

Friday, 22 June 2012

1

2 (9.30 am)

3 THE CHAIRMAN: Good morning. Just before we start,
4 Dr Mulholland who gave evidence yesterday afternoon,
5 left a note for me this morning which has been
6 circulated and it has been paginated as witness
7 statement 243/2, page 7. It is a correction to one
8 point which he gave in his evidence yesterday. He says
9 that, on reflection, his clinical directorate
10 accountability was to Mr McKee, but his reporting role
11 was to the medical director, Dr Ian Carson, as per the
12 diagram which had been provided. Then he clarifies that
13 the organisation known as NCAS is the National Clinical
14 Assessment Service and is now under the umbrella of the
15 Patient Safety Agency. So I'm grateful to Dr Mulholland
16 for that correction.

17 Is there any point arising from it, or is everybody
18 content? Thank you.

19 Mr Lavery, I had left an issue with you and
20 Mr Simpson yesterday afternoon about the DLS letter
21 about the paediatric directorate clinical audit
22 meetings. Do you have a response?

23 MR LAVERY: We are still waiting for firm instructions from
24 the Trust in relation to that. We hope to have
25 a definite answer to that, if not by the morning break,

1 then certainly by lunchtime. The position, Mr Chairman,
2 is that it looks as if the information that formed the
3 basis of that letter came from people who are currently
4 on the Clinical Audit Committee. The difficulty of,
5 course, is that we don't have the minutes of that
6 meeting and really there's no evidence that we have at
7 the moment to say what actually occurred at those
8 meetings and whether or not this was discussed. We are
9 making further enquiries and we hope to be in a position
10 to tell the inquiry, hopefully, by lunchtime.

11 THE CHAIRMAN: Thank you very much.

12 Ms Anyadike-Danes?

13 MS ANYADIKE-DANES: I wonder if I might please call
14 Professor Savage.

15 PROFESSOR MAURICE SAVAGE (called)

16 Questions from MS ANYADIKE-DANES

17 MS ANYADIKE-DANES: Good morning, professor.

18 A. Good morning.

19 Q. Professor, there are a number of issues that I would
20 seek your assistance with today. Most of them are to do
21 with organisational matters, protocols and so forth, and
22 basically how institutions worked. But there's another
23 very important issue that I would like to start off
24 with, which is actually what happened from the moment
25 you notified the coroner of Adam's death up until

1 we have the inquest and we look at the aftermath.
2 Because it is in the light of that that we may perhaps
3 be able to reflect on and see how these organisations
4 actually work in terms of the institutions.

5 So I'm right, aren't I that you're the person who
6 notifies the coroner that Adam has died?

7 A. Actually, I don't know if I phoned the coroner, but
8 I think you're right.

9 Q. Let's put up 011-025-125.

10 THE CHAIRMAN: That is it.

11 MS ANYADIKE-DANES: Sorry, I beg your pardon. That is the
12 coroner's note of 8 December and you can see from the
13 second sentence:

14 "Dr Maurice Savage reported the death to me; he said
15 the death was totally unexpected."

16 So it looks like you're reporting it to the coroner.

17 A. I think that's right. I wasn't quite sure about that.
18 I think the clinical note that was written for the
19 autopsy was not written by me, but I notified
20 the coroner because I immediately knew that there had to
21 be a coroner's inquest.

22 Q. So was your hesitation because you weren't sure that you
23 were the first person to notify his death to the
24 coroner?

25 A. No, I wasn't sure whether you were asking about phoning

1 the coroner or writing to the coroner.

2 Q. I understand. It would appear from the note that
3 the coroner has made that there was a bit of
4 a discussion, or at least you were imparting some
5 information, not just simply saying: we have a death we
6 think is going to be a coroner's case. Do you remember
7 providing --

8 A. I don't know the content of the conversation, but
9 certainly I would have been quite frank with the coroner
10 that there was a child who had gone for a renal
11 transplant, we expected it to proceed successfully and
12 that he had died in theatre or as a result of events in
13 theatre and that therefore I felt it was essential that
14 there was a full coroner's inquest.

15 Q. Would you have indicated why you had the view that it
16 was a case that ought to be subject to a full coroner's
17 inquest?

18 A. Well, I knew that any death within 24 hours of surgery
19 or any death that occurred as a result of an anaesthetic
20 event had to be investigated by the coroner. That would
21 be the main basis for my phoning, but of course from my
22 own point of view, I wanted to know what exactly had
23 happened.

24 Q. And why were you the person contacting him?

25 A. Well, always with Adam I regarded myself as his doctor

1 more than anyone else.

2 Q. I understand. You then provided a letter to, I believe
3 it was Dr Murnaghan. We can pull that up. It's
4 011-001-001. If we pull the second page of it up next
5 to it, 002. There we are. We see it's on 28 November.

6 A. Yes.

7 Q. By 28 November, you had formed a view as to what had led
8 to Adam's cerebral oedema.

9 A. Yes.

10 Q. And your view was that he'd had too much low-sodium
11 fluid.

12 A. Yes.

13 Q. Why were you producing this statement?

14 A. Well, in the structure of --

15 MR FORTUNE: I rise at this stage because my learned friend
16 said that "by 28 November". In fairness to
17 Professor Savage, he ought to be asked in the form of an
18 open question when he formed that view.

19 MS ANYADIKE-DANES: Because I think he has already given
20 that evidence in his clinical evidence. He already said
21 that he was contacted by Dr O'Connor, it was like a cold
22 hand on his heart, he went to see her, they looked at
23 the medical notes and records and they concluded.

24 MR FORTUNE: That that was the 27th.

25 MS ANYADIKE-DANES: That was the 27th, yes.

1 A. Immediately Adam was in the paediatric intensive care
2 unit, Dr O'Connor and I formed the view that there was
3 a major problem with the fluid he had received in
4 theatre. Adam was clearly bloated, his mother pointed
5 that out to me and I already saw it. When we looked at
6 the balance of fluids in theatre it was obvious to us
7 that he had certainly had excessive fluid and had had
8 a lot of fifth normal saline. I was then asked by
9 Dr Murnaghan to produce this letter because I would be
10 required to produce a statement for the coroner. He
11 asked me to produce a statement that was strictly
12 factual.

13 Q. Sorry, can I just interrupt at that stage? Why was he
14 asking you to produce a statement initially as opposed
15 to the clinicians who had actually been in the operating
16 theatre and had been treating Adam during the course of
17 the surgery?

18 A. Well, I wouldn't have known that he hadn't asked anyone
19 else. I assume that he did ask the others.

20 Q. Then what did he ask of you specifically?

21 A. He asked me to produce a report of my own involvement,
22 a factual report of my own involvement. So he didn't
23 ask me to produce a report that had any conclusion in
24 terms of what I thought. He wanted a factual report and
25 my understanding, legally, was that I should only write

1 a report that stated facts.

2 Q. Yes. You copied that report to Dr Taylor.

3 A. Well ...

4 Q. You certainly seem to have intended it to get to him
5 because you've cc'd it.

6 A. I think perhaps he copied it to Dr Taylor and you can
7 see that there are alterations to that report, which
8 I believe were made in Dr Murnaghan's office.

9 Q. Sorry, are you saying that Dr Murnaghan copied this to
10 Dr Taylor?

11 A. I can't remember the detail, but I produced it via
12 Dr Murnaghan and --

13 Q. But how could Dr Murnaghan be putting the "cc" down
14 there to Dr Taylor?

15 A. Perhaps I'm thinking about the final report, but you can
16 see in this report there are things that are stroked
17 out.

18 Q. Yes, and we have a version where there are not. But in
19 any event, what I'm trying to clarify with you is you
20 actually cc'd this to both Dr Murnaghan -- because it is
21 written openly "To whom it may concern" --

22 A. Yes.

23 Q. -- and you have cc'd to Dr Taylor.

24 A. Yes.

25 Q. So you intended Dr Taylor to receive this.

1 A. Yes. If I can clarify: what I'm saying is that I'm not
2 sure whether the copy that went to Dr Taylor was the
3 corrected version or this draft version.

4 Q. Yes, I understand that and if anything turns on it, we
5 can take you --

6 A. I don't think anything does.

7 Q. So you have said that you were being invited or asked to
8 provide a simply factual account.

9 A. Yes.

10 Q. And in fact, if we look at it, you have done that. If
11 you look at, for example, the third paragraph on that
12 first page, you have said what his serum sodium levels
13 were, his haemoglobin, so on. You have talked about
14 your contact with the theatre. Then you talk about:
15 "Post-operatively, Adam failed too breathe
16 spontaneously."

17 That first paragraph on the second page, that is
18 a fact, but you weren't there to view that. That would
19 have been Dr O'Connor, if there was a nephrologist there
20 at that time.

21 A. You mean the statement that says "post-operatively --
22 Q. And going on to "on examination". That's something
23 that's been reported to you:
24 "Post-operatively Adam failed to breathe
25 spontaneously."

1 You weren't there when that happened.

2 A. No, but I obviously knew when he was in the intensive
3 care unit that he required to be ventilated, so he
4 wasn't --

5 Q. I understand that, Professor Savage. What I'm putting
6 to you is that this document is not simply a recital of
7 the things of which you have first-hand and direct
8 knowledge because you weren't there post-operatively
9 when Adam failed to breathe spontaneously. There's no
10 issue; I'm just making sure we understand it --

11 THE CHAIRMAN: If there's no issue, we don't need to go into
12 it.

13 MS ANYADIKE-DANES: Because of what I am then going to go on
14 to say.

15 THE CHAIRMAN: I thought there was no issue.

16 MS ANYADIKE-DANES: There were some other aspects that this
17 report doesn't include. You, at that stage, had formed
18 a view as to -- in fact, you didn't form a view, you'd
19 seen the medical notes and records to say the amount of
20 fluid that Adam had received.

21 A. Yes.

22 Q. That's not included.

23 A. No.

24 Q. Or the type of it.

25 A. No.

1 Q. Nor the rate.

2 A. No.

3 Q. Nor the CVP measurements.

4 A. No.

5 Q. Nor anything to do with his serum sodium levels
6 post-operatively.

7 A. No.

8 Q. You knew that there was a 119 millimoles taken about
9 1.30.

10 A. Yes.

11 Q. But that's not included in here.

12 A. No.

13 Q. Why isn't that information in here?

14 A. I think because the indication that had been given to me
15 was that the events that happened in theatre would be
16 the subject of other people's statements and, as you
17 say, I was not directly involved. I think it is
18 splitting hairs to say that I was not the person who
19 noticed that he failed to breathe spontaneously isn't
20 particularly relevant because I knew he couldn't breathe
21 spontaneously; he was on a ventilator in the intensive
22 care unit. I accept that it is correct that I could
23 have written that he had a low serum sodium.

24 Q. Yes. You could have when you said that
25 post-operatively, when you gave that information and

1 when you gave the information about the chest X-ray,
2 because that is something also that happens. He has
3 a chest X-ray, a CT scan and he has his serum sodium
4 levels. So they're all part of what happens in the
5 immediate aftermath to his surgery. So you could have
6 included that in that section.

7 A. I could have. As I said, so --

8 Q. Yes. And if you had done that, that would have given us
9 a slightly broader picture as to what was happening,
10 even though you wouldn't necessarily have to include
11 your conclusions about that. It would just be factual.

12 A. Correct.

13 Q. Yes. Then there is a similar sort of document that
14 comes from Dr Taylor, dated 30 November. 059-067-155.
15 I think we can pull up the second page to that, which is
16 156. There we are. That is cc'd to you. Did you
17 receive it?

18 A. I don't remember reading it.

19 Q. Sorry?

20 A. I don't remember reading it, but if it was copied to me,
21 I would have read it, yes.

22 Q. And if you would have read it -- then if we start with
23 the third paragraph on the first page, second sentence,
24 after it says "crystalloid fluids" and so forth. Then
25 it talks about three bags of that quantity of

1 No.18 Solution --

2 A. Yes.

3 Q. -- and then that quantity of Hartmann's solution, all
4 that being given over four hours. But that doesn't
5 actually reflect the concern that you had. What
6 concerned you was the amount and the rate of the
7 low-sodium fluid; that's correct, isn't it?

8 A. That is correct.

9 Q. That doesn't really capture what the problem was if one
10 looks at the second page. And you can see in the second
11 paragraph:

12 "Pulse rate, CVP and arterial blood pressure gave me
13 no cause for concern throughout the case and a blood gas
14 at 9.30 confirmed good oxygenation."

15 Did you see the blood gas report of 123 that was
16 taken at 9.32?

17 A. No, I don't think I'd seen it at that time. Obviously,
18 having read so much since, it's difficult to know, but
19 what I did know was that there was a sodium of 119
20 in the intensive care unit.

21 Q. Yes. I think Dr Armour also believes that she didn't
22 see that printout, but she did see the lab result of
23 119. But this is indicating about the CVP giving no
24 cause for concern. Then it goes on to say:

25 "In view of the CVP, heart rate and BP, I did not

1 consider the fluids to be either excessive or
2 restrictive. Indeed, I regard the fluids to be
3 appropriate and discussed this with other doctors
4 present in the theatre."

5 Pausing there, you had formed the view that there
6 might be a concern in relation to the level of the CVP?

7 A. I think at this stage my concern was mainly to do with
8 the fluids.

9 Q. Well, then the statement then continues on to say:

10 "I did not consider the fluid to be either excessive
11 or restrictive."

12 Well, you certainly wouldn't have agreed with that.

13 A. I did not agree with that.

14 Q. Exactly. And if he had referred to a blood gas at 9.30,
15 you'd looked at the immediate medical notes and records,
16 you wouldn't have seen that, would you? Did you ask
17 where that was?

18 A. I don't think so.

19 Q. And then the next sentence:

20 "Indeed, I regarded the fluids to be appropriate."

21 Well, you wouldn't have regarded them to be
22 appropriate.

23 A. No.

24 Q. And he says that he discussed that with other doctors
25 present in the theatre. Did that make you feel that

1 maybe I ought to see what they had to say because
2 I didn't regard them as appropriate?

3 A. I knew that I had discussed this situation with
4 Dr Taylor immediately before speaking to Debra Strain.
5 I know that I had discussed with him the fact that
6 I thought that Adam had had excessive fluids at that
7 stage. I know that I had discussed with Dr Taylor that
8 Adam looked bloated and it would appear to me that
9 he had had excessive amounts of fluid and that that was
10 the cause of his cerebral oedema, not breathing, his
11 fixed, dilated pupils and, in that discussion, I said
12 that I believed that I then had to go and explain that
13 to Debra Strain and asked him to accompany me.

14 Q. Did you agree what you were going to say to Adam's
15 mother?

16 A. I told him I was going to tell Adam's mother that there
17 had been a major problem with fluids during theatre and
18 I believed that was the cause of his current condition
19 and that I thought the situation was probably
20 irrecoverable.

21 Q. Because in fact, if one looks at the documents
22 surrounding what Adam's mother was told, there was a bit
23 of a mixed message. Because if that was your message,
24 that's a very clear and simple message.

25 A. Yes.

1 Q. But Dr Taylor's message is not quite that: it's
2 a one-in-a-million thing and we don't quite know what
3 happened.

4 A. That's right.

5 Q. And how did you feel that a mother in those
6 circumstances ought to be left? On that account, she
7 has two completely different things being told to her by
8 those who were directly connected with the care of her
9 child.

10 MR FORTUNE: Could I invite my learned friend to ask
11 Professor Savage how that conversation proceeded?
12 Because if my learned friend proceeds along that line,
13 everyone will hear how the conversation went.

14 MS ANYADIKE-DANES: How did that conversation proceed?

15 A. The conversation with Debbie Strain?

16 Q. Yes.

17 A. Well, it was obviously a very painful and distressing
18 conversation, both for her and for me, but much more for
19 Debbie. I think I did all the talking and I've read
20 what Debbie's written since and I've read the note of
21 the counselling note that the nurse who accompanied us
22 wrote because I did not make a detailed note. But
23 I explained to her about the fluid, about the fact that
24 his brain was swollen, about the fact that we needed to
25 try and remove fluid, that we needed to get a CT scan

1 just to see how serious the situation was and
2 I indicated to her that I was very seriously concerned
3 that the situation was very grave. Throughout that
4 conversation, I do not think that Dr Taylor spoke, to my
5 memory. And indeed the phrase, "This was
6 a one-in-a-million event", didn't register with me
7 at the time. I was trying to communicate with
8 Debbie Strain and I think Dr Taylor was in such a state
9 of shock, shall we say, because of events and because he
10 realised that he had probably lost a patient in theatre,
11 that he did not or was incapable of speaking or chose
12 not to speak and left it to me. I think that is my best
13 recollection of what happened.

14 I know that you've asked me before why I didn't
15 mention hyponatraemia and I think my judgment was that
16 trying to explain the physiology of the situation to
17 someone who was extremely distressed about their little
18 boy didn't seem like a sensible idea. I realise that
19 most of us here have struggled to quickly grasp the
20 concepts of dilutional hyponatraemia and it did not seem
21 an appropriate time to get into that with Mrs Strain,
22 bearing in mind that I knew she would likely only
23 remember the bad news that I was giving her.

24 Q. Yes. Well, we'll have it checked, but I think that
25 Adam's mother remembers Dr Taylor telling her it was

1 a one-in-a-million thing.

2 A. Oh yes.

3 Q. So that seems to have been said?

4 A. It must have been said. It obviously struck

5 Debbie Strain very strongly when he said that.

6 Q. But you don't remember it?

7 A. Not specifically.

8 THE CHAIRMAN: In fact, you remember something different,

9 which is you don't remember Dr Taylor speaking at all --

10 A. Very much.

11 THE CHAIRMAN: -- for the reasons that you've said --

12 A. Yes.

13 THE CHAIRMAN: -- and without suggesting for one moment that

14 Debra Strain is dishonest --

15 A. Oh no.

16 THE CHAIRMAN: She clearly isn't.

17 A. Debbie Strain clearly remembers that phrase. It stuck

18 in her mind forever.

19 MS ANYADIKE-DANES: It's just simply that you don't remember

20 it?

21 A. That's right.

22 Q. Thank you. So is your position then, or your evidence

23 then, that you don't recall there being a difference

24 between the view or the content of what you were telling

25 Adam's mother and any comment that Dr Taylor might have

1 made?

