 10.30,
14 because that's what the others are saying. But he's
15 saying that's not what he understood it to be. It's
16 very, very curious. I won't put it beyond that, but
17 it's very curious.

18 MR STEWART: Dr O'Connor, that is one of the things we have
19 to explore. The differing accounts given of what
20 happened on that morning of surgery.

21 A. Can I reiterate that one must give the anti-rejection
22 drugs before releasing the clamps?

23 Q. Yes.

24 A. It's like one and one equals two. It's as
25 straightforward as that.

1 Q. And it's for that reason alone that you feel clear that
2 it's a 10.30 anastomosis.

3 A. Plus I've written "10.30". I didn't write that for ...

4 THE CHAIRMAN: For any other reason than you thought it was
5 10.30?

6 A. This was going to be part of my record and accurate.

7 MR STEWART: You were keenly following to a point what was
8 happening in theatre that morning?

9 A. I was in and out, and this has been explored in my
10 evidence before. I cannot give you precise timings of
11 when I was in and out. I know that I must have been
12 there at 10.20 because I prescribed that drug. I have
13 said in my evidence before, I have no recollection of
14 any concern at the time the clamps were released. I
15 cannot say for certain that I was there when the clamps
16 were released because I don't remember anything
17 untoward. I think it's very likely I was there when the
18 clamps were released if I was there prescribing drugs
19 beforehand.

20 Q. When was the first you were aware of anything untoward?

21 A. In terms of Adam --

22 Q. In terms of Adam and his condition, the condition of the
23 kidney, anything about Adam. When was the first you
24 were aware of anything untoward?

25 A. At some stage towards the end of the operation before

1 he was woken up, as you know I have recorded this
2 comment that the kidney was said to be blueish.
3 I cannot remember who made that remark. I don't recall
4 witnessing, seeing a blue kidney. So that has made me
5 think I heard this remark. But the first time I have
6 serious concern about Adam is when I was beeped back to
7 theatre after he was attempted to be woken up and
8 Dr Taylor discovered he had fixed dilated pupils. That
9 was the first significant concern.

10 THE CHAIRMAN: So the comment you heard about the kidney
11 being blueish, that wasn't in the same league of
12 seriousness as being beeped back?

13 A. Oh, no, no, no, no. It was also a comment later on, it
14 wasn't to do with the time of the vascular anastomosis.

15 MR STEWART: So you don't know when the kidney was observed
16 to be blueish?

17 A. In the later part of the procedure, but I don't recall
18 myself observing that. It was a comment that someone
19 made.

20 Q. Do you know what time skin closure was achieved?

21 A. I don't know for sure, but the anaesthetic record goes
22 on to 11 o'clock and I'm not sure if it goes beyond.
23 But if the anastomosis was 10.30 -- and I believe quite
24 definitely that it was 10.30 -- the ... At that point,
25 and maybe these questions are best asked of a surgeon,

1 but in the operating field, the blood vessels are in one
2 place and the bladder's in another place. So the
3 surgeon then has to move his place of operating, if you
4 like. And I do have a memory that it seemed to be the
5 bladder that seemed to be difficult. He'd had previous
6 surgery in and around his bladder, and that, in my
7 opinion, as a non-surgeon, would have made the
8 anastomosis of the ureter to the bladder perhaps more
9 time-consuming than normal.

10 Currently, when we go to theatre for a transplant,
11 normally I would speak to the parents after the vascular
12 anastomosis. I would often leave theatre and go and
13 tell them the kidney is plumbed in now, it looks okay,
14 but we won't be seeing you in intensive care for two or
15 three hours. That's my standard comment to parents.

16 Q. Did you go and speak to Adam's mother and tell her that
17 anastomosis had occurred?

18 A. I spoke to Adam's mother some time in or around
19 10 o'clock I think. Some time ... I wonder if it is
20 when I went to the ward to get some drugs because the
21 drug azathioprine wouldn't be carried in theatre.
22 I don't think the anastomosis -- if anastomosis has
23 happened, I would say so to the parents. I think
24 I spoke to her before the anastomosis. Of course, my
25 habits in theatre and what I say to parents have very

1 much been influenced by Adam's case. Because as I've
2 said in my evidence before, it was not routine practice
3 for nephrologists to go to theatre. In very many of the
4 UK units, they don't go to theatre at all, and my
5 practice of going to theatre and leaving theatre to go
6 to speak to parents has been extensively influenced by
7 Adam's case.

8 THE CHAIRMAN: I want to bring you back to the note because
9 it's the note that we're focusing on.

10 A. Okay.

11 THE CHAIRMAN: Mr Stewart was asking you about what you
12 regarded as mistakes in the note. I think we'd got to
13 the top of page 3 where it says, in this case, the
14 kidney was in around 9.30 and you have explained why you
15 think that is absolutely not correct.

16 A. Yes.

17 THE CHAIRMAN: Can you now take us on to what you regard as
18 the next significant mistake in the note?

19 A. Well, I think there's already been an awful lot of
20 discussion in my evidence about CVP. I don't think
21 I have anything different to add to the comments I've
22 made in my deposition about CVP.

23 THE CHAIRMAN: Yes.

24 A. I think that the next significant comment I would make
25 would be at the top of page 4, when I absolutely cannot

1 understand anybody to make the comment that you would
2 open a bladder early on in the transplant procedure.
3 There's a certain stage in transplantation, you expose
4 the operating area -- and again a surgeon is more
5 qualified to answer this question -- but the first thing
6 is to anastomose the kidney, the artery and the vein.
7 And when the surgeon's happy with that and happy that
8 there's no leak of blood, he then moves on to the less
9 onerous task of anastomosing the ureter. So you don't
10 go near the bladder until the kidney's plumbed in. It
11 doesn't make any sense at all.

12 THE CHAIRMAN: Okay.

13 A. And we've had 69 transplants of Belfast children since
14 Adam, and I was involved in 13 transplants, I think,
15 before Adam. I've never, ever heard of a bladder being
16 opened before the kidney is anastomosed.

17 MR STEWART: We discussed that earlier this afternoon.

18 I think a trail of that comment may go back to
19 Dr Taylor.

20 THE CHAIRMAN: Maybe we can --

21 MR UBEROI: Are we still on the "bladder being opened"
22 point? It's not right.

23 THE CHAIRMAN: Sorry, no. I think you're at cross-purposes
24 with Mr Stewart. I think what is really being said
25 is that you heard what Dr Taylor said this afternoon

1 about the bladder being open.

2 A. Yes, but you asked me did I disagree with this

3 document --

4 THE CHAIRMAN: Sorry, I understand you disagree with it.

5 I understand it's entirely outside all your experience.

6 A. Yes.

7 THE CHAIRMAN: But Dr Taylor explained why he thought that

8 that was so unlikely to have happened and do you agree

9 with that part of the evidence which he gave?

10 A. I wholeheartedly agree. I would adamantly not

11 understand how it could have been opened early on.

12 THE CHAIRMAN: Is that your point, Mr Uberoi, that it's

13 not -- okay. Your next -- this isn't a failing in the

14 note perhaps as much as maybe in a discussion -- it's

15 for me to decide later, I suppose.

16 What's the next medical error that you have

17 identified?

18 A. Hypernatraemia, rather than hyponatraemia. I think it's

19 a typing error.

20 THE CHAIRMAN: Right.

21 A. I suppose going on down, the 10 per cent dextrose is

22 mentioned.

23 THE CHAIRMAN: That's on page 5.

24 A. No, 004. In my experience, one would never give plain

25 10 per cent dextrose to a child of this age. It's

1 sometimes given to neonates because they have low blood
2 sugars, but you don't ever give 10 per cent plain
3 dextrose unless you're treating hypoglycaemia, when you
4 give a small amount of it. So that doesn't make sense
5 to me, 10 per cent dextrose on its own. You don't give
6 10 per cent dextrose to children generally over 4 weeks
7 old, unless there's particular metabolic reason with low
8 blood sugar, so that doesn't make any medical sense to
9 me.

10 THE CHAIRMAN: Okay.

11 A. Further on that page, I don't understand comment "the
12 bladder disadvantage". That's not a medical term,
13 that's not quoting a doctor.

14 THE CHAIRMAN: Unfortunately, it's quoting a lawyer, which
15 might make it more difficult.

16 A. Going on to the next page, I suppose the paragraph we've
17 mostly concentrated on, about the needle in the artery.
18 I was sent this document I think probably on the last --
19 around about the last day of the inquiry. I was at work
20 and I got telephoned and e-mailed. I just couldn't
21 understand this. And I had reason to speak to
22 Mr Connelly, the transplant surgeon, about another child
23 that I was dealing with that day. When I was on the
24 phone, I didn't quote this to him -- I felt that I've
25 understood that we're not to discuss actual evidence

1 from the inquiry. But I asked him, in his practice, had
2 he ever known a needle to be inserted into a renal
3 artery to check blood flow because, in the 13
4 transplants before Adam and in the 69 transplants we've
5 done since, it is not something I've witnessed. I did
6 ask him did he think there could have been some
7 confusion. Someone describing the not uncommon practice
8 of injecting a drug called papaverine, which is
9 sometimes given if a kidney is poorly perfused.

10 That drug is given not if there's a blockage in the
11 main big renal artery blood vessel, but if there is
12 spasm in the vessels inside the kidney, the little ones
13 that we don't see to the naked eye. And Mr Connelly
14 confirmed to me that on the occasions when he gives that
15 drug, he would never give it directly into the renal
16 artery because of the risk of causing an aneurysm in
17 that artery later on and that he would always give it in
18 the more peripheral vessel of the iliac artery. When
19 that drug is given, it is given with a tiny insulin
20 needle because the surgeon doesn't want to make any
21 large puncture in a blood vessel. And with that tiny
22 needle, it wouldn't, as far as I know, be practice to
23 withdraw back to look for blood. So I wondered with him
24 was there any misunderstanding of if that had been done.
25 But I have no recollection of that being done on that

1 day and I would expect: (a) to have been told about it;
2 (b) to have probably witnessed it; and (c) it would
3 definitely have been written in the surgeon's note.
4 I've often seen it done in other transplants but I have
5 no knowledge of that drug being given in Adam's case on
6 that day. The drug is kept in a cupboard, the nurses
7 would have to go and get it out. There would be some
8 discussion of getting it out and so on. So I think
9 there would be evidence if it was given.

10 MR STEWART: You concluded if there was no drug given, you
11 concluded there was no drug given because it's not
12 in the surgeon's record and it's not in the drug record?

13 A. Yes.

14 Q. And you therefore conclude it wasn't given?

15 A. I have no recollection of it being given.

16 Q. Okay.

17 THE CHAIRMAN: Well, there's no record of the drug being
18 given. What Mr Connelly says is that even if you were
19 giving that drug, you would not give it in that way.

20 A. No, you would give it in the iliac artery and it's
21 always given with a tiny, tiny -- most people have met
22 some diabetics. You've seen the little needles they use
23 to give insulin. It's given with that little insulin
24 needle.

25 THE CHAIRMAN: But if it wasn't given for the drug, and that

1 does appear not to be the case that the drug was not
2 administered, then in effect are you relaying to us that
3 Mr Connelly says you just would never ever ever put
4 a needle into an artery to see if it was perfusing?
5 A. Mr Connelly has been our transplant surgeon since the
6 end of 1996, I think, and obviously he trained in
7 Manchester before that. He told me that he has never
8 put a needle into a renal artery to check for blood flow
9 during a transplant. I have witnessed Mr Connelly be
10 concerned about the blood flow into an artery during
11 a transplant and his practice, which would be a good
12 practice, would be to take down the anastomosis and
13 check for clots and so on if he was sufficiently
14 concerned.

15 That can be difficult if the kidney is already
16 perfused with blood. Sometimes you have to actually
17 take the kidney away and put the clear perfusion fluid
18 through it again and cool the kidney down again. It's
19 very complex, it's probably going to put the kidney at
20 big risk. It's possibly best commented on by Mr Keane,
21 whose knowledge would be much more than mine of surgical
22 practice. But I have witnessed Mr Connelly take down
23 the anastomosis on occasions when he has been concerned
24 there might have been a problem with blood flow.

25 MR STEWART: And in other words, have a second anastomosis

1 having cleared it?

2 A. Yes, but it's not without -- you are probably decreasing
3 the chance of a successful transplant if you're trying
4 to do that kind of thing, although I have seen it done
5 successfully.

6 Q. It would only be done if there was a real reason and
7 a real concern?

8 A. Yes.

9 THE CHAIRMAN: Can I just ask you this -- sorry to interrupt
10 again, Mr Stewart. It might be very, very bad
11 practice -- and I'm getting the very strong impression
12 that it would be really, really bad practice -- but
13 would putting a needle into an artery tell you if blood
14 was flowing if you took the needle out and there was no
15 blood with it? Would it be a terrible way of doing
16 something of which there are a number of good ways of
17 doing?

18 A. It's probably best to ask a surgeon about surgical
19 practice, but I think the fact that Mr Connelly in all
20 his years of transplantation told me that he has never
21 done it ... We often put needles into arteries, the
22 usual time is if you want to measure blood pressure and
23 you put needles into the arteries here (indicating). As
24 soon as you put a needle into an artery, usually the
25 blood spurts out because there's a pressure in the

1 artery, so it kind of spurts like that (indicating). So
2 you would usually expect, if you put a needle in, if the
3 needle was sufficiently wide bore, that blood would
4 spurt out. But if a currently practising transplant
5 surgeon has never done it, I would not surmise that
6 it would be good practice.

7 MR STEWART: But it could have happened?

8 A. I have no knowledge of it happening. I didn't see it
9 happen and nobody told me it happened, so I'm very
10 sceptical about the fact that it happened. I don't
11 understand why it would have happened.

12 Q. But you fairly concede it might have happened?

13 A. I have no knowledge of it happening and I can't
14 understand why it might have happened.

15 MR STEWART: Sir, the stenographers would be grateful for
16 a short break.

17 THE CHAIRMAN: I suppose we need to keep it short to get
18 Dr O'Connor finished. Can we do ten minutes and back at
19 3.55?

20 (3.45 pm)

21 (A short break)

22 (3.55 pm)

23 MR STEWART: If I might ask you to comment on some views
24 expressed by Messrs Forsythe and Rigg at
25 page 203-011-004. They were asked to comment at 4(b)

1 about the entry relating to needle being put into the
2 artery. The question was posed of Messrs Forsythe and
3 Rigg:

4 "What was the purpose of putting a needle into the
5 artery? The purpose of putting a needle into the artery
6 is to determine if there is a blood flow into the
7 kidney. If blood flow comes out of the needle, then the
8 surgeon is reassured that there is blood getting to the
9 kidney. But if there is no blood and the surgeon is
10 happy the needle is in the lumen of the artery, then
11 this means that there is no inflow of blood to the
12 kidney."

13 Secondly:

14 "Is this commonly done in transplant surgeries? In
15 our experience this is very uncommon and is only done
16 when there is concern about whether there is blood flow
17 in the artery when no pulse in the artery can be felt."

18 Would you agree with that?

19 A. Because this is in the realm of the experience of
20 a transplant surgeon, it's why, having never witnessed
21 this practice or seen this practice, I asked Mr Connolly
22 for his opinion because he was the surgeon to whom I had
23 access. His results in transplant surgery, if one looks
24 on the UK Transplant website, equal the best in the
25 country. And the fact that he has never done this

1 practice, he actually told me that if you put -- if you
2 were to do such a thing, you run the risk of causing an
3 aneurysm in the renal artery, which could then cause
4 problems later on.

5 So what I have spoken of is really -- I have never
6 seen it and the expert that I have access to has never
7 done it. And obviously --

8 THE CHAIRMAN: They're saying it's very uncommon.

9 A. Yes.

10 THE CHAIRMAN: If you are relying on what Mr Connelly says
11 to you, he's maybe going a bit further than saying it's
12 very uncommon.

13 A. He's actually saying he has never done it and he would
14 consider it bad practice.

15 MR STEWART: Just for the sake of completeness,
16 Messrs Forsythe and Rigg also comment on the bladder
17 being opened at page 203-011-007. There at 7(a)(b)(i):
18 "Please explain what 'the bladder was open' means
19 and why it was not possible to measure the urinary
20 output?"

21 And they respond:

22 "The description of the bladder being open means
23 that during the initial incision and exposure that the
24 bladder was opened by cutting into it. It is likely
25 that this was done inadvertently and not deliberately."

1 Does that, in a sense, answer the query you had that
2 it would be strange to do it deliberately?

3 A. I have certainly never seen it done deliberately.
4 I have also never seen it done inadvertently either.

5 Q. But this, at least, would provide an explanation for
6 your query.

7 A. I don't know that we have any evidence that the bladder
8 was open. I haven't seen any convincing evidence that
9 convinces me.

10 Q. Very well. Can I ask you: you were, once
11 Professor Savage left at about 9.30 that morning, part
12 of the team, the team conducting the renal transplant
13 operation.

14 A. I wasn't conducting the operation, but I was in and out
15 of theatre and I was part of the nephrology team --

16 Q. Part of the team engaged with Adam.

17 A. I was the nephrologist responsible for his care in that
18 time, but he was having an operation, being looked after
19 by the surgeon and anaesthetist primarily at that time.
20 I was obviously very interested in what was happening.

21 Q. I think you told the inquiry before that, in fact,
22 Adam's case was given priority by you that morning.

23 A. I didn't have clinical responsibility for a patient who
24 was anaesthetised and having an operation. A physician
25 would never have the clinical responsibility for

1 a patient who was anaesthetised and having an operation.
2 But I had huge interest in what was happening and
3 obviously my primary task, as I saw it, was to ensure
4 that it was clear about what immunosuppression was to be
5 given, because we had made changes, and in fact
6 I believe we had a further discussion that morning,
7 which is why I prescribed azathioprine.

8 Q. Was that because you changed from the Bristol protocol
9 to the Belfast one?

10 A. Bristol didn't use azathioprine, Belfast did. Bristol
11 did use methylprednisolone and I used ciclosporin and
12 we were kind of doing a bit of both. So I surmised we
13 had a conversation about that and decided to use
14 the azathioprine and that's why I prescribed it when
15 Professor Savage hadn't already written it in the notes.