2 A. I don't believe he made any comment to disagree with
3 what I was suggesting or what I told Debbie Strain.

4 Q. Thank you.

5 THE CHAIRMAN: Sorry, not just in front of her, but when you
6 were speaking to him beforehand about what you intended
7 to say, you don't remember any disagreement on his part?

8 A. No. I think he was struggling to work out what had gone
9 wrong, but accepted that he was obviously fluid
10 overloaded. To look at him, you could see he was fluid
11 overloaded.

12 MS ANYADIKE-DANES: In fairness, Mr Chairman, I'm not
13 entirely sure that it was put to Dr Taylor that there
14 was a conversation between he and Professor Savage
15 preparatory to speaking to Adam's mother. I am not sure
16 that was put. So I am not sure he has had an
17 opportunity --

18 MR FORTUNE: [Inaudible: no microphone] he was not asked
19 that question.

20 MS ANYADIKE-DANES: It's not a criticism; I'm simply saying
21 that we haven't had his view as to what the content of
22 any such conversation might have been.

23 Can we then go on to the final paragraph, where he
24 says:

25 "I remain extremely perplexed and concerned that

1 this happened to Adam and cannot offer a physiological
2 explanation for such severe pulmonary and cerebral
3 oedema in the presence of normal monitoring signs."

4 But you could. You had a perfectly rational
5 explanation for what had happened.

6 A. My analysis and discussion with Dr O'Connor was that
7 Adam's cerebral oedema was as a result of him receiving
8 too much and too rapid fluid in theatre. I think what
9 Dr Taylor's saying in that paragraph is that he was
10 having difficulty accepting it because he still believed
11 the CVP was believable. We now know that that probably
12 was not true.

13 Q. Yes. But the serum sodium levels weren't normal.

14 A. No, they weren't.

15 Q. Can I just take you back to something where you had said
16 in that conversation that you had with Dr Taylor before
17 going to see Adam's mother when you were discussing what
18 you were going to explain or what you were going to say
19 to Adam's mother, how do you know that Dr Taylor
20 accepted that it was obvious that it was fluid overload?

21 A. I think because of the appearance of Adam at the very
22 basic level. You've seen photographs of Adam. He was
23 completely bloated.

24 Q. Well, "completely bloated" is not a description that
25 features in his medical notes and records.

1 A. I can't remember if that's true or not.

2 Q. It doesn't. Dr O'Connor recorded him as being "puffy".

3 A. Well --

4 Q. In fact the view that Dr Armour thought is that if you
5 didn't know him, as she didn't, you might be forgiven
6 for thinking he was rather chubby and slightly
7 overweight.

8 THE CHAIRMAN: "Well nourished" was her phrase.

9 MS ANYADIKE-DANES: Thank you, Mr Chairman, "well
10 nourished".

11 A. But we did know him.

12 MS ANYADIKE-DANES: Sorry?

13 A. We did know him.

14 Q. Did you tell Dr Armour that, "That is not how I know
15 that child to look normally"?

16 A. I don't remember that I said that to Dr Armour. My
17 conversation with Dr Armour would have been to be there,
18 for instance, to give her any clinical information extra
19 to what was written in these sorts of documents and also
20 to make it clear to her that I believed that there had
21 been a major problem with his fluid balance and that the
22 likely diagnosis was dilutional hyponatraemia.

23 Q. Yes, but that might have been something relevant to tell
24 her because her evidence was that, absent that kind of
25 information, she had no idea what Adam looked like

1 normally. And since you formed the view that he was
2 clearly bloated or very bloated and you knew what he
3 looked like normally, why didn't you tell Dr Armour
4 that?

5 A. I'm not saying that I didn't tell her; I'm saying
6 I don't remember discussing that with her, nor indeed do
7 I remember her saying to me, "Does Adam look normal to
8 you?" What I was discussing with Dr Armour was: did he
9 have cerebral oedema, had he coned? And because
10 I believed it was likely that if that was the case, it
11 was as a result of the fluids he got in theatre.

12 Q. Yes. Bloated due to fluids as opposed to swollen due to
13 some sort of cerebral constriction. Those two things
14 are different. In fact, the inquiry's own expert,
15 Simon Haynes, wondered whether the appearance of his
16 face might in and of itself indicate that there was some
17 sort of form of constriction. One sees that from his
18 first report, I believe.

19 So there is an issue there, which you were uniquely
20 in that room, mortuary, in a position to assist
21 Dr Armour with. But in any event your evidence is that
22 you cannot remember whether you told her that or not.

23 A. No.

24 Q. When one goes to this document that Dr Taylor has
25 produced, as I understand it, you wouldn't agree with

1 certain parts of it.

2 A. No.

3 Q. And what did you do about that?

4 A. I didn't write any rebuttal of it, but I did go to the
5 post-mortem and made sure that Dr Armour understood my
6 perception of the fluid balance situation. I'm
7 concerned that there is a suggestion in your questions
8 that I would not have replied to this for some
9 inappropriate reason.

10 Q. No.

11 A. And that is not the case. Always with Adam Strain,
12 I wanted to know exactly what happened and to make sure
13 that it was fully understood and explained.

14 Q. I appreciate that. I'm simply asking what response, if
15 any, you made when you saw that document and you saw
16 that there were things in it that you disagreed with.
17 That's a question that has been asked of all the
18 witnesses.

19 A. Well, I'm quite sure that I made it clear to
20 Dr Murnaghan that I believed the situation in relation
21 to Adam's cerebral oedema and death was related to fluid
22 mismanagement and, also, to the person who carried out
23 the post-mortem and subsequently to the coroner during
24 the inquest and certainly to his mother in the days and
25 weeks and months afterwards.

1 Q. But I thought earlier, when you were giving your
2 clinical evidence, forgive me if I've got you wrongly,
3 that you said that you couldn't actually remember
4 attending the autopsy. But you realise now that you
5 must have been because I showed you a letter that you
6 wrote to the GP, Dr Scott, which established that you
7 had been there.

8 A. Yes.

9 Q. So how can you remember now what you were telling
10 Dr Armour?

11 A. Because I've listened to Dr Armour and that has
12 stimulated my memory and I've thought about it a great
13 deal. I've been in this hearing every day and, if you
14 sit there, then you gradually do come to realise what
15 actually happened. This is 17 years ago. My belief
16 is that I went to the post-mortem, I spoke to Dr Armour,
17 I explained to her what I thought and I believe that is
18 also what Dr Armour believes.

19 Q. I don't think Dr Armour can remember having
20 a conversation with you. In fact, I don't think she's
21 entirely sure that you were there, but we can -- it's in
22 her evidence in any event because she was asked about
23 it.

24 If you communicated your views to Dr Murnaghan that
25 were different from those which we've just seen in that

1 document from Dr Taylor, how did you do that and when
2 did you do that?

3 A. I think I had numerous conversations with Dr Murnaghan,
4 I think the majority of them by telephone. There have
5 been suggestions that I was at meetings with
6 Dr Murnaghan. I don't believe that most, if any, of
7 those meetings actually took place in a round table
8 manner, but we certainly were in communication. And
9 obviously, after the report from Dr Sumner --

10 Q. Sorry, we'll come to that in a minute. I'm trying to
11 move things through in quite a tight chronological
12 order.

13 THE CHAIRMAN: Sorry, I would like to hear what he says
14 about "after Dr Sumner" and then we can pick up the
15 details and go back on any details --

16 A. You will remember the coroner asked me to talk to
17 Debbie Strain and explain reports to her. You did draw
18 my attention to a comment that I made that I was willing
19 to do that, providing there were no medico-legal issues.
20 And subsequently I have seen a document where
21 Dr Murnaghan has agreed that I could speak to
22 Debbie Strain. So there's no doubt that, at that
23 point -- which I think was January -- that Dr Murnaghan
24 was aware of my view, was aware of Dr Sumner's view and
25 I communicated those views to Debbie.

1 MS ANYADIKE-DANES: Okay.

2 A. So if you go right back to December, then it's more
3 difficult to be sure of that because we don't have
4 written --

5 Q. We do have some documentation that I'm going to take you
6 to.

7 A. Right.

8 Q. But it's quite an important thing, isn't it, that
9 Dr Taylor has communicated in writing something like
10 that to Dr Murnaghan? Would you have appreciated that
11 he was producing a like exercise to you, something that
12 could ultimately be going to the coroner?

13 A. Say it again, the end of the question.

14 Q. When I asked you why you produced your document of
15 28 November, you said --

16 A. These were both for the coroner.

17 Q. -- that Dr Murnaghan had asked you to do that because
18 you were going to have to produce a statement for
19 the coroner. I asked you why he had asked you in
20 particular and you said you assumed -- or something like
21 that -- that he would be asking all the others. So when
22 you were copied into that document from Dr Taylor, did
23 you consider that that was actually Dr Taylor's
24 equivalent of the document that you had been asked to
25 produce?

1 A. I think so, yes.

2 Q. Yes. So that's quite important if he's got those things
3 which, to you, are just incorrect.

4 A. It is.

5 Q. Is there any reason why, given the significance of that,
6 you didn't put that in writing?

7 A. I think because I was talking to Dr Murnaghan ...
8 I didn't put it in writing, that's all I can say.

9 Q. Yes.

10 A. I have to say that, looking back, I regret that I didn't
11 push harder to have that area explored at that time.
12 You're aware that Debbie Strain expected me to do
13 everything I could to find out what had happened to Adam
14 and to make sure it never happened again. As I look
15 back, I have to question my own judgment around those
16 early days, that I didn't push harder for a full
17 internal investigation and all the things that have been
18 discussed. I regret now that I did not do that and
19 I feel that I probably let Debbie Strain down by not
20 doing that. And with the knowledge I have now,
21 I certainly would do that if this situation arose again,
22 but I apologise to Debbie Strain and her family that
23 I didn't pursue it with the vigour that I might have
24 done, but at that time I believed there was a difference
25 of opinion, probably, but I left it to Dr Gaston and

1 Dr Murnaghan to follow that up and perhaps I put too
2 much faith in that system.

3 Q. I understand what you're saying. I'm going to pick up
4 something of what you said in a little while.

5 Could you help me with this though, as to what
6 document is what. When Alison Armour is asked by
7 the coroner to provide documents and, effectively, to
8 brief Dr Sumner and Dr Alexander, if you'd been in the
9 chamber, you'd see I pulled up a cover letter. The one
10 to Dr Sumner is actually not necessarily -- yes, to be
11 called up, 011-028-130.

12 That says, "A report from the consultant paediatric
13 nephrologist". Is that your 28 November document?

14 A. I don't know.

15 THE CHAIRMAN: In other words, professor, apart from the
16 note which you wrote, the two-page note which you wrote
17 to --

18 A. Did I write anything else?

19 THE CHAIRMAN: Do you remember writing any further document
20 beyond that within the next three weeks?

21 A. No.

22 THE CHAIRMAN: Thank you.

23 A. But do we not have a copy of the report she refers to?

24 THE CHAIRMAN: Unfortunately not. It may very well be the
25 note that you wrote, the note that we've just looked at

1 that you wrote to Dr Murnaghan.

2 A. We might speculate that she hasn't sent anyone else's
3 report.

4 MS ANYADIKE-DANES: Sorry, I beg your pardon,
5 Professor Savage? I didn't hear you.

6 A. [inaudible] two reports from the consultant anaesthetist
7 involved.

8 THE CHAIRMAN: The consultant anaesthetist involved is
9 obviously Dr Taylor, so she's sending to Dr Sumner the
10 original medical notes and records, two reports from
11 Dr Taylor, a report from you and the equipment check
12 report.

13 A. Yes. I agree.

14 MS ANYADIKE-DANES: So what I was asking you just to
15 clarify -- because it isn't very specific -- is that if
16 she was sending a report from you, is the only document
17 she could be sending the 28 November one?

18 A. I believe so because I don't remember Dr Murnaghan
19 asking me for any other report or to comment on
20 Dr Taylor's letters.

21 Q. I had referred earlier to the letter that you had sent
22 to Adam's GP, which is dated 4 December 1995.

23 A. Yes.

24 Q. And in that, I presume you're not as constrained as to
25 giving your views as to what you think happened as you

1 were when you were trying to produce an entirely factual
2 document for the coroner. We can see your letter at
3 016-004-014.

4 There are two pages of it. I wonder if we might
5 pull the second page up, 015.

6 There's your recital of factual matters and then, if
7 we go to the third paragraph on that first page, that is
8 him being taken down to theatre, identifying who was
9 involved in the surgery, technical difficulties because
10 of multiple previous surgery.

11 And then:

12 "The transplant was successful and the surgery was
13 completed with no evidence of any intraoperative event
14 ... brought through to intensive care. At that time, it
15 became apparent that, on withdrawal of the anaesthetic,
16 he wasn't breathing spontaneously and he was found to
17 have fixed dilated pupils."

18 Then if we go to the second page:

19 "I saw him at that time. I was concerned that
20 he had had some intercerebral event ... Emergency CT
21 scan performed showed gross cerebral oedema and the he
22 had also coned ... obvious it was likely to be
23 irreversible ... Asked David Webb and he felt he was
24 essentially brainstem dead. All that information was
25 communicated regularly to the mother. The following

1 morning, repeated the tests, confirmed the situation.
2 A decision was made in discussion with myself and by his
3 mother that we should switch off the ventilator. We did
4 this with Adam sitting on his mum's knee ... Since
5 attended a forensic post-mortem when no new information
6 was obtained that would explain the events during his
7 surgery, but confirmed the presence of gross cerebral
8 oedema."

9 But you did you have an explanation for his gross
10 cerebral oedema. In fact, I think you have just said
11 you thought that Dr Armour was agreeing with you.

12 A. Yes.

13 Q. Why didn't you put that in your letter to Adam's GP?

14 A. Because there was nothing that proved that at that time
15 in terms of the post-mortem and I was aware that there
16 was a coroner's inquest. And I think I probably thought
17 it would have been inappropriate for me to suggest
18 a diagnosis in advance of the coroner's inquest.

19 Q. But you didn't have to suggest a diagnosis. You could
20 simply tell him about the amount of fluid. That would
21 all be part of the recitation of the facts.

22 A. I could have done.

23 Q. And his serum sodium level.

24 A. I could have done.

25 Q. Why didn't you?

1 A. I think because there was a coroner's inquest pending
2 and I left it at this.

3 Q. Then we can go to the document, which talks about you
4 being asked to speak to Adam's mother. That's
5 011-033-165. At the top, it's reciting a conversation
6 that the coroner has had with Adam's mother and his
7 uncle. In the middle of that first paragraph:

8 "I said I would ask Dr Savage from the Children's
9 Hospital if he would be willing to explain each [that's
10 the reports] to Ms Strain."

11 In the penultimate paragraph:

12 "I subsequently spoke to Dr Savage and he agreed to
13 explain the reports to Ms Strain provided that
14 Dr Murnaghan was happy and there were no medico-legal
15 reasons to suggest otherwise."

16 What did you think they might be at that stage?

17 A. Well, I don't know. I was in completely uncharted
18 water. I was taking advice on the legalistic aspects of
19 how the investigation of Adam's death should proceed
20 from Dr Murnaghan. I had not, unfortunately, contacted
21 my medical defence union because I believed the advice
22 I would get from Dr Murnaghan was appropriate. So I was
23 merely saying, yes, of course I will explain everything
24 as best I can to Mrs Strain, but I just need to check
25 with Dr Murnaghan because I didn't want to do something

1 inappropriate.

2 Q. Firstly, why would you have contacted your medical
3 defence union?

4 A. A child had died in theatre who was my patient.

5 MR FORTUNE: If there has been an unexpected death, it's
6 perfectly proper for any clinician to contact his or her
7 protection body.

8 THE CHAIRMAN: I accept that entirely.

9 MS ANYADIKE-DANES: Then if all you were going to do was to
10 explain the medical terminology, if I can put it that
11 way, of those reports, why did you think that doing that
12 would give rise, potentially, to a medico-legal reason
13 that --

14 THE CHAIRMAN: Presumably because there are questions which
15 arise from it.

16 MR FORTUNE: Absolutely, sir.

17 THE CHAIRMAN: That's the obvious explanation: that you can
18 be giving Debra Strain an explanation of the terms
19 in the reports and an understanding of what the reports
20 mean and then that may very well lead on to her asking,
21 "Does that mean that so-and-so was to blame or so-and-so
22 did something wrong?"

23 MS ANYADIKE-DANES: Is there any guidance provided to you or
24 your colleagues from the hospital or the Trust as to
25 what you do in these circumstances?

1 A. No.

2 Q. Is there any guidance that the GMC provides as to what
3 your duty is and what you do in these circumstances?

4 A. I couldn't be sure of that, but obviously the General
5 Medical Council has a document called "Good Medical
6 Practice".

7 Q. Yes.

8 A. And it does say that you should be open and honest with
9 your patients or, in the case of paediatrics, with the
10 parent, and I believe I always was. But to go back to
11 this question -- I'm not quite sure, it's difficult when
12 you're sitting here to read this letter. Does it just
13 say that he was asking me to explain terms or to explain
14 the reports? Because my understanding was that
15 I explained the reports --

16 Q. Yes.

17 A. -- not just the terms in them. And of course, Sumner's
18 report was quite explicit and it came through
19 in January.

20 Q. Yes. I'm not sure that it had quite come through yet at
21 that stage.

22 THE CHAIRMAN: I think he's correcting your suggestion
23 a moment ago that he was only being asked by the coroner
24 to explain the terms in the reports as opposed to the
25 reports themselves.

1 MS ANYADIKE-DANES: Yes. But then if we go back to where
2 I was with you before. You say there was no guidance
3 provided by the Trust --

4 A. No guidance provided by the Trust.

5 Q. And then I was asking you about the GMC and you had said
6 the GMC had "Good Medical Practice" and it says that you
7 should be open and honest and so forthwith your patient.
8 What did you understand that would mean in circumstances
9 such as this where there's going to be medical reports
10 about what happened in relation to the treatment and
11 death of her son, obviously reports where even
12 the coroner can envisage she's unlikely to be able to
13 understand what it is? You were her son's consultant;
14 what would you understand that duty to mean in these
15 circumstances?