16 Q. Is it because of that change in the prescription that
17 you were intent on being there to ensure that it was
18 properly administered?

19 A. To ensure that it had been prescribed and Dr Taylor was
20 clear what drugs they wanted, yes.

21 Q. And the initial prescriptions were given by Dr Savage?

22 A. For methylprednisolone. I can't remember if he
23 prescribed anything else to be given. Mannitol --
24 Augmentin is an antibiotic and mannitol is to cause
25 a diuresis. So the only immunosuppression that I think

1 had already been prescribed was the methylprednisolone.
2 The azathioprine was additional and the ciclosporin was
3 then given by infusion once we entered the intensive
4 care unit.

5 MR FORTUNE: Can I help, sir? There are two references.

6 You can have either 058-035-133 or 059-006-011. It's
7 Professor Savage's note in the middle of the page, "In
8 theatre to have". And then he sets out four drugs:
9 methylprednisolone, Augmentin, a reference to a double
10 or triple lumen line for the drugs, and dopamine.

11 A. Only one of those is immunosuppression, the
12 methylprednisolone. I think we must have had had
13 a discussion, I surmise, and added azathioprine to that.

14 MR FORTUNE: He made it quite clear that the
15 methylprednisolone was to be administered before the
16 clamps were released.

17 A. Yes.

18 MR STEWART: So your role was to liaise with the
19 anaesthetist to ensure that the immunosuppression was
20 given appropriately.

21 A. Yes, and it's why I had prescribed, in written form on
22 a drug kardex, the additional drug which I wanted him to
23 give.

24 Q. And that was one reason why you'd be going in and out of
25 theatre to liaise with the anaesthetist. Another was to

1 be able to report back to Adam's mother the progress of
2 the operation.

3 A. I suppose at that time if you like, that was
4 a by-product of my going in and out of theatre. I've
5 made it clear that since Adam's transplant I try very
6 hard to communicate with everybody -- surgeon,
7 anaesthetist, parents -- as best I can. But I didn't
8 have a routine or a habit at that stage. I did
9 anticipate that my primary task for the nephrologist was
10 to look after the fluids immediately post transplant,
11 and that would have been my practice in Bristol. And
12 the practice of many of my colleagues throughout the
13 country is that they meet the patient in the recovery
14 room because the common situation -- it obviously wasn't
15 the case with Adam, but the common situation post
16 transplant is that lots of urine is being passed early
17 on and if one does not keep up an appropriate amount of
18 fluid going in and there's lots going out, then the
19 kidney will clot and you will lose the kidney, and
20 that is not an uncommon scenario. It's why the
21 nephrologist would always be immediately present in the
22 post-operative period.

23 Q. So you are very keen to know what the anaesthetist does
24 and you are very keen to know what you might have to do
25 post-operatively.

1 A. My main role is post-operatively. As I have said in
2 Bristol, I didn't go to theatre except for one
3 transplant --

4 Q. And, obviously, post-operatively, you are worried about
5 clotting of the vascular anastomosis.

6 A. You're worried about very many things, but if the
7 patient becomes dehydrated, there is a huge risk of
8 clotting of the vascular anastomosis.

9 Q. So you want to be --

10 A. I sit at the bedside for many hours post-operatively --
11 this is what I do, I watch the in and the out and the
12 CVP and the blood pressure. The fluids are calculated
13 on an hourly basis in the post-operative period.

14 Q. So your critical focus is on that post-operative period?

15 A. Yes.

16 Q. Because that's when you come into your own, that's when
17 you do your specialty?

18 A. Yes.

19 Q. In other words, you are waiting for the operation to
20 come to an end so that your role can begin?

21 A. Yes, in the intensive care unit.

22 Q. So you're not distancing yourself very far from theatre,
23 you're staying there or thereabouts and going in and out
24 to see what happens?

25 A. Well, the ward is perhaps -- as it was then, was maybe,

1 I didn't measure it, maybe 100, 150 yards from theatre,
2 so I wasn't any further away from the ward.

3 Q. So the longer surgery took, I would take it the more
4 interested you become as to when exactly it was going to
5 end so that you could start?

6 THE CHAIRMAN: Or while it's going on?

7 A. I certainly would have wanted to be in intensive care
8 immediately on the patient's arrival.

9 THE CHAIRMAN: But if the surgery's going on longer than
10 expected, you would want to know why because that might
11 have some knock on effect on the complexity of the job
12 which you're going to take over in intensive care?

13 Let's take a silly example. Let's suppose surgery's
14 supposed to last for two hours and it lasts for five.
15 You'll want to know what's going on because this
16 shouldn't be happening and you must wonder, when I come
17 to look after this child, am I going to find more
18 problems than I expected?

19 A. I suppose I find it hard to answer in that my practice
20 is always to be in and around theatre nowadays. While
21 the child is in theatre, the giving of the fluids -- the
22 normal thing is that the fluids are given and
23 I appreciate here we didn't have an accurate CVP, but
24 they're given to order, if you like, according to the
25 blood pressure and the CVP. And while the child is

1 anaesthetised, that's the anaesthetist's job to do that.

2 THE CHAIRMAN: Let's make sure we've got the 1995 picture
3 right. Because you had just come from Bristol, where it
4 wasn't your practice to be in theatre at all.

5 A. No, you met the child in the -- in Bristol they didn't
6 go to intensive care, they came to the ward where we had
7 CVP monitors. So --

8 THE CHAIRMAN: So you were moving from a practice of being
9 out of the theatre --

10 A. Yes and most nephrologists don't go to theatre. I was
11 curious enough to ask my colleagues this.

12 THE CHAIRMAN: -- and to a practice whereby you're beginning
13 to spend more time in the theatre than you had ever done
14 before?

15 A. I think in my return to Belfast, the first case -- and
16 the Trust have still never got me the notes for the case
17 on 17 November. It happened in the middle of the night.
18 I wouldn't have had other jobs to do and I would have
19 been interested to be about and to observe. And in
20 Adam's case, I obviously wasn't very far away, but my
21 practice has entirely been coloured since then so I find
22 it hard to say. I didn't have a norm by the time the
23 second case came up in Belfast.

24 THE CHAIRMAN: Okay.

25 MR STEWART: Your witness statement, WS014/2, page 5 at (b):

1 "Explain what you meant by 'made myself available'.
2 I was on site in the hospital, ready to supervise the
3 post-operative transplant care. I went into theatre on
4 several occasions as I was keen to know how quickly the
5 operation was progressing and when I would be needed in
6 intensive care at the end of surgery."

7 It seems to express the suggestion I was putting to
8 you that you would have been keen to know about the
9 progress.

10 A. Yes, I wasn't very far away. I said I was never further
11 away than the ward.

12 Q. And the longer the operation went on, the keener you'd
13 become to know when exactly it was going to conclude.

14 A. Well, can I say that nowadays if we have a vascular
15 anastomosis done at a certain time, I often nowadays go
16 and speak to the parents and say, "The kidney's plumbed
17 in, it looks pink" -- that is maybe some reassurance at
18 this stage -- "but you won't see your child for another
19 two or three hours until we're into ICU and established
20 with all our monitors". So it's not necessarily a very
21 quick thing to come from the point of the anastomosis to
22 being in ICU and to have anastomosis at 10.30 and be in
23 ICU at 12 o'clock, I could go and look at notes for the
24 last number of transplants and try and get figures for
25 that. It's only an hour and a half, it's not a long

1 time between vascular anastomosis and being in intensive
2 care.

3 THE CHAIRMAN: Are you saying from 10.30 to 12 is not an
4 unusually long time for that process?

5 A. No, normally a lot of our transplants these days are
6 live donors, so we do kind of have a time frame we're
7 kind of used to because the parent goes to theatre at
8 8 o'clock or so in the City, the surgeon arrives over
9 carrying his bag with the kidney about 11.45. The child
10 goes down to theatre to have lines and things put in.
11 We get a phone call from the City first, the child often
12 goes down about 11.30. The surgeon will often start the
13 surgery for the transplant about 12.30. And one of the
14 things we now always do is do an ultrasound scan once
15 the skin's closed. And I suppose I see my job as
16 a facilitator trying to make everything work, and one of
17 the difficulties I have is we're usually looking for
18 that ultrasound scan and skin closure after 5 o'clock
19 when the consultant radiologists have gone home. So
20 currently, my job -- if we have a transplant, I'm
21 usually up in theatre that morning, negotiating with the
22 consultant radiologists, please will you stay after
23 5 o'clock. I'm going to need an ultrasound scan about
24 5.10, 5.15, please don't get in your car and go home,
25 I'm going to need you then. So I don't see an hour and

1 a half after vascular anastomosis as a long time between
2 then and getting into ICU.

3 MR STEWART: [Inaudible: no microphone] you have
4 expressed -- we heard this morning from Dr Taylor about
5 his indicative times. Forsythe and Rigg at 203-011-033,
6 they've given their suggested times.