16 A. I would tell her exactly what the expert's conclusions
17 were and explain them to her.

18 Q. So the concern was, in doing that, that might prove
19 problematic for your employer or for you?

20 MR FORTUNE: Sir, [inaudible: no microphone] the time in
21 question.

22 THE CHAIRMAN: I'm not sure which of the reports would cause
23 Professor Savage a personal concern.

24 MS ANYADIKE-DANES: I don't either. I'm simply -- I --

25 THE CHAIRMAN: Then the question's too broad.

1 MS ANYADIKE-DANES: Then the question is: would cause some
2 concern to your employer.

3 A. I think I should explain that I was not particularly
4 concerned about what in the reports would cause any
5 problem to anyone. I was being given advice by
6 Dr Murnaghan on how the legal process should go forward
7 and I merely wanted to check with him that -- that me
8 explaining reports was fine. I had no problem about
9 saying the report blames this person, blames that
10 person, blames me, blames the hospital. I had no
11 problem with that. I always wanted Debbie Strain to
12 know everything there was to know.

13 Q. Thank you. And then, in fact, I think that Dr Murnaghan
14 accepts that you should be able to explain the report to
15 Adam's mother. In fact, we see that in a note he makes
16 at 059-047-102. That is dated 30 January. A copy is to
17 be given to Dr Taylor for his information and to you so
18 that you may provide counselling to Adam's mother.

19 A. Yes.

20 THE CHAIRMAN: Was it a bit more than counselling,
21 professor? In a way, explaining the reports and, for
22 instance, explaining what Dr Sumner has said and
23 concluded is a little bit, on one interpretation,
24 a little bit different from counselling; it's giving her
25 information.

1 A. It is.

2 THE CHAIRMAN: It may lead to her needing counselling or
3 support.

4 A. Debbie Strain, during these months, was enormously upset
5 by the loss of her son. I mean, I visited her at home
6 and talked with her parents and her on many occasions.
7 For a long time, she kept Adam's bedroom as it always
8 had been and would go there for consolation. I know
9 that she went to his grave every day. So I think a lot
10 of what I did was an attempt to support her and counsel
11 her and I probably was more interested in doing that
12 than thinking about the content of these reports. But
13 obviously, I would have discussed them with her and
14 I know that Debbie Strain, at that time, felt that
15 someone should take the blame for what happened to Adam.
16 And we had discussions about that.

17 MS ANYADIKE-DANES: Can you remember those discussions,
18 Professor Savage?

19 A. Not in detail. But I think the letter that you showed
20 yesterday was certainly as a result of one of those
21 discussions.

22 Q. In fairness, I'm going to pull that up.

23 THE CHAIRMAN: 306-090-001.

24 MS ANYADIKE-DANES: Thank you very much.

25 It's dated 19 February, so it is not far away from

1 this part of the chronology. We see there that you are
2 very clear as to what you consider has happened. The
3 second paragraph:

4 "After Adam came out of theatre, we knew his sodium
5 was low. We realised this was dilutional and set about
6 removing fluid. Tragically, we could not solve the
7 problem because of the development of brain swelling.
8 Once the cause of Adam's death is established, it is
9 right that we should try and work out why. We want to
10 avoid anything like this happening again."

11 And if I just conclude in that paragraph:

12 "It is important we learn anything we can from
13 Adam's death to make the operation safer for them."

14 That is the other children:

15 "Mr Leckey has done all he can to make sure this is
16 the case and so will I."

17 So apart from your commitment to finding out what
18 happened and making sure that, so far as it can be done,
19 that it doesn't happen again, you are expressing your
20 clear view as to what you think is the mechanism of the
21 development of the cerebral oedema that led to his
22 death.

23 A. Yes.

24 Q. And even if you didn't use those words, do I understand
25 you correctly to say that's the sort of thing you would

1 have told Adam's mother when you were with her speaking
2 to her when you realised that Adam's condition was
3 irretrievable?

4 A. Well, I think by the time I replied to Debbie's letter
5 to me, we had obviously discussed the mechanism of
6 dilutional hyponatraemia, otherwise I wouldn't have said
7 these sort of things blandly in a letter without having
8 previously had the perception that she had an
9 understanding of what had happened. And you can see
10 in that letter she must have written to me that because
11 she was looking for someone who should be blamed for all
12 this, that she was saying, "I hope you don't think I'm
13 being spiteful in doing that; it's just to make sure it
14 doesn't happen to anyone else".

15 Q. I understand.

16 A. Debbie Strain is a very caring person in many ways, not
17 just in terms of Adam, and I do believe that she did
18 have that drive. That's probably why she has put
19 herself through this inquiry: to make sure that these
20 things didn't happen again. And that's why I said
21 earlier that examining myself, looking back, I wish
22 I had done more.

23 Q. I understand that. Can I just ask, because I think it's
24 relevant to know what various people saw, so how the
25 investigation into Adam's death was proceeding. Because

1 ultimately, Dr Murnaghan will have to be asked certain
2 questions about that and it will be unfair for us not to
3 explore with others who were involved what their
4 knowledge was of various things.

5 If I pull up this document, 059-053-108. So it's
6 2 February, it's from Dr Taylor to Dr Murnaghan. Had
7 you seen this before, so far as you can recall?

8 A. I don't think I saw it at that time.

9 Q. Had you seen it at any stage prior to Adam's inquest?

10 A. I don't even know that I saw it at the inquest. I think
11 the first time I saw it was when the papers for this
12 inquiry became available to me.

13 Q. I understand. The reason I ask you this is because this
14 is now 2 February. If one looks at the bottom paragraph
15 and starting with "however" -- so he has read Sumner's
16 report in particular, disagreeing with it, and:

17 "Both have failed to comprehend the physiological
18 differences in this case and have used dubious
19 scientific argument in an attempt to explain cerebral
20 oedema."

21 He then goes on to say:

22 "In Adam's case, where the urine output of his
23 native kidneys had to be maintained, deficits had to be
24 replaced, extra fluids had to be given to provide the
25 donor organ with adequate function. The type and volume

1 of fluids were appropriate."

2 There are really two bits to that. The first is his
3 criticism of the way in which Dr Sumner has reached his
4 conclusion. What is your comment on that criticism?

5 Sorry, let me put it a different way. Did you share
6 his view that Dr Sumner had failed to understand the
7 physiological differences between Adam and any other
8 child with chronic renal failure?

9 A. No, but there is a fine point, and this is what, even
10 after the inquest, I believed was the difference between
11 Dr Taylor and Dr Sumner and myself. That is that there
12 was a lot of play put on the Arieff paper and this
13 inquiry seems to have regarded it as a very key document
14 in this area. It is in general, but in terms of Adam's
15 situation, the children, 16 children out of a review of
16 25,000 operations -- they found that there was this
17 small group of children who, after simple surgery, had
18 extra-renal sodium losses, probably vomiting, and that
19 they developed an inappropriate secretion of
20 antidiuretic hormone. Antidiuretic hormone stops your
21 kidneys producing urine.

22 My understanding of Dr Taylor's disagreement at the
23 time of the inquest was that he believed, (a), that Adam
24 did not have extra-renal losses of sodium and he could
25 not, because of his kidney failure, react to

1 antidiuretic hormone. Therefore he had this
2 disagreement that the Arieff scenario applied directly
3 to Adam's case. And I thought that was the only area of
4 disagreement. I did not think that he had any
5 disagreement with the concept that Adam had had an
6 excessive amount of fifth normal saline, which caused
7 his sodium to drop dramatically, his brain to swell and
8 that the cause of his death was dilutional
9 hyponatraemia. I thought that his disagreement was that
10 it was not exactly the same mechanism as Arieff
11 describes. Have I explained myself?

12 Q. Yes, you have, very well. Are you saying that you
13 didn't appreciate that Dr Taylor's position was that
14 Adam couldn't suffer from dilutional hyponatraemia? You
15 didn't understand that?

16 A. I know that he had said that at times, but I thought
17 that after the inquest he had accepted the overall
18 diagnosis and, listening to Dr Taylor yesterday,
19 I thought he was going to say that, but it is unclear to
20 me exactly what he was saying yesterday. Indeed,
21 I wonder if it's clear to him what he was saying
22 yesterday.

23 Q. Well, he was certainly still of the view that Adam
24 couldn't develop dilutional hyponatraemia when he gave
25 his interview under caution to the PSNI.

1 A. I agree.

2 Q. And he was clearly of that view when he provided witness
3 statements to the inquiry.

4 A. I agree.

5 Q. We'll come to --

6 THE CHAIRMAN: Sorry, professor, that's the point about
7 Dr Taylor's evidence. He appears to have been in denial
8 until February and, more specifically, until April.

9 A. I agree.

10 THE CHAIRMAN: And it therefore seems that if you had the
11 impression that, after the inquest, he accepted the
12 overall diagnosis, that is not consistent with what he
13 told the police or what he told the inquiry.

14 A. I agree.

15 THE CHAIRMAN: And I have to ask at the end, on what basis
16 did you form the understanding or the view that he had
17 accepted the overall diagnosis of the inquest? You will
18 have heard me yesterday expressing concerns about
19 whether there are mixed messages being sent out for
20 internal and external purposes.

21 A. I have no recollection of Dr Taylor ever telling me
22 directly he disagreed with the overall conclusion of
23 the coroner's inquest. And I believe that that is also
24 the situation with my colleague, Dr O'Connor, and
25 probably with Dr Crean. We believed that he had

1 accepted the diagnosis of dilutional hyponatraemia, but
2 had some disagreement with the mechanism of it.

3 THE CHAIRMAN: Does that mean that you believed he had
4 accepted it because you did not hear him continue to
5 argue against it?

6 A. Yes.

7 THE CHAIRMAN: So it's putting it in a negative, really?

8 A. It is.

9 THE CHAIRMAN: Because he wasn't complaining after the
10 inquest about the finding, you thought, well,
11 notwithstanding the evidence which he gave at the
12 inquest, that he must have accepted it?

13 A. Yes.

14 THE CHAIRMAN: But because there's evidence at the inquest
15 that would not indicate that he accepts the finding.

16 A. At that time.

17 THE CHAIRMAN: Right. So before the inquest, he doesn't
18 accept the overall diagnosis.

19 A. Mm-hm.

20 THE CHAIRMAN: He gives evidence at the inquest in which he
21 doesn't accept the overall diagnosis. Because he
22 doesn't expressly argue against the inquest finding,
23 a view is formed that Dr Taylor agrees with the finding.
24 Then it must have come as a shock to you when you saw
25 his PSNI interviews and when you saw his statements to

1 this inquiry.

2 A. I was amazed.

3 THE CHAIRMAN: Thank you.

4 MS ANYADIKE-DANES: Thank you, Professor Savage.

5 You had referred to meetings and a number of
6 meetings were scheduled, or at least we can see them
7 from the papers that we have, in the early part of 1996.
8 For example, we see one at 059-043-098. Sorry, I should
9 have gone to 059-042-093, if we do that first.

10 As you see there, in manuscript, what has happened
11 at this stage is that Professor Berry's report has come
12 in, it doesn't seem to help, he's not going to be
13 called. This seems to be a note that Dr Murnaghan is
14 making. The report should be sent to you along with
15 a number of others for information and possible comment,
16 if one sees that right down at the bottom. And then:

17 "Arrange a meeting with the solicitors with all
18 those to be called as witnesses."

19 And you see your name there included with Mr Keane,
20 Mr Brown, Dr Webb and Dr Taylor. And then the document
21 that I referred to just a little while ago.

22 059-043-098, that is actually arranging that meeting.

23 It is confirmed that one has been arranged for

24 17 April 1996 and that has been circulated and you see

25 your name there, you're included in those.

1 Then perhaps in preparation for --

2 A. Can I just say something about this?

3 Q. Yes.

4 A. You will see that it says a meeting has been arranged

5 for the 17th and this is sent out on the 15th.

6 Q. Yes.

7 A. Well, I don't remember being at this meeting. And

8 knowing how busy I was, the idea of arranging a meeting

9 with a letter posted on the 15th, which probably

10 wouldn't arrive until the 16th, asking me to go to

11 a meeting on the 17th --

12 Q. Would it be posted as a memo?

13 A. I don't know. But what I'm saying is these people are

14 all busy, could be in theatre. Wednesday if I remember

15 correctly, I had an outpatient clinic. I don't know

16 because -- what I'm saying is I don't remember being at

17 such a meeting.

18 THE CHAIRMAN: It looks as if it's maybe arranged as

19 a lunchtime meeting at 12.45. Might that make it a bit

20 more feasible for you to be there? Let's assume, for

21 instance, that this is sent by internal mail. I presume

22 there's an internal system within the Royal.

23 A. Mm.

24 THE CHAIRMAN: And you find out about it on the Wednesday or

25 the Thursday -- sorry, this note goes out on the Monday.

1 A. Well, perhaps it's inappropriate for me to have drawn
2 attention to the dates on it. What I'm really saying is
3 I don't remember being at the meeting.

4 THE CHAIRMAN: Okay.

5 MS ANYADIKE-DANES: Right. Then let's go on to 059-039-082.

6 This is a memo:

7 "The attached arrived in the post."

8 We believe "the attached" that is being referred to
9 is the post-mortem report. The undersigned, or the
10 undernoted, which includes you, Dr Savage:

11 "Grateful if you would read it carefully and respond
12 on its contents, particularly if anything therein raises
13 with you a concern which may lead to a development
14 at the inquest for which we would need to be prepared in
15 advance."

16 What did you understand that to be referring to?

17 A. Well, I mean ... It's difficult to comment if I don't
18 know what the report was. But if it was the
19 post-mortem --

20 Q. Yes.

21 A. -- the autopsy report, I had no disagreement with
22 anything in the autopsy report except that perhaps there
23 was some doubt about the ligature, but that wouldn't
24 have been my concern.

25 Q. Then if that's the case and you were responding to this,

1 what is it that you would think that we -- I presume
2 meaning the Trust -- needs to be prepared for in
3 advance?

4 MR FORTUNE: Sir, I'm listening to this with some
5 fascination, but where is it going, bearing in mind that
6 here is Dr Murnaghan, apparently representing the Trust,
7 seeking to pull together the strands of the respective
8 witnesses at a forthcoming inquest? All he's doing is
9 seeking comments that will no doubt be the basis of
10 instructions, either from the solicitor to counsel or
11 from the Trust to the solicitor.

12 MS ANYADIKE-DANES: Yes, that's what I'm asking him about.

13 THE CHAIRMAN: Sorry, remind me what the question is.

14 MS ANYADIKE-DANES: The question is: if you saw the
15 post-mortem report, what, if anything, would you
16 communicate in relation to the Trust needing to be
17 prepared in advance? I think that's what all the
18 undernoted are asked to provide their views on. What
19 would be your view?

20 THE CHAIRMAN: Well, in other words, whether or not you
21 remember receiving this note or responding to it,
22 knowing what you do about the autopsy, the autopsy
23 report, how would you have responded --

24 A. I would have been saying to Dr Murnaghan that I agree
25 entirely with the conclusion of the autopsy.

1 MS ANYADIKE-DANES: What would "prepared in advance" mean?

2 That's the element. That's what's sent to all of you.

3 A. I don't know because I have no difficulty with the
4 autopsy report. If I'm being an honest, professional
5 paediatrician, there is no issue for me. I don't know
6 what the issue for the Trust would be. It should be the
7 same as mine, that the truth is established. So there
8 we are.

9 Can I just say, if we're going to go through lots of
10 these letters, that you will see -- because I looked at
11 this last night, the list of documentation -- you will
12 see, very close to the time of the inquest, there is
13 a note from me to Dr Murnaghan asking for a meeting
14 prior to the inquest. That leads me to believe that
15 I was never at any meetings because they didn't, for
16 some reason, suit me or happen. And I thought, "The
17 inquest is in a few days at the time, I need to speak to
18 Dr Murnaghan".

19 Q. So although you're ticked as these things having been
20 sent to you, and although you're not denying that you
21 received them, what you're saying is you don't think you
22 went to any of those meetings?

23 A. I don't think so.

24 Q. If you couldn't attend a meeting, wouldn't you be
25 letting Dr Murnaghan know that?

1 A. Oh yes.

2 Q. But when there's a phone call, there's a very clear
3 record of that made by Dr Murnaghan's secretary. So for
4 example, if we go to 059-041-092, there we are:

5 "Dr Savage's secretary rang. Dr Savage would like
6 a copy of the PM report as Adam's mother has a copy
7 already. Checked with [so-and-so] at the coroner's
8 office [and so on]."

9 She seems to keep -- and there are a number of
10 those, which I think you've referred to one already,
11 where, if there's a phone call that goes through, she
12 makes a note of it.

13 A. Mm-hm.

14 Q. So if you couldn't attend these meetings, particularly
15 as there's more than one, you'd be missing out on these
16 things where he clearly would like your attendance, then
17 presumably you would be phoning and telling somebody
18 "I can't make that meeting". But there seems to be no
19 record of that.

20 THE CHAIRMAN: That would be a rather different note. In
21 fact, it begs the question whether this is a note at
22 all. This is Dr Savage's secretary, on his behalf,
23 asking for a copy of a report or for whatever document.

24 MR FORTUNE: It begs the question as to whether it's the
25 post-mortem report that went out a little earlier.

1 A. Yes, what was the date of your previous -- because here
2 on the 24th I'm saying I haven't got it. And you will
3 see that, from this, as Mr Leckey had asked, I was
4 trying to explain what all these things meant to the
5 family. But they were getting -- they appear to have
6 got the post-mortem report --

7 MS ANYADIKE-DANES: No --

8 A. -- before I did.

9 Q. I think it was Dr Sumner's report you were being asked
10 to explain. There is a record of you being sent
11 Dr Sumner's report. This is the post-mortem report.

12 A. I thought Mr Leckey asked me to explain any of the
13 reports that came through, but it's splitting hairs.

14 Q. Thank you. Maybe we'll just move on to 060-022-041.

15 A. But the question that my counsel asked was -- you were
16 suggesting to me that that was the post-mortem report
17 that I was asked to comment on.

18 Q. I said we think it was.

19 A. If we compare the dates, we can tell.

20 THE CHAIRMAN: Yes, but actually, if -- sorry, can we go
21 back to the previous document for one second? I think
22 it says in the body of that document, five lines down:
23 "Checked with Linda, coroner's office. Grainne sent
24 copy in post on Monday."
25 So it's on its way, but it hasn't -- doesn't appear

1 to have reached you.