7 THE CHAIRMAN: Was Forsythe and Rigg not up on the screen
8 a few moments ago?

9 MR MILLAR: Sir, is it the most recent report, part of that
10 that you're looking for? It's 203-011, and part of
11 it is --

12 MR STEWART: Try 203-011-003.

13 THE CHAIRMAN: Thank you.

14 MR STEWART: Yes. At the top of this page, second line:
15 "Indicative times for the different stages of the
16 operation are as follows."
17 The one we're interested in is after anastomosis,
18 which is the third and fourth bullet points:
19 "Time to check for bleeding and uretic anastomosis,
20 15 to 30 minutes. Closure of the wound, 10 to 20
21 minutes."
22 So it ranges there from 25 to 50 minutes from
23 anastomosis to being ready to pack up and move on to the
24 intensive care. That might take a further 10 minutes.
25 So at most 50, 60 minutes?

1 A. I haven't had a stopwatch to time this. But between the
2 point that the surgeon is finished and we get into
3 intensive care, first of all the child has to be woken
4 up. Dressings have to be secured to make sure lines
5 aren't pulled out. Monitors changed because the child
6 is monitored en route to the intensive care unit.
7 I wouldn't expect to be in intensive care 10 minutes
8 after the wound's closed.

9 Q. What would be your estimate for reversing the
10 anaesthetic and generally preparing the patient for
11 transfer to PICU? Would these be done simultaneously?

12 A. When the surgery's over and the child's awake, it still
13 takes a time to make sure the monitors are in place and
14 even to move the child from the operating table to the
15 bed, we've got lines here (indicating), a tube here to
16 be secured, an arterial line in the wrist to be secured,
17 we perhaps have a drain in the abdomen to be secured.
18 We've usually got an epidural anaesthetic to be secured,
19 and I've been in situations when children are moved
20 quickly on to the bed and the central line's pulled out.
21 So generally, the team take care that all these lines
22 are secured.

23 Q. Would that take an hour? Would it take an hour and
24 a half?

25 A. Well, in Adam's case obviously there was a catastrophic

1 event that he had fixed dilated pupils and ... That
2 caused consternation to everybody and there would have
3 been a lot of --

4 Q. May I just put to you the timings suggested this morning
5 from Haynes' report. It's 204-016-002, "Times of
6 surgery: Comment", asking first of all about the time
7 span for reversal of the anaesthetic, which for the
8 purpose of this discussion is taken to mean the return
9 of spontaneous breathing. Further on down, second
10 paragraph:

11 "I would expect spontaneous breathing within five
12 minutes or so following cessation of ventilation. Full
13 protective airway reflexes, a further five or ten
14 minutes."

15 That's ten to 15 minutes to come round. Then (b):

16 "Preparation of patient for transfer to PICU. No
17 more than 10 minutes."

18 So in all, at most, about 25 minutes according to
19 this expert.

20 A. I can't comment on anaesthetic drugs and waking up;
21 that's out of my experience. But I can say that we are
22 generally more concerned about all the lines and things
23 being secured than the actual timing of how many minutes
24 it takes to transfer to ICU because the child is at all
25 times accompanied by an anaesthetist and it doesn't,

1 in that respect, really matter whether they're in
2 theatre or ICU, as long as they're being looked after.

3 Q. Can I take you to WS014/2, pages 6 and 7? At the bottom
4 of page 6 you were asked:

5 "State when and where Dr Taylor discovered Adam had
6 fixed dilated pupils."

7 You respond:

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

13 That does suggest that, in fact, the waking up
14 process was really at or about midday.

15 A. Maybe I've misled with the word "immediately". He
16 certainly was moved immediately from the time that I was
17 called back and informed of this because I -- in my
18 memory, I think when I arrived that he was on the
19 journey from theatre to intensive care. I can't be
20 entirely clear, but I have a horrendous memory of seeing
21 him come through a doorway and being told that his
22 pupils were fixed and dilated. I am not sure. I'm not
23 sure if my memory's totally correct, when I was in the
24 theatre or just saw him coming through a doorway. But
25 my note there at 12.05. That's the time I wrote that

1 note. It would have taken me some time to try and find
2 some facts to examine the patient. I think at that
3 12.05 I've recorded an examination as far as I remember,
4 if you wanted to show me the note. It would have taken
5 some time to do that. It probably would have taken me
6 some time to ... I would have been shocked at this
7 news. It probably would have taken me some time to
8 gather my thoughts together to write a note. But the
9 12.05 is the time I wrote the note. Before that note,
10 I have examined him and so on.

11 Q. The words "immediately moved to intensive care" is yours
12 and suggests really the fixed dilated pupils were not
13 discovered until the waking up process, which is about
14 midday.

15 A. The fixed dilated pupils were certainly not discovered
16 until the waking up process.

17 Q. And it would seem to suggest from your note that it was
18 midday. Skin closure is 11 o'clock. Why does it take
19 an hour to get to waking up stage?

20 THE CHAIRMAN: Let's be fair. The witness has asked to be
21 referred back to her note, which started at 12.05.

22 Is that 058-035-134?

23 MR STEWART: It's over the page.

24 THE CHAIRMAN: Yes. Give us 135, please.

25 So what you're saying, doctor, just to get it clear,

1 for you to write this note at 12.05 -- the 12.05 means
2 that that's the time you start to write?

3 A. That's the time I wrote this note and I had obviously
4 gone through some thought processes and I don't know
5 what the next page says exactly, but I think I examined
6 the patient.

7 THE CHAIRMAN: Can you give us 136 as well as 135, please,
8 the two together?

9 A. Yes, so I had examined the patient. I had looked at his
10 pupils, I'd done the examination of the back of his
11 eyes, I'd examined him neurologically in terms of his
12 reflexes, I'd examined his abdomen. I had looked at the
13 fluid balance chart and recorded these numbers. That
14 all would have taken me some time to have looked at that
15 information.

16 THE CHAIRMAN: Right. Okay.

17 MR STEWART: Could I establish when you actually did go into
18 theatre as best we can? Because you've told us that you
19 don't remember --

20 A. I don't have timings, no. I do know that I wrote that
21 drug kardex at 10.20 am.

22 Q. But that doesn't mean to say you were in theatre at
23 10.20 does it?

24 A. Yes it does because the kardex was in theatre, yes.

25 Q. Very well. So that's one fixed point, 10.20.

1 THE CHAIRMAN: Does that mean for you to write that at
2 10.20, that you were there before that and you've
3 been -- or does it mean that you've been there before
4 that and you've been discussing what's going on with the
5 anaesthetist and the surgeon as best you can put things
6 together?

7 A. As best I can put things together. I think I went to
8 the ward to get the azathioprine, and that might have
9 coincided with the time that I spoke to Adam's mother.
10 The fact that I prescribed that drug at 10.20 confirms
11 that to me because I wouldn't give a drug after the
12 anastomosis, that that was before the anastomosis. The
13 comments that I've made previously about looking at the
14 CVP and discussing with Dr Taylor that it was 30 and
15 that alarmed me. The time anyone is most interested
16 in the CVP is immediately prior to clamp release.
17 It would make sense to me that I would have looked at
18 the CVP reading immediately prior to clamp release. So
19 I think I would have had discussions about the CVP at
20 that time.

21 MR STEWART: The first time I can track you into theatre is
22 about 9 or before 9 o'clock.

23 A. I think I came to work at 9 o'clock, so I have been
24 questioned extensively before about what time exactly
25 I first went into theatre, and I wasn't able to clarify

1 a precise time for you.

2 Q. Mine was a separate point and it is the point that in
3 one of your witness statements you say that you saw
4 Dr Montague in theatre, and Dr Montague --

5 A. Yes.

6 Q. -- has given evidence to the inquiry that he left at the
7 end of his shift, the end of his duty came at 9 o'clock.

8 A. I can only give my own evidence.

9 Q. But you did see him?

10 A. My recollection is very clear that I saw him.

11 Q. So that places you probably in theatre at or about
12 9 o'clock?

13 A. I came to work at 9 o'clock and some time shortly
14 thereafter I went to theatre.

15 Q. And at 10 o'clock, it seems that you looked at a CVP
16 monitor and saw that it was giving an elevated reading.

17 A. I'm not sure if I can time that as precisely as
18 10 o'clock. I would expect that I looked at the CVP
19 monitor before the clamps were released, but I don't
20 have a written note that I said, "This is the time
21 I looked at the CVP monitor".

22 Q. If I could draw your attention to your transcript of
23 25 April 2012 at page 121. Five lines from the bottom,
24 line 21, at that point you're being taken through
25 evidence about the CVP monitor giving a reading of 30.

1 The question is:

2 "Question: Okay, just so we're clear, you saw the

3 30?

4 "Answer: I did.

5 "Question: That means you saw it on the monitor;

6 is that right?

7 "Answer: Yes."

8 A. Mm-hm.

9 Q. And it seems that the inquiry can track by the trace,

10 the reading of 30 to 10 am.

11 A. Could I see the trace just to remind me? Would that be

12 okay?

13 Q. I will let you have that in due course.

14 MR BRADLY: Sir, I think "I'll let you have it in due

15 course" is not an entirely fair way -- the witness has

16 asked for it.

17 A. My question is there could be many moments in time that

18 the CVP was 30. It could have been at 10 am, it could

19 also have been at 10.30.

20 MR STEWART: Of course. I will do my best to get that for

21 you, Dr O'Connor.

22 THE CHAIRMAN: Let's see if we can find that reference now

23 for the witness. I think we looked at this earlier

24 today, didn't we, about the alarm being off? Was it at

25 the end of Dr Taylor's evidence? (Pause).