2 A. But was the previous letter to this one --

3 THE CHAIRMAN: It was an earlier date.

4 MS ANYADIKE-DANES: Right at the bottom, Mr Chairman,

5 24 April 1996:

6 "Porter to collect and take to Dr Savage's office in

7 Musgrave Ward."

8 THE CHAIRMAN: Yes. I think Professor Savage's concern, if

9 we go back again to an earlier document, if his

10 secretary is ringing up and asking for the post-mortem

11 report, is it doesn't support our supposition that the

12 post-mortem report had already been issued with --

13 I think the document is 059-039-082.

14 A. Thank you.

15 MS ANYADIKE-DANES: Well, the post-mortem report had been

16 received.

17 THE CHAIRMAN: It's the 25th. So that is -- whether this is

18 directly in response to your secretary's raising of the

19 issue or not, that is the post-mortem report. It has

20 now come in.

21 A. It seems to me that that --

22 MS ANYADIKE-DANES: Thank you. Just for completeness, not

23 to be called up, 059-035-068 is Mr Leckey's letter to

24 Dr Murnaghan, dated 22 April, attaching the post-mortem

25 report.

1 THE CHAIRMAN: That confirms what Dr Murnaghan's secretary
2 said in that note.

3 MS ANYADIKE-DANES: Thank you. Can we then go on to
4 060-022-041? This is a memo to the undernoted. You're
5 one of them. It attaches correspondence, which I will
6 come to in a minute. Did you receive this? (Pause).

7 THE CHAIRMAN: It might help the professor to know if he
8 received it if we put up the correspondence which is
9 attached.

10 MS ANYADIKE-DANES: Yes, of course, except it goes over
11 a number of pages.

12 A. I don't think it matters because I don't remember
13 receiving this and I do not believe I have kept anything
14 on file of a reply to this to Dr Murnaghan, unless
15 you have it. So I can't answer that. I do remember,
16 however, that when the litigation was settled,
17 I remember feeling surprised that the litigation had
18 gone on and I wasn't aware of what the discussions were.

19 Q. Sorry, you mean that the litigation had proceeded to
20 a level where it then had to be settled?

21 A. Yes.

22 Q. But you weren't surprised that there was litigation?

23 A. No, I'm not surprised that there was litigation, but
24 I wasn't -- I don't remember being involved in how the
25 litigation was settled and I don't remember replying to

1 this.

2 Q. But you did know that there was litigation, didn't you?

3 A. Well, I must have done because it looks like I got this
4 letter.

5 Q. Yes. The only reason I ask you that is because when you
6 were asked about the letter which you've just been
7 referring to, which actually is 060-010-019, not to be
8 pulled up, that's the letter that Dr Murnaghan writes to
9 a number of the clinicians after the matter's been
10 settled. When you were being asked about that,
11 I believe by the chairman, actually, in your evidence on
12 18 April, you said that that was the first time you knew
13 there was any litigation. In fact, just to have it,
14 it's 18 April, page 169 --

15 A. I accept that.

16 Q. It starts at line 13.

17 A. That was my memory: that I was quite surprised to hear
18 that there was litigation and it was settled when I got
19 that letter. But by the look of this, it looks like I
20 did know before, but perhaps in the midst of
21 the coroner's inquest and so on, this had slipped my
22 mind.

23 Q. We'll go to what the solicitor's letter is in just
24 a second. But there you see he's referring to the fact
25 that:

1 "All of you have provided information to ensure that
2 a witness statement could be prepared for and provided
3 for the coroner."

4 And I take it that's your 28 November --

5 A. Yes.

6 Q. -- and, in the case of Dr Taylor, that's the other
7 document that we looked at:

8 "However, you will appreciate that more detailed
9 information will now be required by me as case manager
10 for the Trust in order that proper instructions may be
11 given to our legal advisers. In particular, it would be
12 helpful if you would clearly identify and give as much
13 detail as possible, supported by references, with
14 copies, of the strengths and weaknesses, if any, of the
15 care provided for Adam."

16 And if we go to 060-022A-042, there's another page
17 to that at 043. So that's the solicitor's letter. The
18 first paragraph simply recites the details of being
19 admitted for the surgery, subsequently dying and what
20 they're really looking for is voluntary disclosure of
21 all his medical notes and records. But it is clear from
22 the first sentence that:

23 "[They] have been consulted in connection with
24 a potential claim for damages for personal injury, loss
25 and damage sustained by reason of negligence in and

1 about the performance of the renal transplant
2 operation."

3 A. Mm.

4 Q. So that's what you have got. All of you are being asked
5 to provide, if you can, details on the strengths and
6 weaknesses of the care that was provided for Adam. Even
7 if you didn't respond in writing, did you respond at all
8 to the preparation of the Trust's position, if I can put
9 it that way, in that litigation?

10 A. Well, I hate to say that I don't recall because I don't
11 think it's helpful, but I honestly do not recall. And
12 what I would therefore ask is: do you have a copy of any
13 response that I made? Has that been provided by the
14 Trust? Because I don't remember making one.

15 Q. No, that's why I'm asking you. Some who received that
16 did respond. For example, if we go to 059-034-067 --

17 MR FORTUNE: Sir, where is this going? Because
18 Professor Savage has said, "I don't recall". He has
19 challenged my learned friend to produce a document.
20 There is no document that the Trust can produce that
21 emanates from Professor Savage. Merely to show that
22 others responded may or may not be helpful to you, but
23 how is it going to help Professor Savage?

24 MS ANYADIKE-DANES: It may jog his memory. Professor Savage
25 has been fair enough to say that having sat and listened

1 to evidence, some of that evidence has had the effect of
2 jogging his memory so that he can assist us further and
3 that's what I'd seeking to do.

4 THE CHAIRMAN: I'm sorry, but the fact that Mr Keane
5 responded --

6 MS ANYADIKE-DANES: I was going to ask him if he saw it. If
7 he saw the responses, Mr Chairman, it might help him
8 recall whether he responded in like mind, even though at
9 present he can't remember doing it.

10 THE CHAIRMAN: Does it help you?

11 A. No. I don't remember. I was hoping that you might
12 produce the document and then that would certainly jog
13 my memory. And I also have to say that having got that
14 letter, I would have thought I would have responded.
15 That was why. I wasn't challenging you about the
16 document. I'd hoped that if I got a letter like that,
17 I would have responded appropriately and I would have
18 hoped you had that response.

19 MS ANYADIKE-DANES: I'm afraid we are only as good as the
20 documentation provided to us.

21 THE CHAIRMAN: Professor, you said a little while ago that
22 you are sure you made it clear to Dr Murnaghan that
23 Adam's death was due to fluid mismanagement --

24 A. Oh yes.

25 THE CHAIRMAN: -- and that you had numerous discussions with

1 him, mostly by phone.

2 A. Yes, and I think following the inquest there was no
3 doubt that Dr Murnaghan understood that.

4 THE CHAIRMAN: I think the documentation which has already
5 been produced over the last few days seems to
6 indicate -- I think there's a letter from Mr Brangam
7 indicating that that issue's raised before the inquest
8 about the differences between you and Dr Taylor.

9 MS ANYADIKE-DANES: If you're telling him very clearly,
10 "This is my position on what happened, in fact my
11 position from very, very early on", would Dr Murnaghan
12 be telling you what others were saying? Did he discuss
13 with you what others were saying?

14 A. Well, I think when I said that I was surprised to learn
15 that the litigation was settled is that because I don't
16 have any recollection of people communicating with me on
17 a regular basis as to the progress of any litigation.
18 And of course, I was also, around that time, talking to
19 Debbie. I don't remember that she even told me that
20 there was litigation. But then she might not have
21 wanted to. But there is --

22 Q. I didn't actually specifically mean about the progress
23 of the litigation. What I was really asking you is: was
24 Dr Murnaghan sharing with you the views that he was
25 receiving from the other clinicians?

1 A. I do not think so.

2 Q. Then what were you discussing in your many discussions?

3 A. I thought you were talking about the litigation.

4 Q. I was talking about your discussions. You said you had
5 many discussions with Dr Murnaghan. I'm trying to find
6 out what you were discussing in those discussions.

7 A. I was discussing the fact that I believed that Adam had
8 died from dilutional hyponatraemia, that I agreed with
9 Sumner's conclusion, that I agreed with the autopsy
10 report. Those sorts of things. I was putting my
11 position to him.

12 THE CHAIRMAN: Can I ask you this: were you raising concerns
13 about Dr Taylor?

14 A. No.

15 THE CHAIRMAN: Why not?

16 A. Well, I think because I didn't have any particular
17 concerns about Dr Taylor. I mean, the situation, as
18 I understood it, was that he had made some catastrophic
19 mistakes in theatre. He accepted my hypothesis that he
20 had got too much fluid and I believed that particularly
21 after the inquest and, therefore, I believed that the
22 chances of him making a similar mistake again were
23 negligible and I also believed that because he had been
24 interviewed by Dr Gaston and by -- in that way, that
25 they formed the same view that there was no particular

1 risk. But as I've said, I regret now that there wasn't
2 a more thorough investigation that may have brought out
3 some of the evidence that you've received 17 years
4 later.

5 THE CHAIRMAN: Let me ask you this because this point was
6 raised a number of times: it was said on a number of
7 occasions about Dr Taylor that he's a good anaesthetist,
8 that he is well regarded; is that right?

9 A. Yes. And I think that probably is what influenced a lot
10 of us. We knew Bob Taylor's work. I never heard any of
11 his colleagues have any criticism of him, either
12 anaesthetists or surgeons who worked with him day and
13 daily because I didn't work with him day and daily,
14 I worked with him occasionally. Therefore, that in
15 a way supported my view that this was a one-off tragic
16 mistake that he had made.

17 THE CHAIRMAN: But when you were giving me your longer
18 answer a few moments ago, you went back to the point
19 that you believed he accepted your hypothesis that Adam
20 had got too much fluid and you believed that
21 particularly after the inquest.

22 A. Yes.

23 THE CHAIRMAN: But I don't want to go over old ground again,
24 but you believed that on the basis of his silence after
25 the inquest.

1 A. I think so.

2 THE CHAIRMAN: Okay.

3 A. I think what I said was he never -- I don't remember him
4 ever saying to me directly, "I admit I was wrong,
5 I accept that what the coroner said is right". He has
6 said that now, but that was what I thought he was
7 indicating in those early days.

8 THE CHAIRMAN: He's accepted that now after what he told me
9 in April that he was, in a sense, overwhelmed by the
10 number of expert reports coming out from this inquiry,
11 saying he'd got it wrong. But they're only saying,
12 largely, what Dr Sumner said.

13 A. Exactly.

14 MS ANYADIKE-DANES: In your answer to the Chairman, you said
15 "particularly after the inquest". But you didn't think
16 he agreed with you before then, did you?

17 A. I thought he was contesting the situation, yes.

18 Q. Exactly.

19 A. Again, it's reading what he wrote, and I don't remember
20 how much of that I saw during that interval
21 between December and June.

22 Q. I appreciate that. In your evidence, I think, you --
23 and others have said so as well -- have said that
24 Dr Taylor was a good and liked and respected colleague;
25 would that be fair?

1 A. Yes.

2 Q. Yes. But you nonetheless regarded -- and I think this
3 was your expression -- he had made a catastrophic
4 mistake and that had led to the death of a child in
5 surgery.

6 A. Yes.

7 Q. Did you go and sit down with him and see how on earth
8 could he have made that catastrophic mistake?

9 A. I certainly discussed it with him and I knew that some
10 of the calculations he'd made were incorrect. For
11 instance, he thought his urine output was 200 ml per
12 hour.

13 Q. Did you share with him the view that that couldn't
14 possibly be right?

15 A. Probably, yes.

16 Q. But if you shared that view with him, then was he
17 accepting, "Yes, I see now, I can't for the life of me
18 see how I thought that", or was he still maintaining the
19 view that that didn't matter because Adam's polyuria
20 meant that he could simply accommodate such large
21 volumes of fluid?

22 A. I don't remember him ever saying that to me.

23 Q. This is an important issue: you're having to deal with
24 the fallout of it, which is the effect on Adam's mother.
25 Either you are satisfying yourself that he is accepting

1 that he made an error or you are simply conveying your
2 view and walking away from that and not really knowing
3 for sure whether he has accepted he made an error.

4 A. My understanding is that he accepted that he got the
5 fluid calculations wrong.

6 Q. And on what basis prior to the inquest did you think he
7 was accepting that?

8 A. From my conversations with him.

9 Q. Then, when he gave evidence at the inquest, you must
10 have been shocked because his evidence certainly doesn't
11 indicate that he had got the fluid calculations wrong.
12 So why didn't you say something at that stage? "That
13 can't be right, I've explained to you the basis of your
14 error and you've accepted that to me, how can you
15 possibly be giving that evidence to the coroner?"

16 MR FORTUNE: Sir, is my learned friend suggesting that
17 Professor Savage, at the inquest, should have
18 intervened?

19 THE CHAIRMAN: Well, let's look at it in a slightly
20 different way. If Professor Savage is saying that he
21 had conversations with Dr Taylor before the inquest that
22 he knew from what Dr Taylor was saying that Dr Taylor
23 had got the urine output wrong and then he hears him say
24 at the inquest the evidence which he did give. Well,
25 whether or not he should stand up at the inquest and

1 say, "You're wrong, you're wrong", or intervene in some
2 way, it makes it exceptionally difficult for me to
3 understand how, after the inquest, a view could have
4 been formed that Dr Taylor accepted the inquest verdict.
5 Because the inquest verdict was directly in the face of
6 what Dr Taylor said.

7 So we now have three phases. We have
8 Professor Savage's understanding on 27/28 November that
9 Dr Taylor had made catastrophic mistakes. That's
10 a view, which, as we know from the last few days of
11 evidence, he expressed in different terms internally
12 with the Royal and, in terms, he expressed it to Debbie
13 Slavin.

14 He said a few moments ago that he had then spoken to
15 Dr Taylor and understood that Dr Taylor was accepting
16 some of the things that had gone wrong. Dr Taylor then
17 comes to the inquest and adheres to his original
18 position, but somehow a view is formed after the inquest
19 verdict -- based, apparently, on silence -- that
20 Dr Taylor accepts the verdict of the inquest. That's
21 what concerns me: not whether he should have stood up
22 at the inquest and intervened, but it's how that leads
23 on to a view being formed afterwards that this good,
24 competent, likeable anaesthetist now accepts what went
25 wrong. I just don't understand that, Mr Fortune.

1 MR FORTUNE: Sir, let's just break it down. At the inquest,
2 the Trust is represented by a competent solicitor. If
3 there was a conflict in the evidence, then it was his
4 duty to take a certain position and to give advice.

5 THE CHAIRMAN: Yes.

6 MR FORTUNE: And in reality, Dr Taylor should have been
7 separately represented. Insofar as he wasn't, there is
8 some obvious criticism that can be laid at the door of
9 the solicitor. However, moving on --

10 THE CHAIRMAN: And an experienced client. The Trust wasn't
11 some novice at the inquest, whose senior officers would
12 not have had some understanding of the concept of
13 conflict of interest because this would not be far
14 removed from a medical negligence case, in which they
15 would know that doctors get separate representation from
16 the institution from time to time.

17 MR FORTUNE: I don't know that I can impute to Dr Murnaghan
18 particular knowledge. But certainly I can impute --

19 MR LAVERY: Sir, I rise. With respect, Mr Chairman, in our
20 submission, there is a difference between a medical
21 negligence action and an inquest in terms of conflicts
22 of interest arising. A coroner's interest is an inquest
23 held by the coroner, an officer of the state, and he is
24 the one that calls witnesses to the inquiry, and he's
25 the one that carries out the investigations, it's not

1 adversarial. Whereas a medical negligence action is
2 adversarial and, as has happened on numerous occasion
3 when conflicts do arise, then doctors and clinicians
4 have been advised to seek independent representation.
5 That is something that has commonly occurred over the
6 years.

7 THE CHAIRMAN: Did they not also do that at inquests from
8 time to time?

9 MR LAVERY: From time to time, yes, individual clinicians
10 will be represented by their MDU, but that's not
11 something that, as a matter of course, comes from the
12 Trust.

13 THE CHAIRMAN: Okay.

14 MR LAVERY: That's a different situation, in my respectful
15 submission, Mr Chairman.

16 MR FORTUNE: Sir, I'm staggered to hear that because I have
17 no doubt that, as counsel for a Trust on previous
18 occasions, if I have had any concerns about whether
19 I can represent a particular doctor, then unless it is
20 safe, the advice is: go elsewhere.

21 THE CHAIRMAN: And you're talking in terms of both inquests
22 and medical negligence cases?

23 MR FORTUNE: Certainly so far inquests are concerned. And
24 here, the advice should have been that Dr Taylor was to
25 consult other solicitors and, if necessary, be

1 represented independently.

2 THE CHAIRMAN: Okay.

3 MR FORTUNE: But move on from there --

4 THE CHAIRMAN: Let's get back, somehow, to where we were
5 a few minutes ago.

6 MR FORTUNE: The fact is Her Majesty's Coroner heard the
7 evidence, was satisfied firstly as the medical cause of
8 death and then returned his verdict. It was then up to
9 Dr Taylor to continue to express his concerns about the
10 mechanism or to accept. And it would appear from what
11 Professor Savage has said that he, Professor Savage,
12 understood that Dr Taylor now accepted what had been --

13 THE CHAIRMAN: What I'm getting at is: what is the basis for
14 that understanding? Because the basis for that
15 understanding appears to be silence on Dr Taylor's part.

16 MR FORTUNE: And that is Professor Savage's evidence.

17 A. There's one other thing I would like to draw to your
18 attention.

19 THE CHAIRMAN: Please do.

20 A. If you remember -- and I don't have the facility to draw
21 things up -- that at some point in Dr Taylor's
22 evidence -- I think perhaps his written evidence -- he
23 said that he had had a discussion with myself and
24 Dr Sumner --

25 THE CHAIRMAN: Yes.

1 A. -- at lunchtime or after the inquest indicating that he
2 did not accept the mechanism of the Arieff scenario in
3 Adam's case. That is where I formed the view that he
4 accepted the overall cause of Adam's death but did not
5 accept that it had happened as in the Arieff cases. So
6 it wasn't entirely silence. The second thing I would
7 say is that I think Dr Taylor has indicated that he then
8 changed his practice so that he never again used fifth
9 normal saline, but as he said, used and taught textbook
10 fluid balance.