1 MR McALINDEN: Mr Chairman, it's 094-037-217.

2 THE CHAIRMAN: Thank you.

3 A. Okay. Looking at this, it goes from 0 to 60. It's the
4 bottom line. And the CVP -- so 30 is the dotted line in
5 the middle. And the CVP is over a value of 30 from
6 about 9 am until 11 am, it doesn't go under the value of
7 30 except very brief blip. So my saying that I saw
8 a reading of 30, I don't see any evidence that tells me
9 what precise time, according to this trace, I saw
10 a reading of 30. But I know that the time that I would
11 have been interested in knowing the CVP would have been
12 prior to clamp release. There's no time on that trace
13 that it's under 30 from -- there's that sort of 9 ...
14 It goes up at about 9 am. In fact, it goes up about
15 8.30 and there's a very slight blip around about 9.30
16 where it goes to maybe 28. And the whole of the rest of
17 the time from 8.30 through to well after 11, it's above
18 30. So I think that's consistent with my memory.

19 We also see here that the monitor -- at the time
20 this monitor stops, it would seem to make sense to me
21 that that's the time that the child was moved. Now we
22 take the same monitor into ICU, but I don't remember
23 whether in those days that was possible or not. But
24 this monitor trace for the blood pressure seems to go to
25 about 11.40 or so.

1 THE CHAIRMAN: No, it's short of 11.30, surely.

2 A. Do you see the middle one, the blood pressure? It goes
3 past the halfway mark there, so it's about 11.40. And
4 that would suggest to me that that was the time of the
5 physical move.

6 MR STEWART: Can I take you to the top of that little chart.
7 Do you see the number 40? 60 and then 40.

8 A. Yes.

9 Q. Could that top dotted line not refer to 40 and the
10 mid-line, PAM, be actually 20?

11 A. Not on my interpretation of it because usually with a
12 graph the scale goes up the side.

13 Q. What does 40 mean?

14 A. I don't know.

15 Q. Can I suggest to you that it does mean the upper end of
16 that scale, in which case 10 o'clock is exactly at 30?

17 A. But the scale for everything else is on the left-hand
18 side and, in normal practice, the scale for things are
19 always on the left-hand side. It's the method we
20 learned in mathematics at school.

21 Q. But somebody's put 40 there for a very good reason.
22 Can you suggest what that might be?

23 A. I don't use anaesthetic monitors personally.
24 I wouldn't -- I don't understand why the 40's there.

25 Q. What would the mid-dotted line be, marked PAM, at the

1 end?

2 A. Sorry, I do not know what PAM means.

3 THE CHAIRMAN: Between 0 and 60 there's mmHg, PAS, PAM --

4 A. I don't know what the abbreviation means.

5 MR STEWART: We learned this morning that the alarm would go

6 off on the CVP monitor at 20 if it was not disconnected.

7 That seems to be conveniently the midline if 40 is the

8 top line.

9 A. My interpretation is that the trace is all along the

10 side and it's nought to 60, but you would be better

11 speaking to -- I think you probably have spoken to

12 technicians and people about this.

13 THE CHAIRMAN: But your other point is all of these traces

14 end at about 11.40 or so.

15 A. Yes.

16 THE CHAIRMAN: And you suggest that that is consistent with

17 these readings being disconnected and, at about that

18 time, Adam's moved to PICU.

19 A. And that would fit with the fact that I took some time

20 to examine him before writing the note at 12.05.

21 MR STEWART: Yes. Thank you. So you may or may not be in

22 theatre at 10 o'clock. But on one reading, you might

23 be?

24 A. I think Adam's mum has said at what time I spoke to her.

25 She had a record of it more accurately than myself.

1 Q. She has told the inquiry that at some time after
2 10 o'clock you spoke with her --
3 A. Yes, I think --
4 Q. -- to say that the operation was taking a little longer
5 than you thought --
6 A. Yes.
7 Q. -- due to adhesions?
8 A. Yes.
9 Q. Is that right?
10 A. That's my recollection. I don't have a time on it, and
11 in my experience and practice of telling parents as much
12 information as I have, if the vascular anastomosis had
13 been carried out at the time I was speaking to mum,
14 I would have told her that because it's a very crucial,
15 very important thing.
16 Q. So the fact that she doesn't recall you telling her
17 about anastomosis would suggest that --
18 A. It hasn't happened at that stage.
19 Q. It was before 10.30?
20 A. Yes.
21 Q. So then you're in theatre at 10.20. You have prescribed
22 your drug and it's marked on the sheet.
23 A. Yes.
24 Q. And I think when you told the inquiry before that if you
25 were there at 10.30, it's likely that you would have

1 stayed on for anastomosis because it was such an
2 exciting, near-miraculous moment where you see the
3 kidney pink --

4 A. Yes.

5 Q. -- and you want to stay there and watch it?

6 A. I always watch it if I'm in theatre, yes. It's
7 a very -- what I describe as a modern day miracle, yes.

8 Q. But you can't remember it?

9 A. I can't have a specific memory here, no. I think my
10 memory would be more likely to be clear if something
11 wrong happened, if it didn't pink up, because um ...
12 I don't remember any transplants that I've been at where
13 the kidney didn't pink up. I remember one transplant
14 where the kidney went blue afterwards and had to be
15 removed because of kinking in the blood vessel every
16 time the skin was closed, and that kidney was removed
17 at the time. But otherwise, the reasons why a kidney
18 doesn't pink up could either be hyperacute rejection,
19 which is extremely rare -- less than 1 per cent -- or
20 a clot in the blood vessels, which a surgeon would be
21 best placed to answer questions about. But usually, it
22 might take a little bit of time to develop. Our
23 practice nowadays is always to do an ultrasound of the
24 kidney once the skin is closed to confirm the blood flow
25 immediately on skin closure, to make sure the blood

1 vessels haven't been kinked in the skin closure.

2 I don't think it was our practice then.

3 Q. If you were there, would you not have taken a note of

4 the timing at that time?

5 A. Yes, I did. 10.30.

6 Q. Are you now saying that you made that note at 10.30?

7 A. Um ... I don't have a recollection of when I wrote that

8 down.

9 Q. Dr Taylor gave evidence that the kidney paled after it

10 was initially perfused.

11 A. Yes. I don't have any recollection of seeing that, but

12 I do have a recollection later in the procedure of

13 somebody using the term "blueish". I cannot be more

14 precise as to what conversation that was.

15 Q. He's also described how there would have been discussion

16 amongst the team as to what to do in the event of

17 something like that happening.

18 A. I have no recollection of any discussion about poor

19 perfusion of the kidney at the time of the vascular

20 anastomosis, none whatsoever.

21 Q. So you have no recollection of any want of perfusion,

22 you don't remember being there at the time of

23 anastomosis, you don't remember it being --

24 A. I think it's likely that I was there at that time

25 because I was there at 10.20. I cannot tell you that

1 I actually remember, but I think it would be very
2 unlikely that I would go away between 10.20 and 10.30.

3 Q. Is it likely that you'd be there for that and not go
4 outside and tell Adam's mother that it's okay, it's
5 good, it's --

6 A. I didn't ... I didn't speak to Adam's mother.

7 Q. Yes. Why not?

8 A. It wasn't -- it's now my practice, but as I said before,
9 I didn't. I came from a practice where I didn't go to
10 theatre at all, so ... I just didn't -- it's not ...
11 If you ask most units in the country, "Does the
12 nephrologist go and speak to the parent immediately on
13 the vascular anastomosis?", I think you'll find that
14 it is not normal practice anywhere except Belfast.
15 We have been totally influenced in our practice by the
16 case of Adam and the tragic case of Adam. But most
17 nephrologists won't be present at all to relay
18 information to parents.

19 Q. One of the purposes you are there for is to relay
20 information about progress.

21 A. It's one of the purposes now that I have continued to
22 see as important, but I didn't have a practice of such.
23 As I said, in Bristol, where I came from, the
24 nephrologists didn't go to theatre at all so there was
25 no relaying of information about progress until the

1 child came to the recovery ward. That was normal in
2 Bristol where I came from.

3 THE CHAIRMAN: Because there was nobody to come in and out
4 to keep the parent informed?

5 A. Yes. It's --

6 THE CHAIRMAN: Because the surgeon and the anaesthetist
7 can't leave, so if the nephrologist isn't there --

8 A. It is not normal for people to come up and down from an
9 operation to speak to parents. I think I've made an
10 exception because of the tragedy and we've been
11 influenced by it.

12 THE CHAIRMAN: Okay.

13 MR STEWART: Can I suggest that it's odd if you saw this
14 great miraculous event and one of the reasons you were
15 there was to keep Mrs Strain up-to-date with what was
16 happening to her son that you didn't go out and speak to
17 her?

18 A. I don't think it was odd that I hadn't developed any
19 habit of going to speak to parents after anastomosis at
20 that time. I now have developed that habit.

21 MR BRADLY: Sir, forgive me for rising again, I don't wish
22 to prolong things. I wonder if my learned friend could
23 explain the basis of his suggestion that the purpose of
24 her being there was to provide parents with the
25 information [inaudible].

1 MR STEWART: 093-020-059. Halfway down:

2 "I can state it is my normal practice during
3 transplant surgery, if I am able to be present, to relay
4 to parents information from theatre, informing them as
5 to the stage of the operation and generally how matters
6 are progressing."

7 MR BRADLY: Sir, the [inaudible: no microphone] Police
8 Service of Northern Ireland.

9 A. In 2005, at which time I had developed normal practice,
10 and I suppose my statement would have been influenced by
11 that.

12 THE CHAIRMAN: "I cannot recall a specific conversation with
13 Adam's mother, but it would have been my normal practice
14 to have had such."

15 Anyway. Okay.

16 A. I think I've said in my evidence before, and could I say
17 again, I find this part of the statement difficult
18 because Detective Cross, what he did, he had the written
19 part of my statement for the inquiry, then he spoke to
20 me, and I have the handwritten copy. He hand wrote at
21 the end as I was speaking to him. So if you like, it
22 was his words. We were having a conversation and he was
23 writing down the record of that conversation. But it
24 wasn't -- I suppose I wasn't having time to ... The
25 nuances of language -- I didn't have time to think about

1 the nuances of what he was writing in his language of
2 our conversation.

3 THE CHAIRMAN: To an extent, we are going back over ground
4 which was covered. You gave evidence in April, so
5 we can move on, I think.

6 MR STEWART: I was going to bring you to an example of your
7 own words, which was your transcript of 25 April 2012,
8 page 169. At the top:

9 "I was aware that Adam had gone to theatre some time
10 before 7 and I might have expected everything to be
11 finished after sort of 3.5, 4 hours, and we weren't at
12 the point of being near finished here. So I think I was
13 aware she was anxious. I was trying to give whatever
14 information I had. It was probably fairly meaningless
15 information, but I was trying to be reassuring that
16 I had no evidence of any cause for concern at that point
17 in time. That is what I will have been trying to convey
18 to an anxious mother."

19 This is what you might have said at some time after
20 10 about the adhesions and so forth. But the same,
21 I would suggest holds true, that you were trying to give
22 whatever information you have and that you realise that
23 she is anxious for information.

24 A. Could I clarify that word "meaningless"? I think that
25 was ill-chosen by me. What I meant by that was there

1 was no information of substance yet because the vascular
2 anastomosis hadn't happened. So anything that I had to
3 say about how it's taking a bit longer -- I had no
4 useful information to give her about the progress of the
5 transplant before 10.30 because nothing important had
6 happened.

7 THE CHAIRMAN: Okay.

8 MR STEWART: After 10.30, there's no further evidence
9 we have to show that you were in theatre. You haven't
10 taken any notes. Can you trace any notes for us?

11 A. I wouldn't normally write a note until -- I sometimes
12 start the note in theatre to be my post-operative note,
13 but my main time of writing notes is on arrival in the
14 intensive care unit. So the records in theatre are
15 those of the surgeon and the anaesthetist. The
16 nephrologist doesn't have a record-keeping role in
17 theatre.

18 Q. I see. So that is a shame because you don't remember
19 the key moments of this surgery, you weren't witness to
20 them and you weren't brought in to discuss them. For
21 example --

22 A. I don't remember any witnessing of or description of any
23 difficulty around the time of the vascular anastomosis.
24 I think the contrary is that if there had been
25 a problem, that would have stood in my mind. Most

1 kidneys do turn pink.

2 Q. Do you remember Mr Keane --

3 A. Yes.

4 Q. -- leaving the theatre?

5 A. Um ... I don't have a clear recollection that I was

6 there when he left the theatre. I do have

7 a recollection later on in the day of being anxious that

8 he was contacted because he didn't and wouldn't have

9 known that something devastating had happened. I don't

10 remember which of us contacted him, but I remember being

11 anxious about having to ... I don't know, was it myself

12 or Dr Savage having to give him that information because

13 I knew he'd be shocked.

14 Q. Is there any note of that obligation or duty in the

15 record?

16 A. I don't think so, but I think it's in his evidence that

17 he was contacted by somebody from the Children's

18 Hospital.

19 Q. Do you remember another anaesthetist coming into

20 theatre?

21 A. I don't, no.

22 Q. Dr Campbell?

23 A. I don't.

24 Q. You don't remember the moment when the eyes were found

25 to be fixed and dilated?

1 A. I wasn't there at that time. I was called back to
2 theatre after that had happened.

3 Q. You're quite sure about that?

4 A. I'm quite sure of that.

5 Q. Page 148 of your transcript of 25 April, starting at the
6 top:

7 "17 years later, I find it hard to be entirely sure
8 if I was called back into theatre or met them on the way
9 to intensive care."

10 A. Yes.

11 Q. "I don't have any recollection of being there at the
12 moment --

13 A. I have already alluded to that. I have this image of
14 him being wheeled through a doorway rather than being
15 static in the theatre. I think he was en route to
16 intensive care by the time I was called, but I can't
17 give you any more information about that than I think
18 I remember him being wheeled through a doorway.

19 Q. Do you have any recollection that we can pin to the
20 period of 10.30 to midday?

21 A. I recollect that someone used the word "blueish" in
22 terms of how the kidney --

23 THE CHAIRMAN: Sorry, doctor, I think the point of the
24 question is this -- and you may have picked up from
25 earlier evidence today that what we're concerned about

1 is timings.

2 A. Yes.

3 THE CHAIRMAN: And times seeming to be missing.

4 A. Yes.

5 THE CHAIRMAN: And it's that confusion, I have to say,
6 that is to some degree caused by inconsistent evidence
7 that we've received from the people who were involved
8 at the time.

9 A. Mm-hm.

10 THE CHAIRMAN: So Mr Stewart isn't accusing you of anything
11 at all, we're just probing to see how the hours passed.

12 A. The vascular anastomosis was 10.30.

13 THE CHAIRMAN: Right.

14 A. And to plumb into the bladder, I would have thought --
15 and I'm not a surgeon, but it was a difficult job to
16 plumb into the bladder. I would have thought that would
17 have taken until about 11.15. Then there's skin to sew
18 up and muscle layers to sew up and catheters to be
19 sorted and tubes to be sorted. And the anaesthetic
20 trace that you showed me suggests that Adam left theatre
21 about 11.40, so ...

22 THE CHAIRMAN: That's the best timeline you can put
23 together?

24 A. Yes. I don't -- it doesn't give me the impression that
25 there's missing time there from 10.30 to leave theatre

1 at 11.40.

2 THE CHAIRMAN: But it's partly because you have a very
3 strong assertion that it was 10.30?

4 A. Yes.

5 THE CHAIRMAN: The evidence has not always pointed that way
6 from Dr Taylor and it doesn't point that way from the
7 consultation note. That's the --

8 A. I don't understand the consultation note.

9 THE CHAIRMAN: You think that's definitely wrong?

10 A. Absolutely.

11 THE CHAIRMAN: Okay, thank you.

12 MR STEWART: I was asking, is there anything else that you
13 can point to to show that you might have been in theatre
14 from 10.30 to midday? And I take it that there is
15 nothing that you can point to that says, "That shows
16 that I was there".

17 A. No.

18 THE CHAIRMAN: Do you remember seeing Eleanor Donaghy, now
19 Boyce?

20 A. Um ...

21 THE CHAIRMAN: You know who she is?

22 A. Yes, I know her very well, and normally, in those early
23 days, Eleanor actually used to bring the kidney over and
24 it often would have been her who recorded the timings of
25 out of ice and so on. I do remember seeing her,

1 I think, early on that day. She normally -- when I came
2 first, she used to be in theatre for the whole time of
3 transplants, but she obviously had other jobs to do.

4 THE CHAIRMAN: For paediatric transplants?

5 A. Yes, uh-huh.

6 THE CHAIRMAN: Because her evidence here was that she wasn't
7 intending to go into the theatre at all.

8 A. She often was the one who brought the kidney over.

9 THE CHAIRMAN: In this case -- let me just clarify it -- she
10 didn't know that Adam's transplant was taking place
11 until she arrived in work on the Monday and was told
12 about it. That means by definition she could not have
13 brought the kidney over. Her evidence was, she came
14 over to the Royal only to speak to Adam's mum to ask her
15 to, when it was over, contact the donor's family. So
16 that's why she was there and she didn't intend to go
17 into the theatre, but it was only when she heard
18 everything had gone terribly wrong that she did change
19 and go into the theatre and she described what she found
20 there.

21 A. It doesn't fit with my recollection. I don't have
22 a clear recollection, but I -- and, of course, she was
23 there for so many cases, I could be mixing up ...

24 THE CHAIRMAN: Maybe things changed as time went on in the
25 way that your own practice changed as time went on, but

1 she was quite clear about not expecting to be in the
2 theatre with Adam and why she went into the theatre with
3 Adam.

4 A. I think she filled in the times. You know the form that
5 goes back to UK Transplant?

6 THE CHAIRMAN: Yes.

7 A. Normally, that's a job that she carried out, and she
8 took those forms back with her to the City Hospital. So
9 in the early days of transplantation, when I came back,
10 I was used that she -- I think she was the only
11 coordinator then. I was used that she would often be
12 about for a lot of the theatre. I can't give times for
13 sure.

14 THE CHAIRMAN: That turns out to be another problem because
15 the timings on the form, which was returned to the
16 transplant agency, are different again.