11 So I'm not trying to defend the situation. I accept
12 that I probably should have pursued this more
13 vigorously, but that was my thinking at the time.

14 THE CHAIRMAN: Just on your first point there, professor: to
15 the extent that the aggravation which he appears to have
16 felt at the time of the inquest that Dr Sumner was --
17 and I think more particularly directed at Dr Sumner --
18 that Dr Sumner was agreeing with Dr Taylor about one
19 thing and then saying something different in the witness
20 box. And that seems to have been your understanding,
21 that that was only related to the mechanism. The
22 trouble about that is that Dr Taylor's understanding of
23 the mechanism then -- that somehow is swollen enormously
24 into a complete disagreement, which is much more
25 fundamental than just the mechanism, isn't it? Maybe

1 "Adam Strain's death would have been discussed
2 at the paediatric directorate clinical audit meeting
3 in December 1995."

4 The information that provided the basis for that
5 letter came from two members of the clinical audit
6 committee, who are presently on the clinical audit
7 committee. It was stated that this would have been
8 discussed on the basis that every death would have been
9 discussed. But the position, Mr Chairman, is that the
10 Trust is not in a position to say categorically that
11 Adam's death would have been discussed at that meeting.
12 The minutes are no longer available. The Trust did
13 carry out further investigations and, indeed, spoke to
14 a Dr Mike Shields, who may well have been sitting on the
15 committee at that time. But unfortunately, he's not
16 able to say one way or another whether or not the death
17 was discussed and, unfortunately, that's as far as the
18 Trust is going to be able to advance this matter.

19 You can see that the letter was carefully worded to
20 say that it would have been discussed rather than it was
21 discussed.

22 THE CHAIRMAN: That's on the basis that every such death
23 would be discussed at the clinical audit meeting?

24 MR LAVERY: Indeed, Mr Chairman, yes. But unfortunately the
25 minutes are no longer available and it's just impossible

1 to say whether or not, in fact, it was.

2 THE CHAIRMAN: Then there's a bit of a debate yesterday
3 that -- you'll remember when Dr Mulholland was querying
4 whether a death would be discussed if it had already
5 been referred to the coroner or if it might be, for
6 instance -- there's a number of variations -- it might
7 not be discussed at all. It might be because it has
8 gone to the coroner that it might be mentioned, but then
9 discussion deferred until after the inquest. There's
10 now a degree of uncertainty whether, in fact, it was
11 discussed in December 1995.

12 I think we don't know whether there was any
13 discussion of it after the inquest.

14 MR LAVERY: We don't know that, Mr Chairman.

15 THE CHAIRMAN: Is that again because there were some minutes
16 but not the -- the inquest was in June 1996, so if it
17 was picked up again at the audit committee, that would
18 be July, August or September, depending on how
19 frequently the committee meets during the summer.

20 MR LAVERY: Yes. The difficulty is that any individual
21 patients would be anonymised during these audit
22 meetings, so even if the minutes were available they
23 wouldn't necessarily identify any particular patient.

24 So we just can't say. The Trust believes --

25 THE CHAIRMAN: If you had a child who died in Adam's

1 situation and, in respect of whom, there had been an
2 inquest, it wouldn't be difficult to glean enough from
3 anonymised minutes to know who was being discussed,
4 would it?

5 MR LAVERY: I think that's fair to say, Mr Chairman, yes.

6 THE CHAIRMAN: We ask the DLS to do a lot and I'm sure it
7 raises hackles somewhere down the line, but if I could
8 ask that a fresh effort is made to see if there are
9 available minutes from July, August and September 1996,
10 even if anonymised, which help to identify whether
11 Adam's case was picked up again after the inquest.

12 MR LAVERY: Certainly further efforts can be made, although
13 I suspect that they won't prove fruitful.

14 THE CHAIRMAN: Let's see.

15 MR LAVERY: I can undertake to arrange for those
16 investigations to be carried out. Thank you,
17 Mr Chairman.

18 THE CHAIRMAN: Okay. Ms Anyadike-Danes?

19 MS ANYADIKE-DANES: Can we go to 059-020-046, please?

20 If we pull up the second page of that, which is 047.

21 That's a letter from the Trust solicitors to

22 Dr Murnaghan, dated 30 May. And the first sentence of

23 it indicates that, at least by this, it seems that there

24 is a meeting that you attended because it says:

25 "I refer to a recent meeting with yourself,

1 Mr Savage and Dr Taylor concerning this inquest, which
2 has been listed for hearing on 18 June."

3 And then it refers to issues to do with the
4 correspondence from the solicitors and I am not going to
5 take you to the substance of this unless you tell me you
6 saw it. Did you see this letter?

7 A. I don't remember it, but I see that I am mentioned in
8 it.

9 Q. Yes.

10 A. I do see that it says that --

11 Q. I'm going to come to that in a minute. Can you tell me
12 if you saw this letter as far as you can recall?

13 A. I don't remember.

14 Q. Then you are referred to, if one goes to the final
15 paragraph in the first page:

16 "Given the complexities of this case and the
17 particular anxieties of all concerned, I believe
18 a further consultation nearer the time of inquest would
19 be helpful and I believe that the views expressed by
20 Mr Savage in relation to the attitude which we should
21 adopt in respect of this matter are entirely correct and
22 responsible in that we should acknowledge that everyone
23 concerned in the care of this child was devastated by
24 his death and that, where possible, answers will be
25 provided to the queries raised by the solicitors on

1 behalf of the next of kin."

2 Do you know when you were expressing those views?

3 Sorry, the first question is: do you accept that that is
4 a record of the views that you were expressing at the
5 time?

6 A. They're the views that I have always held.

7 Q. Yes. And do you know whether you were doing that at
8 that recent meeting or is that just a general sense of
9 your position?

10 A. I don't know. It looks as if it's more or less a minute
11 of the meeting, doesn't it?

12 Q. Yes, it looks like that. Can you recall anything
13 further about the attitude that you were saying should
14 be adopted other than the fact that everybody concerned
15 in the case should acknowledge being devastated by his
16 death and seeking to provide answers so far as possible?

17 THE CHAIRMAN: I think we have that at the top of the next
18 page, don't we? If you look at the first paragraph
19 on the next page it, in effect, says the essential issue
20 is about fluids and Mr Savage --

21 MS ANYADIKE-DANES: Sorry, what I was trying to get at is
22 that if there was anything further about the attitude he
23 said we should adopt. That, I think, is
24 Professor Savage's view and he has fairly said that that
25 has always been his view as to what the problem was.

1 But I was actually dealing with this question of the
2 attitude that you thought the Trust and its clinicians
3 should adopt. Can you help us with any more detail on
4 that?

5 A. No, I don't think so.

6 Q. Well, why would you have to say that you should
7 acknowledge or those concerned should acknowledge that
8 they were devastated by the death of Adam?

9 MR FORTUNE: Sir, I do rise again at this stage. This is
10 a solicitor's letter. What is the purpose of asking
11 Professor Savage about what Mr Brangam thinks should be
12 the Trust's position?

13 THE CHAIRMAN: Because Mr Brangam has reported these as
14 being the views of Professor Savage. Professor Savage
15 has said consistently -- and I entirely accept -- that
16 he was devastated and that those who knew Adam and
17 worked with Adam were devastated by Adam's death. The
18 slight twist on that, which Ms Anyadike-Danes is asking,
19 is -- if it's right that this letter from Mr Brangam is
20 correct -- why is it that Professor Savage would need to
21 be expressing the view that the Trust's position should
22 be that everyone concerned was devastated by his death?
23 And to put it bluntly, were you suggesting that to
24 Mr Brangam because somehow you were concerned that that
25 wouldn't be acknowledged as the Trust's position?

1 MS ANYADIKE-DANES: Thank you, Mr Chairman.

2 A. Well, I shouldn't speculate.

3 Q. Well, why were you --

4 A. I obviously felt that it needed to be said.

5 Q. That's exactly the point, Professor Savage. Why did you

6 think it needed to be said?

7 A. I don't remember exactly, but I may have felt that

8 we were pursuing a very legalistic approach to the

9 inquest and the evidence that was given, whereas I felt

10 that the family's needs were paramount rather than the

11 Trust's or the doctors'.

12 Q. Exactly. Did that mean therefore that you felt that was

13 being lost sight of?

14 A. Perhaps.

15 THE CHAIRMAN: Or that it might be lost sight of and you

16 were giving a reminder?

17 A. Yes.

18 MS ANYADIKE-DANES: Thank you. So then if we go to the next

19 page, you have again stated your view. I know, although

20 we had this terminology "retrospect" yesterday, but in

21 any event:

22 "Mr Savage feels the child may have received

23 excessive fluids. I presume that Mr Savage will hold to

24 that view if asked at the inquest. Again, I believe

25 it is of critical importance that we obtain Dr Taylor's

1 specific instructions on that point."

2 And that continued to be your view, that he received
3 excessive low-sodium fluids?

4 A. Yes, I think it's mildly put. It says, "Dr Savage feels
5 the child may have received excessive fluids". I think
6 that's understating my position.

7 THE CHAIRMAN: That's a legal understatement, isn't it?

8 A. Yes.

9 THE CHAIRMAN: What you would say it confirms --

10 A. I've always made that position clear.

11 THE CHAIRMAN: That was your position, your position was
12 known to Dr Murnaghan, your position was known to
13 Dr Taylor and it's now well-known by the solicitors.

14 A. Yes.

15 MS ANYADIKE-DANES: Can we go to 059-009-027? That is
16 a memo that is attaching a fax, which we'll come to in
17 a minute, but it's being circulated to the three of
18 you: Dr Taylor, yourself and Dr Gaston. It says it's
19 sent on 7 June. Then if we go to 059-014-038. That's
20 the first page of it. This again is the Trust's
21 solicitor writing to Dr Murnaghan. It is
22 a two-and-a-half page letter in which the Trust's
23 solicitor, as you can see, is setting out the various
24 positions as he has distilled them from meetings. So
25 for example, if one goes to the second paragraph:

1 "As you know, there are a substantial of number
2 issues contained in the experts' reports which will
3 require to be carefully and exhaustively examined and
4 investigated and, in that regard, I have already had the
5 benefit of very detailed instructions from Dr Taylor and
6 these have now been reinforced to me by Dr Gaston."

7 He refers to Dr Sumner and:

8 "[Welcoming] a further statement from Dr Taylor in
9 which he would deal with each of the criticisms raised
10 by the medical experts. Although they don't entirely
11 agree, you will be aware that Dr Sumner and Dr Alexander
12 both thought that it was dilutional hyponatraemia that
13 was the issue."

14 Then over the page, he sets out what Dr Armour
15 classifies as the problem or at least the cause of
16 death:

17 "Cerebral oedema due to dilutional hyponatraemia.
18 Impaired cerebral perfusion during renal transplant."

19 And then sets out the veiled criticisms that the
20 solicitor has distilled from Dr Sumner's report and,
21 essentially, is saying will have to be addressed. You
22 can see them there: Dr Taylor's estimated fluid deficit,
23 the electrolyte values, the CVP readings. And then
24 at the bottom of that page he raises two other issues:

25 "Dr Gaston has indicated during the course of the

1 procedure that there had not been an opportunity for
2 Dr Taylor to accurately measure the urinary output."

3 If one goes over the page again, to 040, an
4 additional point raised by Dr Gaston, which relates to
5 the potential for this child, for whatever reason, to
6 absorb fluid into the brain. He's asking for further
7 literature or information on that, which could be put
8 forward as a reason for why things ended up the way that
9 they did. And:

10 "In conclusion, Dr Taylor has also undertaken to
11 provide certain documentation on anaesthetic monitoring
12 guidelines and a resume of learned papers [and so on]."

13 Then it ends up with:

14 "It will be necessary to have a further consultation
15 with Dr Taylor and, no doubt, you will make the
16 arrangements."

17 The reason for taking you to this is because this is
18 a document that is sent to you as well as to Dr Gaston.
19 Do you know why it was being sent to you?

20 A. How can you tell it was sent to me?

21 Q. Because the cover memo says so.

22 A. Can I see that?

23 Q. I've just pulled it up to you. That's where I started.

24 059-009-027:

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 Make the arrangements and then it's circulated and
5 you're one of the noted people to whom it's circulated.

6 A. And you're asking why it was circulated to me?

7 Q. Yes. Why do you think Dr Murnaghan, who you say that
8 you spoke to many times, he knows your views, you have
9 set that out quite clearly -- in fact, he has received
10 parts of your views in the solicitor's correspondence.
11 Why is he sending you this, do you think?

12 A. I suppose because I was Adam's consultant, but he
13 doesn't ask me to comment on it. He would have known my
14 views quite clearly.

15 Q. Did you comment on it?

16 A. I don't remember.

17 Q. Sorry?

18 A. I don't remember.

19 THE CHAIRMAN: You're also going to be a main witness at the
20 inquest.

21 A. Oh yes.

22 MS ANYADIKE-DANES: These are the things that, not to put
23 too fine a point on it, the Trust solicitor is
24 envisaging are likely to cause the Trust some difficulty
25 in the inquest. Difficulty, that is, if you're trying

1 to ensure that you come through that process with the
2 minimum amount of criticism, if I can put it that way.
3 So he's sending that to you and what is your response to
4 it?

5 A. I don't know what my response was, but I know what
6 it would have been. It would have been --

7 Q. That might help.

8 A. I would have maintained my position that I believed Adam
9 got excessive fluids and his death was due to that
10 because of the results dilutional hyponatraemia and
11 cerebral oedema.

12 Q. Given what you're recorded as having said, that we
13 really ought to be acknowledging that we're all
14 devastated that Adam has died, you have an earlier
15 letter to Adam's mother of 19 February saying, we really
16 need to find out what happened, do all that we can to
17 learn the lessons and make sure it doesn't happen again.
18 Did you think this process of getting information, this
19 kind of information together, was assisting that attempt
20 to find out what happened, learn the lessons and make
21 sure it didn't happen again?

22 A. I think it was assisting Dr Taylor.

23 Q. Yes. Thank you. Then can we go -- you do actually
24 write on 7 June. Sorry, I hadn't appreciated how
25 quickly that came afterwards. 059-003-005. I beg your

1 pardon, professor; I hadn't realised that you had

2 actually responded to that.

3 A. I remember this letter.

4 Q. So there's another page to that, 006. Let's put that up

5 as well. It says:

6 "I have received your fax regarding Adam Strain's

7 inquest and the points raised by Dr Sumner's report."

8 Do you envisage that to be a direct reference to the

9 document we were just looking at?

10 A. Yes.

11 Q. And you set out information regarding the child's

12 urinary output --

13 A. Yes.

14 Q. -- prior to surgery. You say what you think his

15 insensible losses would be. Then if we go down:

16 "Assuming normal urine output for Adam was

17 approximately 70 ml per hour, or in Dr Sumner's words,

18 75 ml per kilogram, I think it is acceptable that the

19 maintenance fluids during surgery should have taken into

20 account the overnight fluid deficit."

21 THE CHAIRMAN: It's the critical conclusion, isn't it, that

22 whatever the deficit was, it's the last sentence in that

23 paragraph:

24 "The difference between the two figures."

25 MS ANYADIKE-DANES: Yes, and just before that, because the

1 rate is something that you have previously regarded as
2 important:

3 "The infusion rate per hour would then vary on how
4 quickly one wished to catch up this deficit and giving
5 200 ml per hour would have ensured that the deficit was
6 corrected in four to five hours. Giving 150 ml per
7 hour, this would have taken much longer. The difference
8 between the two figures, of 50 ml per hour, would only
9 have accounted for 250 ml over the period of the
10 operation and I doubt if this difference would have
11 given rise to hyponatraemia."

12 Is what you're trying to say there that given what
13 his urinary output was, given what he received, even if
14 you had a slight quibble about whether it's 150, 200 or
15 whatever it is, that's unlikely to have produced the
16 level of hyponatraemia that has been identified in Adam;
17 is that actually what you're saying?

18 A. Yes, it's a bit like when you asked myself and all the
19 experts to analyse the input/output that there is always
20 a little bit of discrepancy when you're reading through
21 those figures. I'm saying that the discrepancy between
22 Sumner and the other figure is not significant. And
23 I think that's the question, probably, that Dr Murnaghan
24 put to me.

25 Q. Yes. Is there any reason why, when you're setting it

1 out like that, you don't just say as the final point,
2 "This child received excess low-sodium fluids and, as
3 a result, he developed dilutional hyponatraemia"?
4 Because in your view, it really was as simple as that in
5 terms of the fluid input/output?

6 THE CHAIRMAN: I'm sorry, that's not fair to
7 Professor Savage. Because in the letter from Mr Brangam
8 to Dr Murnaghan, to which this is a response,
9 Professor Savage is already acknowledged as having
10 adopted that position.

11 MS ANYADIKE-DANES: Yes.

12 THE CHAIRMAN: It's the second page of the letter that we
13 looked at a few moments ago. This is a specific
14 response to two points. But it's unnecessary and
15 a waste of Professor Savage's time to repeat in this
16 response a position which he has already adopted and
17 which has already been acknowledged by Mr Brangam as
18 having been acknowledged.

19 MS ANYADIKE-DANES: I understand that point, Mr Chairman.
20 Firstly, what the solicitor did was incorporate
21 a reference in solicitor's correspondence. This is
22 Professor Savage's own letter to the medical
23 administrator, which has a degree of formality, and
24 I was simply exploring with him why he didn't put it in
25 those terms. This letter could be used to be shown to

1 anyone, given the proximity of it to the inquest. And
2 I'm simply asking why you didn't include, in this
3 letter, those views that you have had all along about
4 dilutional hyponatraemia.

5 A. They were transparently clear to Dr Murnaghan. And
6 of course, I wouldn't have been aware that a letter
7 I wrote to the person who I assumed was my legal
8 representative would have been made available to the
9 coroner.

10 MR FORTUNE: Sir, I'm going to rise because clearly there
11 would have been, at that stage, legal professional
12 privilege attaching to this correspondence.

13 THE CHAIRMAN: I think this is unnecessary. I think that
14 Mr Brangam specifically acknowledges Professor Savage's
15 position in the letter that we looked at a few moments
16 ago.

17 MR FORTUNE: One matter that concerns me -- and I have
18 already touched on it -- is that when you go back to
19 that letter from the solicitor to Dr Murnaghan, it is
20 quite clear that the solicitor failed to ensure his duty
21 to advise the Trust that there was an obvious conflict
22 of interest.