17 A. Okay.

18 THE CHAIRMAN: But that's for me to sort out; you can't
19 really comment on that. But we have had quite a lot of
20 evidence about that before the summer.

21 A. Okay.

22 MR STEWART: Anyway, you think you remember seeing her?

23 A. I think I do.

24 Q. And, of course, you arrived at 9 that morning.

25 A. Yes.

1 Q. So it would have had to be after 9 o'clock?

2 A. Yes.

3 Q. Did you see her in theatre?

4 A. I think I saw her in theatre, yes. I can't give a time
5 precisely, but I think I saw her in theatre. I cannot
6 make any sense of the evidence that has been quoted, but
7 that's been gone into in some length, that Staff Nurse
8 Clinghan, who's now Nurse Sharratt, wouldn't have known
9 anything about Adam's fixed dilated pupils until the
10 point in time when Dr Taylor was waking him up and the
11 surgeons had gone.

12 Q. If information was leaking from the theatre so that
13 Nurse Sharratt knew about it outside --

14 A. Nurse Sharratt was doing haemodialysis on a child called
15 [REDACTED] and she was in the haemodialysis room in
16 Musgrave Ward and could not leave the room. Part of my
17 job as the consultant that morning would have also been
18 being responsible for the child on dialysis, so I would
19 have had reason to be in the dialysis room during that
20 morning as well. I wasn't -- I didn't just have the one
21 patient, there were other patients to be looked after.

22 Q. And why do you remember her being there at that time?

23 A. Because she was very close to Adam's mother, she was
24 very good to the patients on home dialysis, she did
25 a lot of home visits, and I remember her devastation.

1 She came up to visit Adam's mum after Adam's mum had
2 been brought up to be with Adam, and I just remember the
3 grave upset. But she wouldn't have been free to leave
4 the child on haemodialysis until the session had
5 completed, and children usually came for dialysis at
6 9 or 9.30 and their sessions were for three hours. You
7 can't leave a child who's having dialysis treatment, you
8 can't leave the room.

9 Q. Do you find it odd that you should remember that Nurse
10 Sharratt was there with dialysis when you can't remember
11 seeing the kidney pink, you can't remember it being
12 blueish, you don't remember whether or not you were
13 there for the eyes being found to be dilated and fixed?

14 A. I wasn't in the room when the eyes were noted to be
15 dilated and fixed. I have never said otherwise. I was
16 called back when Dr Taylor discovered that. I remember
17 Nurse Sharratt's reaction because she was very close to
18 Adam, she had known him since he was born. She was very
19 upset; she cried. We were all very upset, but Joanne
20 was particularly close to this little boy.

21 Q. So I take it that you are saying that Eleanor Donaghy
22 is --

23 A. I don't understand the sequence of what she said; it
24 doesn't make any sense to me, is what I'm saying.

25 Q. Is it pure invention?

1 A. I'm just saying I can't make any sense of it.

2 THE CHAIRMAN: It's not pure invention. There are a number
3 of possibilities. One is that she may have found this
4 out, but she may be wrong in recollecting that it was
5 Nurse Sharratt who told her; she may have got that
6 information from somebody else, but she describes being
7 in the operating theatre.

8 A. At the time when Dr Taylor was waking the child up, my
9 understanding is that the surgeons were gone at that
10 stage. So it doesn't make sense.

11 THE CHAIRMAN: That's part of the issues that I have to
12 decide on. She says the word was outside the theatre
13 that Adam was in effect dead but that -- not medically
14 dead and brainstem tested dead, but in effect dead. But
15 the word was already outside the theatre and she went
16 into the theatre, not intending to be there, and saw
17 Dr Taylor and Mr Keane.

18 A. But Mr Keane left before the skin was closed and there
19 was no concern about Adam in terms of his survival until
20 he was woken up and the pupils were fixed and dilated.

21 THE CHAIRMAN: Okay.

22 A. Absolutely.

23 MR STEWART: Are you telling the inquiry that you remember
24 Mr Keane leaving?

25 A. I don't know that I was there when he left, but he was

1 not there when I was called back because of the fixed
2 dilated pupils. And I do remember the anxiety of
3 somebody having to tell the surgeon who'd done the
4 operation that the child was effectively dead.
5 I remember thinking that was a difficult thing to
6 have --

7 Q. All you can say of your own knowledge is that he wasn't
8 there at midday approximately?

9 A. Yes.

10 Q. Yes. Nothing else? Did you tell Adam's mother that the
11 surgery was over at ten to twelve?

12 A. Once I was called and Adam's pupils were fixed and
13 dilated, I felt that my responsibility was to the sick
14 child, and I would not have left the child. Important
15 as it was that somebody spoke to the parents, my
16 responsibility was to the sick child to try and find out
17 what had gone on, to organise investigations. I phoned
18 Dr Savage, who knew the patient's family very well, and
19 he was in a position to come and speak to them. But
20 I would have felt that my duty of care was to be at the
21 patient's side when the patient was so sick. I wouldn't
22 have left at that time to walk down to the ward.

23 Q. Well, can I ask the question again. Did you tell Adam's
24 mother that the surgery was over at ten to twelve?

25 A. I have no recollection of doing so, no.

1 Q. Well, she says that you did, and I will just take you to
2 a reference; it's in a letter that she wrote.
3 011-049-182, halfway down the main paragraph:
4 "Another thing is that I was told by Dr O'Connor,
5 who was keeping me in touch with what was happening with
6 Adam in theatre that morning, that surgery ended at
7 11.50 am, not 11 am, as Dr Sumner said in his report.
8 This may only be a small point, but I can't help
9 wondering at exactly what time surgery ended."
10 A. I only recollect speaking to her once and I know we were
11 over this point the last time I gave evidence, and
12 I think the transcript shows that Adam's mum --
13 apparently this was discussed with her, and in the
14 transcript it has been said that she had said that she
15 didn't remember speaking to me a second time. There's
16 a point in the transcript where that's said by
17 Ms Anyadike-Danes.
18 THE CHAIRMAN: If we look at witness statement 001/2 at
19 page 12, maybe it's the next -- question 76, so it may
20 be the ... If you could put up the next page with it.
21 Question 76:
22 "Who informed you that Adam was out of surgery?
23 I am not certain."
24 So --
25 A. I think it's also covered. There is a bit in the

1 transcript where Ms Anyadike-Danes said to me -- there
2 was a break and I came back to the witness stand, and
3 she said that mum had confirmed that she wasn't clear
4 that I had told her that surgery was over. But maybe
5 you might want to look at that.

6 THE CHAIRMAN: That's where I got the reference from,
7 thank you.

8 MR STEWART: There may be a difference between telling her
9 that surgery was over and telling her that the eyes were
10 fixed and dilated. Could it be that you went as
11 a matter of a progress report to inform her that surgery
12 was now complete?

13 A. I could have done, but I don't have a recollection of
14 that conversation. But once I knew that there was
15 a problem with Adam and his pupils were fixed and
16 dilated, I did not leave his side. When there were two
17 of us there, I sent for Dr Savage, who knew the family
18 better. Obviously someone needed to speak to the
19 family, but the immediate priority was to look after the
20 patient.

21 Q. In your transcript of 25 April 2012 at page 133, the
22 second line:

23 "I am afraid I don't recall my conversations with
24 Adam's mum, but I'm aware that she has said that I told
25 her the surgery had finished about 10.50."

1 A. Yes, that was from some of the documents I read on the
2 website.

3 Q. Well, it seems that this document shows that she says it
4 was 11.50.

5 A. Okay.

6 Q. "It could be that I'd gone to tell her that the surgery
7 was at an end, but then I got called back. I certainly
8 did not leave Adam once I knew that he had fixed dilated
9 pupils."

10 Can you point to where she is said to have recorded
11 you speaking to her and telling her that surgery was
12 over at 10.50 as opposed to 11.50?

13 A. I think it was on one of the documents that I had read
14 on the website. I can't point it out, but I obviously
15 didn't think it was accurate from my recollection.

16 Q. Well, neither is accurate. Neither 10.50 nor 11.50 is
17 accurate for surgery being over.

18 A. We know that the monitoring -- looking at the CVP trace,
19 the monitoring finished about 11.40, the child was
20 possibly moved at that time. I haven't seen any dated
21 and timed records of exactly when the skin closure was.
22 I don't have evidence that that was 11 o'clock;
23 I haven't seen that anywhere.

24 THE CHAIRMAN: In a way, that's part of the problem. You
25 would expect there to be notes of that, wouldn't you?

1 A. No, not -- I mean, a surgeon writes a note afterwards to
2 describe exactly what happened. He doesn't put "skin
3 closure 11.50". The times you record for a transplant
4 are the kidney out of ice and the times that the clamps
5 are taken off. Those times are recorded, but it's not
6 routine to record other times. The monitors obviously
7 give some indication of the progress with times attached
8 and the anaesthetic record is timed because the
9 anaesthetist is making a very close record and we've
10 seen that the drugs have been timed in that record.

11 MR STEWART: This brings us back to your note because we
12 don't know therefore what time skin closure was, we
13 don't know then at what time the kidney looked blueish
14 at the end of theatre, do we?

15 A. It would have obviously been before skin closure, yes,
16 uh-huh.

17 Q. But we don't know when that was?

18 A. No.

19 Q. And can I ask you about the consistency of that note
20 that it looked blueish with Mr Keane's note that "the
21 kidney perfused reasonably at end". Isn't there an
22 inconsistency? It's either perfused reasonably or it's
23 blueish, but it's not both?

24 A. I have been questioned in my written evidence about this
25 and I have made comment that I didn't really understand

1 his use of the word "reasonably" because I would have
2 thought it's either well perfused or there's a problem,
3 and the word "reasonably" didn't make sense to me, but
4 I think it's best to question Mr Keane about his
5 evidence than me.

6 Q. Well, just one final question if I may. It's going back
7 to that vexed question of the CVP graph. I'm asked to
8 go to the transcript of 24 April 2012 at pages 174 and
9 175. This is an exchange between Ms Anyadike-Danes and
10 Mr Millar at line 22. My learned senior says:

11 "No, the dotted line is the 20 mark. The maximum is
12 40. The 60 is measuring something else."

13 Mr Millar:

14 "Sorry, it looked kind of halfway to me."

15 Ms Anyadike-Danes:

16 "I understand that the 40 is the top line for CVP.
17 I beg your pardon. So that puts the middle mark at 20
18 and therefore that highest point is roughly 30."

19 Mr Millar:

20 "Absolutely right."

21 So Mr Millar seems to be conceding --

22 A. I don't know that Ms Anyadike-Danes or Mr Millar would
23 be the expert, but I think you have had experts.

24 THE CHAIRMAN: Neither of them would pretend to be experts,
25 but Mr Millar is acting on behalf of Mr Keane.

1 Ms Anyadike-Danes has access to the inquiry's experts,
2 and that exchange between them was not challenged at the
3 time or subsequently by any other witness until now.

4 A. I would be interested to know what the expert
5 technician -- you probably have evidence from him.

6 THE CHAIRMAN: If need be, we can follow it up again.

7 MR STEWART: Thank you.

8 THE CHAIRMAN: Thank you.

9 MR HUNTER: Sir, I wonder if you could give me a couple of
10 minutes. There's one issue I would like to explore.

11 THE CHAIRMAN: I will sit here, Mr Hunter, to wait for you
12 to take instructions on that issue. (Pause).

13 MR HUNTER: Thank you, sir. There's just one issue if
14 I could put it to the witness.

15 THE CHAIRMAN: Let's hear what the issue is, please.

16 Questions from MR HUNTER

17 MR HUNTER: It says that there are two times when one would
18 make recordings during a transplant, and that is when
19 the kidney is taken out of ice and when the clamps are
20 removed; is that correct?

21 A. Mm-hm.

22 Q. But you have recorded the time of anastomosis --

23 A. That's the equivalent of clamps being released. It's
24 just a use of language. It's the same thing.

25 Q. Okay. Can I just ask you about -- I think I'm correct

1 in saying that you weren't aware that there was actually
2 a transplant taking place until you arrived in the
3 hospital that morning.

4 A. That's quite correct.

5 Q. It would have been Professor Savage who had laid out the
6 immunosuppressant drugs to be given in the original
7 prescription?

8 A. The original note which we looked at today, and he has
9 written "methylprednisolone to be given", yes.

10 Q. Can I ask you, did you have a conversation with
11 Professor Savage before you prescribed the additional
12 immunosuppressants?

13 A. Yes, most certainly. I don't have a record of that, but
14 the azathioprine came from his protocol and the
15 methylprednisolone came from my protocol. I was
16 concerned that in the overlap -- and we didn't have
17 a new written protocol -- that something could have been
18 missed out. The one child who'd been done before,
19 I think I just gave things in the manner I was doing in
20 Bristol, but azathioprine was a drug that he was used to
21 using, so definitely we had a conversation as to what
22 would be best.

23 MR HUNTER: Okay, thank you.

24 THE CHAIRMAN: Thank you.

25 Mr Bradly, you'll be last if anyone else has

1 anything.

2 MR BRADLY: Sir, I'm grateful. Might I please just ask that
3 the doctor confirm that she's finished dealing with the
4 conference note of 14 June? We got as far as --

5 THE CHAIRMAN: Halfway down page 5.

6 MR BRADLY: She may have finished, I know not.

7 THE CHAIRMAN: Doctor, Mr Bradley is reminding me that you
8 had been pointing out what you regarded as significant
9 mistakes or inexplicable statements through the
10 document. We had got to the middle of page 5. Is there
11 anything beyond that?

12 A. There were two other sentences that I found strange
13 because they weren't, if you like, in doctor speak.
14 There's a sentence here:

15 "Mr Brangam pointed out that Dr Sumner's conclusion
16 is that, on the balance of probabilities, that oedema
17 was caused by hypernatraemia [which I presume is
18 hyponatreaemia] and does not put the case any more
19 strongly than this."

20 I was surprised to see that Mr Brangam was
21 commenting on medical evidence. I just -- that confused
22 me.

23 THE CHAIRMAN: Right.

24 A. And then on the last page, again I think towards the
25 very end, the wording shows that it's written by -- you

1 know, without full understanding of what someone's
2 describing. It does say:

3 "Again, it was pointed out that for some reason this
4 child had higher sodium levels in the brain than
5 elsewhere in the body."

6 And so on.

7 The natural medical understanding is, the sodium
8 levels in the brain and the blood are generally the
9 same, but if there's a sudden change in the blood
10 sodium, it takes the brain longer to equilibrate with
11 that change. So this kind of reads as if there was
12 something wrong with the amount of sodium in Adam's
13 brain; there wasn't, it would have been equal to his
14 blood sodium initially before the administration of the
15 fluids. So it's just the way it's worded, it's worded
16 by someone who doesn't have the medical understanding of
17 what they're writing.

18 THE CHAIRMAN: That could be for a number of reasons. That
19 could be because, for instance, the notetaker is trying
20 to record as accurately as she can what is being
21 discussed, but she's not a medic.

22 A. Yes.

23 THE CHAIRMAN: But also part of it is because -- and from
24 some of your earlier criticisms, some of it may be
25 because the people who were there, the medics who were

1 there, were inaccurately stating what had been
2 happening.

3 A. It's just not medical type language. That's all.

4 THE CHAIRMAN: But it's more than the language; in some
5 cases, it's the substance of what they said. The one
6 that you highlighted very vigorously at the top of
7 page 3, that the kidney was in at around 9.30. That, in
8 all the evidence, does not seem to be Mrs Neill's
9 mistake; that seems to be a mistake which has been made
10 by Dr Taylor.

11 A. Well, the kidney actually would have been taken,
12 I suspect, out of the ice and put into the wound at
13 9.30. So it's an interpretation of what the word "in"
14 means.

15 THE CHAIRMAN: Yes, but if you read it in conjunction with
16 the next sentence, the vein was in and the arteries were
17 being finished.

18 A. Yes, that doesn't make sense.

19 THE CHAIRMAN: You say that isn't right.

20 A. It's definitely not right.

21 THE CHAIRMAN: Doctor, thank you very much indeed. You're
22 free to go.

23 Ladies and gentlemen, we resume tomorrow morning.
24 We've got Mr Brown and Mr Keane tomorrow. Mr Keane was
25 unable to be with us when we were here in June doing

1 governance evidence, so apart from any issues arising
2 from his consultation note which are raised with him, he
3 will also be asked some issues about governance, which
4 he couldn't deal with last time, Mr Millar, because
5 he wasn't here.

6 MR MILLAR: That's news to me, sir.

7 THE CHAIRMAN: Well, I'm surprised, because you knew that
8 we wanted him as a governance witness. He wasn't able
9 to be here, for reasons which I accepted. He is now
10 available to be here. I'm surprised that you think that
11 we might just ask him questions about the consultation
12 note and not ask him anything about the evidence which
13 he would have been asked to give in June.

14 MR MILLAR: I say it's news to me, it is news to me.

15 The other thing, sir, is that I think other witnesses on
16 governance were given notification of lines of
17 questioning and things of that sort, and certainly I've
18 had nothing to indicate lines of questioning for
19 Mr Keane on governance. If there's to be questioning,
20 it would be helpful to have what the other witnesses
21 had.

22 THE CHAIRMAN: What I think we should do is we should
23 start -- Mr Brown has already given his evidence and
24 Mr Brown was inconvenienced a number of times earlier on
25 in the inquiry's hearings by being here and then not

1 being reached. What I propose to do is to start with
2 Mr Brown tomorrow. His evidence will certainly finish
3 almost certainly tomorrow morning. We'll then start
4 with Mr Keane's evidence and we have in the timetable,
5 as you know, allowed for the possibility of Mr Keane
6 running into Monday, and then Professor Savage giving
7 evidence. So we'll run on that basis.

8 I understand, Mr Fortune, that you had suggested
9 that maybe we start at 9.30 to get through both
10 witnesses, but I'm not going to do that because the
11 timetable that we have allows for both witnesses not to
12 be finished tomorrow and we have also had a very long
13 day today.

14 We'll start at 10 o'clock tomorrow with Mr Brown and
15 we'll continue with Mr Keane. Thank you.

16 (5.15 pm)

17 (The hearing adjourned until 10.00 am the following day)

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I N D E X

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