23 MS ANYADIKE-DANES: I wonder, Mr Chairman, if we can come to
24 those sorts of points with another witness? I'm not
25 sure it's an appropriate place to do it at this stage.

1 MR FORTUNE: Well, Professor Savage is being asked, at
2 different stages, about his view. His view has been
3 consistent throughout: that Adam died as a result of too
4 much fluid administered too quickly. And yet in that
5 letter from Mr Brangam, the solicitor is setting out
6 various points, essentially put forward by Dr Taylor,
7 that he, Mr Brangam, wants arguments or suggestions to
8 address.

9 MS ANYADIKE-DANES: And we are going to come to that, but
10 I'm not sure that this is the appropriate witness to
11 deal with it.

12 THE CHAIRMAN: I've got that point.

13 MS ANYADIKE-DANES: Thank you.

14 Can we go to your paragraph 2:

15 "It is true after examining the notes that I have
16 said that Adam's electrolytes should have been repeated
17 before going to theatre. The junior staff involved were
18 unable to obtain venous access because he got extremely
19 upset. This was not pursued in the ward situation.
20 I understand that venous access was readily achieved in
21 theatre and therefore it would have been possible to
22 check the electrolyte picture at that stage. I am not
23 sure whether these comments are particularly helpful
24 and, obviously, we will need to discuss them further."

25 What did you think you particularly needed to

1 discuss further about these comments with Dr Murnaghan?

2 A. I don't know. I suspect that I expected the opportunity
3 to reiterate my position, since the letter mainly
4 referred to Dr Taylor's position and not to mine.

5 Q. Was it the implications of these being your views that
6 you wanted to discuss with Dr Murnaghan? Because at
7 that stage, you will have received the solicitor's
8 letter, so you know what is trying to be achieved. Was
9 this really putting down a marker for what your views
10 were?

11 A. Yes, I think so.

12 THE CHAIRMAN: Or putting down another marker?

13 A. Yes.

14 MS ANYADIKE-DANES: Then there is a further consultation
15 arranged. We see that by 059-002-003, the memo there.
16 There we are:

17 "I write to confirm that a further consultation has
18 been arranged for Friday 14 June."

19 And it is circulated to -- well, you are included in
20 those noted. And of course, the inquest was due to
21 start on the 18th. You will have seen,
22 Professor Savage, that there was an effort made by the
23 consultant paediatric anaesthetists, with some
24 involvement of Dr Murnaghan, to produce a document, and
25 ultimately two documents were produced really. One was

1 a draft of recommendations that was presented to the
2 coroner and the other is a document that was,
3 effectively, like a press release. And in fact, we can
4 see that there was press reporting quite close to the
5 press release document.

6 Were you involved in any of those meetings that
7 produced either of those documents?

8 A. I don't know. I remember the -- I remember seeing the
9 document that was presented at the coroner's inquest,
10 but I don't remember that I was involved in drawing it
11 up in any way, unless you can, as you often do, produce
12 something that shows that I was. But I don't remember
13 it.

14 Q. It's usually inadvertent. 011-014-107A.

15 A. I know the document, yes.

16 Q. That's the one that was provided as part of Dr Taylor's
17 evidence.

18 A. Yes.

19 Q. Do you recall, if you did see it, whether you saw it
20 before it was produced for the coroner or at some stage
21 afterwards?

22 A. I don't know.

23 Q. Is there anything in there which, if you had been part
24 of a meeting discussing its formulation, would have
25 troubled you or anything that isn't in there which you

1 would have preferred to see?

2 A. No. I think I regarded it as a letter to show that the
3 Trust were concerned about the circumstances around
4 Adam's death and were going to continue making efforts
5 to make sure it didn't happen again, and this was
6 a preliminary statement.

7 Q. Were you aware --

8 THE CHAIRMAN: Sorry. Do you mean a preliminary statement
9 or a statement preliminary to further steps which the
10 Trust would take to improve practice?

11 A. The latter, I think, yes. It says, "The Trust will
12 continue to use its best endeavours, [et cetera]".

13 MS ANYADIKE-DANES: Were you aware of what those endeavours
14 were?

15 A. No.

16 Q. Were you aware that there were any endeavours being made
17 that they were then going to continue?

18 A. Not at that stage, no.

19 Q. Were you aware that they instigated such action
20 afterwards?

21 A. Well, I know in relation to the last paragraph that they
22 did improve the turnaround time for emergency blood
23 samples between the laboratory and the intensive care
24 unit.

25 Q. Do you know when that happened?

1 A. No.

2 Q. Well --

3 THE CHAIRMAN: Do you know that it happened as a result of
4 Adam's death and the inquest?

5 A. Yes, I think so. But I think Adam's -- I think that had
6 been an issue before and Adam's death probably
7 highlighted it.

8 MS ANYADIKE-DANES: Can I just ask: on what basis do you
9 think that it happened as a result of Adam's death?

10 A. Because I need to be -- I need to be careful because
11 I know that perhaps Dr Crean said there were meetings
12 with Selwyn Nesbitt(?), who was head of the laboratory
13 shortly afterwards and the situation improved. So that
14 may be what I remember from recently rather than from
15 17 years ago.

16 Q. That's actually what I meant. Do you recall --

17 A. I was not involved.

18 Q. And so you don't recall, at the time, anything happening
19 that was directly related to Adam's death in relation to
20 turnaround times?

21 A. No.

22 Q. Do you know if this document was circulated at all --

23 A. No.

24 Q. -- within the paediatric department?

25 A. No, I don't know.

1 Q. You don't know it was circulated or you do know that it
2 wasn't circulated?

3 A. I do not think it was circulated.

4 Q. Thank you. When you came to give your evidence to the
5 coroner, were you -- let's pull it up. 011-015-109.
6 Then the second page, before we get into your answers to
7 questions, 110.

8 So there is a typed-up version of the answers you
9 gave to questions. But your direct evidence is
10 reflected in the typed part, if I can put it that way.
11 Is it clear there, when you're giving your evidence,
12 that you think that Adam received too much low-sodium
13 fluid too quickly and, as a result, developed dilutional
14 hyponatraemia?

15 A. No.

16 Q. Why?

17 A. Because, as I said before, my advice was to put
18 a strictly factual statement of the areas in which I was
19 involved and not to draw any conclusions because that
20 was the role of the coroner.

21 Q. I understand.

22 A. It may not have been wise advice, but that was the
23 advice I had.

24 Q. As we said before, in relation to your 28 November
25 letter, here you are before the coroner and you do

1 actually have some factual things to say because you and
2 Dr O'Connor went and looked at the medical notes and
3 records and you identified certain things which are
4 a matter of fact.

5 A. Yes.

6 Q. And some of them are a matter of actual record which
7 could have been adduced to the coroner. Is there
8 a reason why you didn't do that?

9 A. No, but it's perfectly clear from the handwritten --

10 Q. Yes --

11 A. -- that I did explore that when asked.

12 Q. That was in answer to questions. Is there any reason,
13 when you were giving your evidence, why you didn't
14 provide that information to the coroner?

15 A. There was no reason, but I would have expected the Trust
16 solicitor to explore that with me.

17 Q. What do you mean, "explore it with you"?

18 A. Ask me what my view was or, indeed, the coroner or
19 someone.

20 THE CHAIRMAN: Just to get it right, when you come to give
21 evidence to the coroner, it's the typed statement which
22 is your evidence and then you're asked questions by
23 representatives of the Trust, representatives of the
24 family and by the coroner himself if he wants.

25 A. That's correct.

1 THE CHAIRMAN: So when you come to give evidence, it starts
2 off as a page-and-a-half of written statement and
3 that is then supplemented by any oral questioning and
4 answers?

5 A. Yes. I was immediately asked about his sodium, as you
6 can see.

7 MS ANYADIKE-DANES: Yes. I appreciate that, and I'm going
8 to pull up the typed-up version, which is much easier to
9 read. The question I simply asked you is why you didn't
10 volunteer that. It's an important consideration. It
11 was what was at the heart of your view as to how that
12 had developed. I am simply asking why you didn't
13 volunteer that to the coroner.

14 THE CHAIRMAN: The short answer to that is because the
15 statement that we've already looked at earlier this
16 morning became the statement to the coroner and
17 Professor Savage has given his answers about that. So
18 we know that that was topped and tailed, in effect.
19 That became the written statement to the coroner and was
20 then supplemented by the oral evidence.

21 MS ANYADIKE-DANES: Yes, Mr Chairman, of course that is so.
22 But between 28 November and, on this occasion,
23 Professor Savage has seen much to indicate other
24 positions taken by other people, and it might have made
25 things clearer if he had simply set out some of those

1 facts in relation to the serum sodium and the fluid.

2 THE CHAIRMAN: I don't think we need to go down this route.

3 If the coroner wants supplementary statements, he can
4 ask for them. That's the process.

5 MS ANYADIKE-DANES: Can we then go to 059-001-001? That is
6 a note that Dr Murnaghan makes, his own aide-memoire, it
7 looks as if it is, of him attending the Coroner's Court:

8 "Generally, the outcome was satisfactory with a fair
9 write-up in Friday's Evening Telegraph. Other issues
10 identified which relate to structure and process of
11 paediatric renal transplant services. Agreed with
12 IWC --"

13 I think that's Dr Carson, isn't it?"

14 A. Could be.

15 THE CHAIRMAN: We were told yesterday that it was.

16 MS ANYADIKE-DANES: "-- should deal with this as an RM issue
17 and arrange a seminar."

18 We understand "RM issue" to be a risk management
19 issue.

20 So before that went out, had you formed the view
21 that there were issues which had been identified
22 relating to the structure and process of the Paediatric
23 Renal Transplant Service?

24 A. Well, we knew it wasn't perfect.

25 Q. Well, what were the issues that you think had been

1 identified that related to the structure and process of
2 the Paediatric Renal Transplant Service?

3 A. Well, those sorts of issues had been identified and
4 addressed by reviews of renal services in
5 Northern Ireland, both in 1990 and 1995, and were being
6 attended to.

7 Q. I have a slightly different question. This is something
8 that, as I understand Dr Murnaghan to say, he is taking
9 out of issues that were identified at the inquest.

10 A. He never communicated that to me.

11 THE CHAIRMAN: That seems to be the sense in which the note
12 is written. It's in the context of the inquest and it
13 ends up:

14 "Generally, the outcome was satisfactory. Other
15 issues identified ..."

16 Which, on a reading, suggests other issues
17 identified in connection with the inquest. But that
18 doesn't mean anything to you?

19 A. He never discussed it with me.

20 MS ANYADIKE-DANES: But did you form the view that other
21 issues had been identified "relating to the structure
22 and process of the Paediatric Renal Transplant Service",
23 irrespective of whether Dr Murnaghan mentioned them to
24 you?

25 A. What do you propose the phrase "structures and process"

1 means? Because I'm not quite clear. I assume only
2 Dr Murnaghan knows what he means.

3 Q. So far as you're concerned, did anything come out of the
4 inquest relating to the Paediatric Renal Transplant
5 Service?

6 A. Well, I think -- I mean, I can draw conclusions at this
7 distance. For instance, it was a very young service
8 in the Children's Hospital. We had relatively
9 inexperienced surgeons on call on occasions, as was the
10 case with Adam's transplant. So yes, we needed to look
11 at all that again and, of course, shortly afterwards,
12 a full-time transplant surgeon was appointed, who took
13 a special interest in transplanting children. So there
14 were issues like that, but --

15 Q. What do you think he meant by "a risk management issue"?

16 A. I don't know.

17 Q. Did you think there were risks?

18 A. I didn't think there were risks, no. I thought that
19 Adam's situation was unique. And subsequently, we
20 didn't have any other deaths of any similar nature.

21 Q. I understand that. I have taken you through -- and the
22 reason for doing so is so that I'm in a position to ask
23 you this question. I have taken you through, so far as
24 we have it, all the documentation that relates to the
25 correspondence with you about different people's views

1 and what was going on and meetings.

2 A. Yes.

3 Q. So that's what we understand you to have known, unless
4 you tell us something different. Did you regard that as
5 an investigation into Adam's death?

6 A. Not a full investigation, no.

7 Q. Did you regard that as an adequate attempt to
8 investigate Adam's death?

9 MR FORTUNE: Before that question is answered, is my learned
10 friend saying that the coronial inquiry was not an
11 adequate investigation?

12 THE CHAIRMAN: There are different sorts of investigations,
13 Mr Fortune. So as I understand the answer -- and maybe
14 Professor Savage will clarify this -- you accept that
15 the coroner did fulfil his remit, but that would not
16 necessarily be the extent of the remit which you would
17 want to be followed within the Royal; is that right?

18 A. Well, my understanding within the Royal was that
19 Dr Gaston and Dr Murnaghan would complete their
20 investigation, and if they felt that anything needed to
21 be addressed or investigated further, that that would be
22 set up and perhaps that's what this scribbled note
23 means. But that was not communicated to me.

24 MS ANYADIKE-DANES: I understand that. But I had asked you
25 it in a slightly different way and I think you were

1 helping me with the answer. I think you said that you
2 didn't believe what you knew of what was happening -- or
3 what happened -- constituted a full investigation.

4 A. At this distance, I don't think so. At that time,
5 I took the view that if Dr Gaston and Dr Murnaghan, in
6 their respective positions, were satisfied that that was
7 the process in 1995 --

8 Q. Yes.

9 A. As I've said, I regret that perhaps I didn't think about
10 that outside the box and think, "This isn't quite what
11 we need, we need something further".

12 Q. That was going to be my next question. From the
13 correspondence that we've seen, there would appear to be
14 quite a bit of time taken up with positioning the --
15 well, various positions in relation to the evidence
16 that's going to be given to the inquest, if I can try
17 and put it neutrally in that way, and dealing with
18 slight differences of view.

19 A. Mm.

20 Q. But that is a different process to one which I thought
21 you were alluding to, as to the sort of thing that might
22 have been investigated into in Adam's death in the way
23 that you had written to Debbie Strain in February. If
24 we go back to that letter --

25 A. I remember the letter.

1 Q. Just for the benefit of others.

2 THE CHAIRMAN: Sorry, maybe the way to deal with it is
3 this: when you said a few moments ago:

4 "I regret perhaps I didn't think outside the box and
5 think isn't quite what we need, we need something
6 further."

7 Looking back on it now, what further do you think
8 now that you he needed at the time?

9 A. I have listened to the expert witnesses and I have
10 thought about what the process should be. And,
11 of course, there is a very structured process now for
12 risk management within the Trust. My view is that the
13 first step that I needed to take was to check with
14 Bob Taylor that he understood what had gone wrong and
15 accepted it. And I came to the view, as I've said,
16 particularly after the inquest, that that was the case.

17 I think then there needed to be an independent view
18 taken of that within the Trust. And I believe that
19 Dr Gaston and Dr Murnaghan were undertaking that and had
20 also been satisfied. I think if that was not the case
21 that everyone was satisfied, then you needed to bring in
22 some sort of internal -- sorry, external expert or
23 experts who would review the situation around Adam's
24 death, and if they thought it was necessary to look at
25 the way the transplant service was run, then that might

1 evolve from it.

2 But I think that what did happen, that it wasn't
3 continued on after the coroner's inquest. The coroner
4 made his decision, we accepted it, and things seemed to
5 have ended there. What I'm saying is that, with the eye
6 of hindsight and listening to what experts say -- and
7 of course they're talking in 2012, often from ivory
8 towers -- I can see that what they recommend would have
9 been better and certainly would be something I would do
10 today.

11 THE CHAIRMAN: They weren't really ivory tower experts,
12 professor. The experts were practising. I think it's
13 unfair to say that the inquiry's experts are ivory
14 tower --

15 A. I withdraw that.

16 THE CHAIRMAN: Because they are people -- and one of the
17 reasons we went to them was because they're people who
18 are active in these areas and who -- most of them have
19 been active through this period.

20 A. Mm-hm.

21 THE CHAIRMAN: We specifically say to them: we are not
22 asking you to look back and apply 2012 standards; we're
23 asking you what was happening, what were you doing, what
24 might have been done better in 1995. There isn't --
25 I mean, I don't want you to be too defensive about this.

1 There is not a wholesale attack on your renal transplant
2 service. Far from it. You should understand from the
3 evidence that has been given to date that there are
4 people who are under far closer scrutiny at this inquiry
5 than you are. I don't want you to take away any
6 different impression. But I think it's unfair to the
7 witnesses and a bit unfair to the inquiry to suggest
8 that we have some sort of ivory tower approach.

9 A. I withdraw that suggestion. It's perhaps overstating
10 the case. But I think if we look at the Bristol
11 inquiry, which has been referred to, to set a standard,
12 the situation in Bristol and in other places was no
13 different to Belfast in 1995.

14 THE CHAIRMAN: Well --

15 A. And there are criticisms obviously.

16 THE CHAIRMAN: There are lots of other places that had lots
17 of problems. Bristol was one, Alder Hey was another.
18 And in different areas, different institutions had
19 different problems.

20 A. I want to say I'm not trying to be defensive. I would
21 prefer that the best was done to investigate any
22 situation in which I was involved.

23 THE CHAIRMAN: Okay.

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

25 What I had just taken you to -- we can pull it up,

1 the second page or the next page of that note. The
2 reference is to RM, we see, and then a seminar. It
3 says:

4 "With Mulholland, Hicks, Gaston, Taylor, Savage,
5 O'Connor, Keane."

6 And we believe that to be, "Ian Carson and
7 Dr Murnaghan present. ASAP". Was there any
8 communication with you about a seminar?

9 A. Not that I remember.

10 Q. If there had been a suggestion, given that you're
11 wanting to keep Adam's mother informed, if there had
12 been a suggestion that the way in which they were going
13 to deal with some of these broader issues was through
14 a seminar, do you think you would have remembered that?

15 A. I think I would.

16 Q. Can you help us with how that would actually work? It's
17 not your document, so you may not be able to help us
18 with it, and maybe a slightly better way of putting
19 it is: if there is going to be some sort of meeting,
20 seminar, conference, call it what you will, afterwards,
21 that is going to explore the wider picture in relation
22 to Adam's death, what would you have thought that should
23 involve?

24 A. Well, I certainly would have thought that it should have
25 involved an examination of the clinical notes.

1 Q. Mm-hm.

2 A. And going through them page by page, and the same with
3 the anaesthetic notes. And I think it would have been
4 wise to have had someone independent doing that and
5 presenting their findings so that they could be further
6 explored. And then -- of course, we were before the
7 days of root cause analysis and so on. But it would be
8 that type of thing that I would have thought would have
9 been useful. I don't know why the word "seminar" is
10 used because it's hardly an appropriate word.

11 THE CHAIRMAN: In terms of an independent expert, there
12 already was one, wasn't there? So you could bring back
13 Dr Sumner and say, "You know the case, you have already
14 given your evidence. Sit down and let's discuss what
15 lessons there are to be learned".

16 A. Mm-hm.

17 MS ANYADIKE-DANES: So that could have happened. And if
18 that had happened, or at least part of that, do you
19 envisage that that would have involved something broader
20 than just the anaesthetists, that there would have been
21 issues there of more general application?

22 A. Well, as you can see, one of the transplant surgeons is
23 in the list and so are the nephrologists.

24 Q. Yes, but that might just be exploring --

25 A. Do you mean --

1 Q. -- the details in the way that you said, "Let's get the
2 medical notes and records and go through them". I meant
3 coming out of that, do you think that coming out of that
4 you would be trying to reach a broader audience, if I
5 can put it that way, for the lessons being learned than
6 simply the anaesthetists?

7 A. Well, I've thought about whether the inappropriate use
8 of fifth normal saline in Adam's case would have
9 informed a much broader audience. I think what people
10 were thinking was that this was a unique operation.
11 I don't think we appreciated that there was a problem
12 with fifth normal saline in general and, as you are
13 aware and the chairman, there is a wealth of medical
14 publications relating to what is the appropriate fluid
15 to use in children, which went on for 20 years after
16 Adam, before fifth normal saline fell into disrepute.
17 Because it was the standard maintenance fluid in those
18 days.

19 Q. It's not so much that element, Professor Savage, that
20 I'm wondering whether you had wanted to tease out.
21 Because if one looks simply at the cause of his cerebral
22 oedema, it was dilutional hyponatraemia and the way that
23 developed was through providing too much low-sodium
24 fluid too quickly. Irrespective of exactly how that had
25 happened, that was, so far as Dr Sumner thought, so far

1 as Dr Armour thought, and so far as you concluded. And
2 for that matter, Dr Alexander. That was the mechanism
3 for the development of Adam's cerebral oedema. So that
4 particular situation could happen in any number of
5 circumstances. For example, what Dr Armour took out of
6 that is that she had not appreciated that that kind of
7 condition could develop while surgery was ongoing and
8 she said in her evidence that's why she published the
9 paper for other pathologists, to alert them to that. So
10 she has a solution broader than just Solution No. 18 and
11 paediatric anaesthetists.

12 So what I'm exploring with you is -- and you being
13 another paediatric discipline -- did it occur to you
14 that, if we were going to have a symposium, seminar,
15 whatever it is, where we look at these things, that we
16 could look at them more broadly and see what lessons
17 could be imparted to others about that issue: that
18 giving too much of that type of fluid could produce
19 fatal results and relatively quickly?

20 A. It obviously did exercise my mind. And as you know,
21 I did subsequently write to the Nephrology Association,
22 the British Paediatric Nephrology Association and
23 communicated with the transplant service to explore
24 whether, in fact, this was a problem that had been seen
25 elsewhere, and you've seen the references that I had

1 that someone had said to me "I think there are other
2 cases like that".

3 Q. Was it Mr Postlethwaite?

4 A. Yes. Then there was an audit carried out and published,
5 but they were unable to determine whether the deaths
6 from overhydration were actually due to hyponatraemia.
7 I certainly alerted the national nephrology
8 professionals and, indeed, of course, Adam's death had
9 such an impact on me that any meeting I went to, I was
10 talking to people and asking: have you seen this before,
11 it was a terrible tragedy in our unit.

12 Q. That's actually the very -- you're making the very
13 point. You see, Dr Armour had thought: there's
14 something in here for those in my discipline, if I can
15 put it that way. You had thought the same thing. The
16 Trust seems to have thought that about anaesthetists,
17 but it didn't travel very far, if I can put it that way.
18 But what I'm trying to get at is: if people are thinking
19 that it has these other aspects to it that have learning
20 points for others, did it not occur to you that we
21 might, in a concerted way, try and get out the lessons
22 more systematically from Adam's death?

23 A. No, it didn't because it was one case, it was one
24 situation, and I think that's probably what influenced
25 my thinking. However, it's interesting that when

1 I subsequently met with Mr Koffman who was carrying out
2 a transplant for us at Great Ormond Street, he was able
3 to tell me about the case that they'd had, and
4 subsequently because of our discussion, they published
5 that case. And certainly I thought afterwards that's
6 something I could have done, I could have published the
7 case in a paediatric journal and alerted other people to
8 the fact that it had happened and that might have
9 stimulated other people to think, "That has happened to
10 us", and it would have helped the momentum of the
11 situation. That did develop in the paediatric
12 literature, where there was increasing questioning of
13 the use of fifth normal saline, until the point when it
14 was removed from normal use.

15 Q. I was going to ask you about that. You published in the
16 Ulster Medical Journal in 2000, a piece that dealt
17 with -- I think it's from 1984 to 1998, I believe, was
18 the span of years.

19 A. Yes.

20 Q. And you did identify in that article that there had been
21 two fatalities.

22 A. Yes.

23 Q. One was Adam and one was another death that you
24 identified. Just while we're at it, when did that child
25 die?

1 A. Some time before, but that child died from respiratory
2 complications.

3 Q. I understand that, but shortly after or during a renal
4 transplant?

5 A. Oh no, after renal transplant.

6 Q. And for a point of comparison, was there any
7 investigation into that child's death?

8 A. No. We knew the cause of that child's death.

9 Q. I understand. But the point that I'm making is, you did
10 actually publish and, although you don't refer to him by
11 name, you refer to his case --

12 A. Yes.

13 Q. -- but you don't develop anything out of his case
14 in that paper.

15 A. No.

16 Q. Is there a reason for that?

17 A. I think we were just looking overall to see if our
18 results in Belfast were comparable to other national
19 units.

20 Q. Yes, that's what the paper was addressing.

21 A. Exactly.

22 Q. What I meant was: was there a reason why you didn't
23 publish in relation to Adam's case?

24 A. We didn't mention any specific cases in it. We were
25 looking at how our unit was able to perform and compare

1 it with places like Great Ormond Street or Manchester or
2 Glasgow. It is part of that audit that you look and
3 say: are we doing as well or better than other people?

4 Q. I apologise, Professor Savage, I think I have not made
5 myself clear. I know that's what the paper was about,
6 I've read the paper. What I'm asking you is: since you
7 were publishing, did you not think that you could,
8 in the same way as Dr Armour thought, publish about this
9 case?

10 A. No, I didn't.

11 Q. Why not?

12 A. I don't know. Perhaps I didn't have time. Perhaps it
13 didn't occur to me. Perhaps -- I mean, I didn't do it.
14 I could have done it, and as I say, Mr Koffman did with
15 their case, and at that time I thought perhaps that's
16 what we should have done with Adam.

17 Q. Yes, thank you. Can I pull up the evidence to this
18 inquiry by the coroner? Witness statement 091/1, page
19 2. The coroner is being asked in the second question
20 the details of the mechanism he believed was in place in
21 1995 for the dissemination of expert opinions that he
22 obtained for his assistance at inquest to the medical
23 profession. And he says he didn't think there were any.

24 And there was a discussion at the inquest as to how
25 the views of Dr Sumner could be disseminated amongst the

1 medical profession in Northern Ireland. The consensus
2 was that there was no effective means of doing so, other
3 through the medical literature.

4 A. Mm.

5 Q. And Dr Sumner mentioned that he was the editor of the
6 Journal of Paediatric Anaesthesia and he was going to
7 try and arrange for Professor Arieff to write an
8 editorial.

9 So it's at that stage it would appear that
10 the coroner is being told: the only really effective way
11 of doing that is for publications. Then that was an
12 avenue that was open to you and that's, in a way, why
13 I'm really asking why you didn't do it.

14 A. If I remember the sequence of events with Dr Sumner, he
15 wrote to Mr Leckey to say: as a matter of interest and
16 by coincidence, I have had a paper submitted to me
17 in relation to hyponatraemia and because of that paper,
18 I'm going to ask Arieff to also write an editorial.
19 Because this was the developing view within the
20 paediatric community that maybe fifth normal saline was
21 not as safe as it might be. But of course, publishing
22 one case isn't always accepted by a journal. So it is
23 possible that I could have written the case and
24 submitted it, yes, but I didn't do so.

25 Q. That's all that I wanted --

1 A. But I was aware, of course, that Sumner had done that in
2 the journal of anaesthesia.

3 Q. And we have seen that. It's not clear that it's
4 entirely dealing with the situation that you had here
5 with Adam. But in any event, publishing in the Ulster
6 Medical Journal might have been a more direct way of
7 getting it to your colleagues.

8 A. It might have been.

9 Q. Yes. And then he goes over the page, witness statement
10 091/1, page 3:

11 "I had assumed that the Royal Belfast Hospital for
12 Sick Children would have circulated other hospitals in
13 Northern Ireland with details of the evidence given at
14 the inquest and, possibly, some best practice
15 guidelines. Children are not always treated in
16 a paediatric unit and, in the event of surgery, the
17 anaesthetist may not be a paediatric anaesthetist."

18 It seems that the coroner is taking the point
19 in relation to Arieff's paper, really, which is that
20 there's more to this than the problem of dilutional
21 hyponatraemia. Whichever mechanism that leads to it,
22 there's more to that than major paediatric surgery. And
23 in any event, there's other surgery taking place in the
24 rest of Northern Ireland.

25 So what he's suggesting is that the Trust could

1 have, or the Children's Hospital could have, done that.
2 Was there any suggestion that you were aware of at the
3 time that the Children's Hospital could have done that
4 to have alerted other paediatricians or other
5 anaesthetists, for that matter?

6 A. Well, if you take the Arieff paper, I think the most
7 significant thing in that paper is that the children
8 identified in it were children who were having minor
9 surgery.

10 Q. Exactly.

11 A. Therefore I accept what he's saying, that it would have
12 been beneficial to have circulated that to any
13 anaesthetist in Northern Ireland who was carrying out
14 any form of anaesthesia in children and drawing their
15 attention to Arieff's paper, yes. But I don't know that
16 there was a mechanism to do that. And it would not have
17 been my responsibility; that was for the anaesthetist to
18 do.

19 Q. I am not suggesting it was your responsibility. The
20 question I asked you is: were you aware if there was
21 there any discussion that that might happen?

22 A. Not that I know of. Subsequently, of course, there were
23 working parties that were set up to develop the
24 guidelines on fifth normal saline, and I think
25 Northern Ireland led the way on that.

1 Q. Yes, that's a slightly different point and that's after
2 other children had died.

3 A. Yes.

4 Q. The purpose of communicating lessons learned is perhaps
5 to try and avoid that.

6 A. Exactly, and hopefully it has avoided that and has
7 avoided it across the United Kingdom and the world.

8 Q. Can I take you back to something that you answered to
9 the Chairman, which is when you were trying to explain
10 why you reached the view or had the view that Dr Taylor
11 had accepted the coroner's verdict. I think you
12 referred to the fact that he said that he was teaching
13 out of a textbook, so the conventional teaching, if I
14 can put it that way. And you also said that he had
15 changed his practice. Did you know that at the time?

16 A. No.

17 Q. So that wouldn't have helped reassure you that he was
18 accepting the verdict at that time?

19 A. No.

20 Q. Thank you. I would like to move on to something
21 slightly different in terms of the education.
22 If we just pull up your CV, you have a quite onerous --
23 I don't say that in the sense that you regard them as
24 being a burden -- teaching responsibilities. If we move
25 on through, if we look, we can see that you became

1 a professor at the university in June 1990.

2 A. Mm-hm.

3 Q. And then, in 1997, you became assistant director for
4 medical education. And then, in 2001, you're director
5 for medical education at the university. Can I ask you
6 how --

7 A. I think I may have become a professor in 1996, actually.

8 Q. I think you did correct it before when we showed that.
9 Yes, I beg your pardon. Can I ask you how the
10 connection at an organisational level worked between
11 those at the Trust who were going to provide training
12 and the university, where the students were? How did
13 that work exactly?

14 A. In 1995?

15 Q. In 1995. I appreciate it has changed significantly, but
16 in 1995, how did it work?

17 A. The university has responsibility for undergraduate
18 education --

19 Q. Yes.

20 A. -- and to produce safe and competent doctors.

21 Q. Yes.

22 A. They are then provisionally registered so that they can
23 practice for one year and continue their education as
24 pre-registration house officers in 1995. There's now
25 what's called the foundation programme, which is two

1 years. The responsibility for the education of those
2 pre-registration doctors was shared between the
3 university medical school and the postgraduate deanery,
4 or I think it was the Northern Ireland Postgraduate
5 Medical Council then. They took the responsibility
6 primarily for that educational year and it was devolved
7 to them by the university. There are no
8 pre-registration doctors who work in paediatrics.

9 Q. Okay.

10 A. So the university, in terms of paediatrics, didn't have
11 any role in the education of pre-registration doctors in
12 paediatrics. People did paediatrics and still do after
13 their pre-registration year --

14 Q. Yes.

15 A. -- or after the foundation programme now.

16 Q. And in terms of how that was actually managed, there was
17 a pre-registration committee, wasn't there, which
18 included the Dean of Medicine, the Postgraduate Dean or
19 professors of medicine and surgery? And that
20 pre-registration committee -- correct me if I'm wrong --
21 included the approval of the hospitals that were going
22 to participate in providing that training --

23 A. Yes.

24 Q. -- monitoring the attachments and the appointment of the
25 clinicians who were going to act as the educational

1 supervisors; is that right?

2 A. Yes, for the pre-registration year.

3 Q. And on the Trust side, though, that had an educational
4 supervisor subcommittee. And did that subcommittee
5 report to the Pre-registration Committee?

6 A. I think there were members of -- each Trust would have
7 had a member on the Pre-registration Committee. I mean,
8 I don't actually know the exact structure, but it was
9 that type of structure.

10 Q. Okay. So if we can confine ourselves now to the Trust
11 side because it is going to organise the appropriate
12 training in that pre-registration year, and I presume
13 there's a formal link. Is there a contract or an
14 agreement as to what they have to provide to the
15 university?

16 A. I don't know what the situation was in 1995.

17 Q. I understand.

18 A. Today, there is a very clear structure with postgraduate
19 sub-deaneries, who relate directly to the university --

20 Q. Okay.

21 A. -- and they're related to the major trusts in
22 Northern Ireland.

23 Q. But in 1995, Dr Taylor was on the education subcommittee
24 of ATICS.

25 A. Mm.

1 Q. Was there an education subcommittee for paediatrics?

2 A. Yes.

3 Q. So on the Trust side, you had these subcommittees of the
4 various -- are they the rotations that the trainees in
5 their pre-registration year would go round?

6 A. I'm not sure what --

7 Q. I'm trying to see what the set-up is at the moment.

8 A. I'm trying to say to you that I had no involvement in
9 the pre-registration year --

10 Q. Ah, I understand.

11 A. Because the university had no involvement in the
12 pre-registration year.

13 Q. So your only link is to do with the undergraduate year?

14 A. Yes.

15 Q. Did the university have somebody like you who was
16 overseeing, if I can put it that way, the
17 pre-registration year?

18 A. The pre-registration year where?

19 Q. Well, as we understand it, the trainees are coming to
20 the hospital and they are going through their rotations.

21 A. Yes.

22 Q. There are subcommittees for each of those rotations.

23 A. Yes.

24 Q. There are people who will sit on that. I presume that
25 the clinicians who are providing that training are

1 discussing how the trainees are managing, whether
2 they're keeping up, whether they're not. That sort of
3 business, if you like. All to deliver an appropriate
4 pre-registration training. And all I'm asking is: did
5 the Trust have somebody higher up above those individual
6 subcommittees that was managing that process so far as
7 you were aware?

8 A. I think so, yes. I think the Royal Trust had an
9 education committee and probably a director.

10 Q. And a director of that?

11 A. Yes.

12 Q. Thank you.

13 A. But I want to go back and emphasise that that had no
14 relationship to paediatrics or to the Children's
15 Hospital.

16 Q. What do you mean, it had no relationship to paediatrics?

17 A. Because we did not have any pre-registration doctors in
18 paediatrics.

19 Q. Okay.

20 A. It's a post-registration training. Sorry, am I not
21 making myself clear?

22 Q. I didn't understand you at that point in relation to
23 that, no.

24 A. There are no pre-registration doctors in 1995
25 undertaking jobs in paediatrics.

1 Q. Okay. So if they were being trained, they were being
2 trained in their post-registration year?

3 A. Yes.

4 Q. And who was involved in that?

5 A. That was the postgraduate deanery.

6 Q. And who, on the side of the Trust, would be managing the
7 delivery of that training; is it the same education
8 committee?

9 A. No, the deanery has a paediatric education subcommittee
10 or, as it was in those days, I think, the
11 Northern Ireland Postgraduate Medical Council, which
12 eventually became the deanery.

13 Q. And if one wanted to introduce clinical-based learning,
14 how would that happen at either the pre-registration or
15 the post-registration level?

16 A. That decision would have to be taken by those training
17 committees.

18 Q. Sorry?

19 A. That decision would be taken by the training committees.

20 Q. Yes.

21 A. And the requirements for training in paediatrics or
22 surgery or whatever are laid down by the deanery and by
23 the Royal colleges.

24 Q. We know ultimately, for example, that the hyponatraemia
25 guidelines became something that was taught about and

1 trained about.

2 A. Yes.

3 Q. So that did find its way into that process. Short of
4 having a guideline issued by the Chief Medical Officer,
5 is there a way in which the learning that comes out of
6 clinical experience can be channelled through?

7 A. I can only comment on the undergraduate curriculum.

8 Q. I understand that.

9 A. There is no formal method or has not been, whereby the
10 findings, for instance, of a coroner reach the medical
11 school. However, in the case of hyponatraemia, and
12 indeed other cases related to electrolyte problems such
13 as hyperkalaemia, which can also result in fatality, the
14 medical school would pick up on those things and, if
15 necessary, include them in the undergraduate curriculum
16 and they have done that with the hyponatraemia issue.
17 Every medical student has to take the online training
18 that's provided by the British Medical Journal and
19 produce a certificate that they have completed it as
20 well as having core training in managing electrolytes in
21 children.

22 Q. I understand that, Professor Savage, but that's now and
23 not then. In 1995, if you had wanted to do something
24 like that, what would be the mechanism for getting those
25 case studies, effectively, and the learning out of that,

1 into the education and training?

2 A. Well, the undergraduate curriculum is laid down by the
3 GMC in a series of documents called "Tomorrow's
4 Doctors". So they define what should be core medical
5 training to make safe and competent doctors. They do
6 not define that you should have extensive training in
7 intravenous management of children because that is
8 a postgraduate training issue. Nevertheless, medical
9 schools have the freedom to include in their curriculum
10 any issue which they think is pertinent in the local
11 situation. So if for instance you lived in a city where
12 there was a high incidence of tuberculosis, that medical
13 school would probably have considerable emphasis on
14 that, and in Belfast, because of our concerns about
15 hyponatraemia, that has been included in the
16 undergraduate curriculum here.

17 Q. I understand that because you explained that before.
18 But what is the mechanism of doing that? Is it
19 something that the clinicians who also teach, if I can
20 put it that way, could bring to any of these meetings
21 and say, "Look, this is a very interesting situation
22 we have here, we think we could use it as a teaching
23 example", is that how it would work?

24 A. I don't think we would particularly use it -- we're
25 teaching principles of management, not --

1 Q. Yes, but it's --

2 A. -- examples. You have seen the teaching material --

3 Q. Yes, I have.

4 A. -- that's used and it doesn't specify particular cases.

5 It gives you a range of cases where there are

6 electrolyte disturbances in children and asks the

7 students: how would you cope with this, what would the

8 treatment be? And then it gives you the correct answer.

9 So that's part of the core teaching in paediatrics. And

10 even in 1995 -- and I think you have the outline

11 curriculum from then -- it does list electrolyte

12 management in children as being part of what they should

13 learn, the basic principles --

14 Q. I understand that. The only point I was trying to get

15 at is: if you wanted to get --

16 THE CHAIRMAN: Sorry, you have to let him finish his

17 answers. It's a number of times, he has been finishing

18 answers, and you say interrupt and say, "I understand

19 that". The professor has to finish.

20 MS ANYADIKE-DANES: I'm sorry, Mr Chairman, it's because

21 I don't think I'm communicating the question that I'm

22 inviting the professor to answer.

23 THE CHAIRMAN: It doesn't help me to cut off his answer

24 then.

25 MS ANYADIKE-DANES: I apologise, professor.

1 What I'm --

2 A. The mechanism?

3 MS ANYADIKE-DANES: Yes. That is what I had meant. You had
4 given the example that, in relation to the hyponatraemia
5 guidelines, they did become part of teaching. So what
6 I'm trying to ascertain is: how does that happen?

7 A. It happens within the university that, if they feel
8 there is an issue that's relevant to medicine in general
9 or to a local situation, then the education committee of
10 the university would decide that that was going to
11 become part of the core teaching. So in paediatrics,
12 the core teaching is run by the Department of Child
13 Health. And following Adam Strain's death, and
14 following the investigation and production of guidelines
15 for hyponatraemia, the Department of Child Health then
16 acted to -- in fact, they had acted in advance of the
17 instructions from the Patient Safety Agency to put that
18 into undergraduate teaching, despite the fact that it's
19 not a requirement of the GMC.

20 Q. Thank you. So there was a mechanism for doing that?

21 A. Yes.

22 Q. Thank you very much indeed. I'm sorry to cut you off;
23 I'm always so conscious of the time that we have
24 available, and if I don't correctly communicate my
25 question, I then become a little concerned that there

1 will not be sufficient time to address the points that
2 I really do want to cover with you. So I apologise for
3 cutting you off. It doesn't mean that I'm not
4 interested in what you have to say.

5 A. I'll try and make my answers shorter.

6 Q. No, I will try and be clearer about what I want you to
7 answer. If I move then to the point about how the
8 Paediatric Renal Transplant Service came from Belfast
9 City Hospital to the Children's Hospital. You did give,
10 in your evidence, as to why you wanted that to happen.
11 If young children -- which is what you wanted to
12 happen -- were to have the opportunity to be
13 transplanted, then for that to happen in an adult
14 hospital was inappropriate. And it was appropriate for
15 them to be brought over to a children's hospital
16 setting, is what I understood your evidence to be.

17 A. Yes.

18 Q. And that what you wanted was to be having children
19 transplanted who were of the age of Adam and maybe even
20 younger. In fact, I think the first transplant that
21 happened in the Children's Hospital was in 1990 --

22 A. Yes.

23 Q. -- when there were two. And I think there were there
24 was one in each of the next years and then you had
25 Adam's year of 1995 when actually there were three: one

1 in September and two in November, including Adam's.
2 What I want to ask you is: when you wanted to extend the
3 service to make it available for children of that age
4 and therefore wanted to bring it to the Children's
5 Hospital, what actually had to happen from an
6 organisational point of view to enable that to take
7 place?

8 A. Well, I think you have been provided with the Renal
9 Services Review 2002.

10 Q. Yes.

11 A. There are renal services reviews that take place
12 regularly, so this one is 1995. There was one in 1990
13 and one prior to that. In the 1995 one, it makes the
14 point that it has been shown that death rates are lower
15 and graft survival better when children are treated in
16 paediatric units. The conclusion of that report is that
17 a paediatric nephrology unit at RBHSC should be
18 developed as the regional paediatric nephrology unit for
19 Northern Ireland with nephrology beds and
20 a haemodialysis facility and funding for
21 multidisciplinary team, special provision for
22 adolescents, et cetera.

23 So essentially, the Department of Health are the
24 people who review the renal services and the needs of
25 children and they take evidence and then say, "This is

1 what should happen and this is what we will fund".

2 Q. Then what actually happened from those two trusts to

3 make that possible? That's what the Department of

4 Health wants, that's what it perceives as the

5 community's need, if I can put it that way. What then

6 happened between those two trusts for that service to be

7 brought to the Children's Hospital?

8 A. Initially, as you know, the transplant and dialysis

9 service was developed in co-operation with the adult

10 service --

11 Q. Yes.

12 A. -- because it was an enormously successful and

13 innovative service. And it was led by Professor

14 Mary McGeown. So when I started developing

15 a service in Northern Ireland, I worked very closely

16 with her and with the team there. And we started doing

17 the transplants in the older children, we started

18 developing home dialysis for the children, which wasn't

19 available for adults at that time. Until we got to the

20 point where we needed some children to have

21 haemodialysis, which was very stressful for the adult

22 nurses, they weren't used to coping with children who

23 would get a bit distressed. And also, we now had

24 smaller children who did not fit well into an adult

25 environment.

1 So the budget was there for the renal service for
2 Northern Ireland, we then proposed moving gradually the
3 service for children to the Belfast Children's Hospital
4 and, as that was done, the finance followed the patients
5 so that money moved within the renal budget from the
6 adult service because the children's costs were
7 obviously included in that move to the Children's
8 Hospital.

9 This report and subsequent reports then said what
10 needed to be developed and what they would fund and how
11 many nurses they would fund, psychologists, how many
12 paediatric nephrologists. For instance, this one says
13 that the previous report had agreed there should be
14 a second nephrologist. It points out that person is
15 about to be appointed, but also recommends that a third
16 one will be appointed. So that's the general mechanism
17 of how it developed.

18 Q. And those are the resources that the department is going
19 to make available --

20 A. Yes.

21 Q. -- and that's its vision, if I can put it that way, for
22 how the service ought to develop. And from the Trust's
23 point of view -- and this is the Royal Hospital Trusts'
24 point of view -- what structures did they put in place,
25 to, if I can put it this way, monitor and develop

1 what was a fledgling service that was coming over? It
2 was something that you were starting, in terms of the
3 very young children, from scratch.

4 A. Yes.

5 Q. So what did the Trust do to put in place the appropriate
6 structures to assist the development of the service for
7 you and for the children?

8 A. Well, they had appointed me obviously.

9 Q. Yes.

10 A. They then appointed renal nurse specialists, they
11 appointed a part-time psychologist, and renal dietician
12 and a social worker with a special interest in the needs
13 of children who were on dialysis, so they set up that
14 structure. They also developed an annex to the major
15 paediatric medical ward where we could carry out
16 haemodialysis, and they also developed an area in the
17 intensive care unit where haemodialysis could also be
18 developed and provided the expensive machinery and
19 infrastructure needed. Because if you're doing
20 dialysis, you have to have special water plants and all
21 sorts of things like that. But in terms of them
22 monitoring the success and safety of the programme, that
23 would have been left to the clinicians involved,
24 reporting as the lead clinician in that area, to the
25 director of paediatrics, who would report further up

1 through to eventually the chief executive in --

2 Q. So that was you --

3 A. Yes.

4 Q. -- reporting to Dr Mulholland, essentially?

5 A. Mm.

6 Q. Was he the person that you had to report to?

7 A. Yes. He was my immediate line manager, I suppose you

8 would say.

9 Q. And when you performed a transplant, did you use that as

10 an opportunity to see how well all these structures

11 worked, and so carry out your own mini review of each

12 one, because they don't happen very often?

13 A. Yes, of course. And as you know, we have a Tuesday

14 morning meeting where we review every patient on

15 dialysis, every patient waiting for a transplant, every

16 patient who has been transplanted. I don't review them

17 all each day, but related to outpatient visits and so

18 on.

19 Q. And leaving aside the investigation into Adam's death

20 that you envisaged the Trust might carry out, did you,

21 after that, look at it from the point of view of: what

22 are the lessons that we learned and what do we take from

23 this in terms of this paediatric transplant service?

24 A. Yes, of course we did. As you know, we completely

25 rewrote the protocol to try and make it as safe as

1 possible.

2 Q. Yes. Sorry, if I might just pause there.

3 MR FORTUNE: No, in fairness to the professor, he's trying
4 to answer the question. Unless, sir, you intervene and
5 say this isn't, in fact, going to be an answer to the
6 question, he must be allowed an opportunity.

7 MS ANYADIKE-DANES: Mr Fortune, he had just literally
8 touched on something that I wanted to direct him as to
9 how I would like him to expand before he goes on to the
10 next point. That is all. Of course I want --

11 THE CHAIRMAN: I'm sorry. When the witness starts to answer
12 a question in the way which seems to the witness to be
13 appropriate, he should be allowed to give the answer,
14 and if you want then to develop that answer, because it
15 touches on to another area, then that's what happens.

16 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
17 Sorry, Professor Savage.

18 THE CHAIRMAN: You were about to say that you completely
19 rewrote the protocol to try and make it as safe as
20 possible.

21 A. Yes, and I think I have answered in the written
22 statements what the key changes were.

23 THE CHAIRMAN: And Dr O'Connor gave evidence about this as
24 well.

25 A. So that was one thing we did. We also reviewed --

1 I certainly reviewed my approach to the transplants and,
2 for instance, the involvement of surgeons so that,
3 subsequent to Adam's death, we tried to make sure that
4 prior to anyone being called for a transplant, the child
5 and the family had met with the surgeon. And that was
6 greatly facilitated by the appointment of
7 Mr John Connolly, the transplant surgeon.

8 We also would have drawn up then a draft plan for
9 any transplant that was likely to happen in the near
10 future so that was it was in the notes. And finally, on
11 day of the transplant, rather than just having the new
12 transplant protocol in the notes, we would have written
13 an individualised transplant plan in the clinical notes
14 in much more detail than we had ever done before. Does
15 that answer your question to some extent?

16 MS ANYADIKE-DANES: I think it does.

17 Can then I go back to the protocol? I think
18 Dr O'Connor had given evidence to the effect that,
19 actually, you had started to use a bit of the Bristol
20 protocol, even before Adam's -- well, actually as part
21 of Adam's surgery. Because the immunosuppressant
22 medication came from that protocol. So I think what she
23 was indicating is that you were already starting to look
24 at the protocol and the extent to which it might be
25 revised. Would that be fair?

1 A. Well, yes, and I think what she was mainly referring to
2 was that at some time in 1984 or 1985, we were changing
3 from using hydrocortisone to using methylprednisolone
4 intravenously as one of the immunosuppressants. And
5 that certainly was what had become the practice in
6 Bristol. If you remember, they had just rewritten their
7 protocol a few months before.

8 Q. Yes.

9 A. So their protocol was extremely up-to-date. We've
10 already discussed whether it was a protocol or
11 a guideline, but certainly it was a guideline and,
12 if we thought there was an improvement, we would start
13 doing that without necessarily rewriting the entire
14 protocol.

15 Q. Yes.

16 A. But every few years, we would revise the entire protocol
17 and make sure it was best practice.

18 Q. That's where I was getting to. When Mr Koffman gave
19 evidence, he said that he thought that, nevertheless,
20 the 1996 protocol -- which is how it finally emerged,
21 in September 1996 -- could have addressed more the issue
22 of the intraoperative fluids, so the fluids actually
23 being administered during the course of the operation.

24 Did you accept that?

25 A. Well, I'll tell you what I thought about that was that

1 we had looked at his protocol and taken advice from it.
2 So I think his protocol was the same as the 1996
3 protocol and I believe that was what he actually
4 implied: that he could have improved his local protocol
5 to have more stringent statements about intravenous
6 fluids.

7 Q. Yes, I appreciate that. The point that I was getting at
8 is that, actually, it's the intraoperative fluids that
9 have gone awry, if I can put it that way, in Adam's
10 fluid management. So as a direct consequence of Adam's
11 case, did you think about how that might be better
12 addressed, if I can put it that way? There's always an
13 endless development of one's guidelines, as you keep
14 them up-to-date, but did you think about how that might
15 be addressed?

16 A. Yes, we did, and if you remember, there was no mention
17 in the 1990 protocol of fifth normal saline and
18 dextrose. It mentions half normal saline and dextrose.
19 We were more explicit in the 1996 protocol that fluid
20 replacements should be Hartmann's, normal saline or
21 blood, and that the standard intravenous fluid for
22 a renal transplant patient should be half normal saline
23 and dextrose. And it should also be moderated
24 post-operatively based on urine electrolytes, which was
25 one of the other things that we learned from Adam's

1 case, that you needed a closer grip on the electrolyte
2 content of urine to help decide which fluids you give.

3 Q. That was what I was getting at. The mechanism, though,
4 for updating your protocols -- I think you have
5 sometimes said they were a guidance or an aide-memoire
6 or something of that sort. The mechanism for doing
7 that -- I had understood from the evidence that both you
8 and Dr O'Connor gave that it was something that you and
9 she discussed. Did it occur to you that you might
10 involve another discipline? For example, the
11 anaesthetists?

12 A. I don't think so, no.

13 Q. The one that she brought over from Bristol also featured
14 a consultant paediatric anaesthetist.

15 A. Mm.

16 Q. Is there a reason why you thought, particularly after
17 Adam's case, that might not be helpful?

18 A. I don't know the answer to that, except that the -- as
19 you say, the protocol from Bristol, which was probably
20 the starting point for our new protocol, had had the
21 advice of an experienced anaesthetist doing renal
22 transplants in a much bigger centre.

23 THE CHAIRMAN: Therefore, if you were adapting or updating
24 the Royal protocol and you had the Bristol one, which
25 had the imprimatur of an anaesthetist, the need for you

1 to go to your own in-house anaesthetist was maybe a bit
2 more limited?

3 A. It was a bit more limited, but I accept that it might
4 have been best to involve the anaesthetists so that they
5 owned the protocol as much as we did.

6 MS ANYADIKE-DANES: That's where I was going with that.

7 You have, in fact, revised them on successive occasions.

8 A. Yes.

9 Q. When you do that now, who is involved in that process?

10 A. Usually, the paediatric nephrologists, but we would
11 discuss the immunosuppression with the surgeons and
12 we would probably discuss the intraoperative things with
13 the anaesthetist as well. But we don't all sit down
14 together and do it. What would happen is that -- in
15 fact, the most recent one as drawn up by Dr McKeever(?),
16 I think, one of the newer paediatric nephrologists.
17 It's often useful to have someone who has just come from
18 a big centre back to Northern Ireland, so we get them to
19 draw up a protocol and then we sit down and circulate it
20 and refine it until we've one that seems to be the best
21 we can manage.

22 Q. So the process, as it has evolved now, is actually to
23 take the benefit of a multidisciplinary approach?

24 A. Yes. And I think, as the Trust has developed its
25 management of protocols, once you have a protocol like

1 that -- now I've retired, of course, or in the near
2 future -- will have to go to a committee that looks at
3 it independently and decides that, yes, they put their
4 stamp on it as well. And we put it online, that's the
5 other thing.

6 Q. You said Mr Connelly was appointed and he is now the
7 transplant surgeon?

8 A. Yes.

9 Q. When was he appointed?

10 A. I can't remember.

11 Q. I suppose we can discern it roughly.

12 A. Late 1990s, I think.

13 Q. Was he appointed as just the gradual evolution of the
14 service or because there was an appreciation that it had
15 been perhaps unsatisfactory not to have a dedicated
16 transplant surgeon for the service?

17 A. I think it's fair to say that we believed that having
18 a dedicated transplant surgeon with that specific skill
19 was much better than having urologists who also did
20 transplants. And of course, we have more than one
21 transplant surgeon now. We have a team of transplant
22 surgeons, but they are hard come by.

23 THE CHAIRMAN: How many nephrologists are there now?

24 A. In Children's? Three.

25 THE CHAIRMAN: You eventually got the three and then when

1 you retired, you were replaced?

2 A. I was replaced.

3 MS ANYADIKE-DANES: I'm sure not!

4 A. They got someone much prettier!

5 Q. I think probably I only have one or two more questions
6 to ask, but something struck me in relation to
7 education. It might be that it's not within the area of
8 the education in the university that you deal with, but
9 you might be able to help with it. It comes out of the
10 Royal's annual report, 1995 to 1996. It is to be found
11 at witness statement 061/2, page 101.

12 Do you have it, Professor Savage?

13 A. Yes, it has just come up this minute.

14 Q. If you can see, up at the top right, it says:

15 "A long-standing close association between the
16 directorate and the Department of Anaesthesia at Queen's
17 University leads to significant anaesthetic research
18 within the Trust."

19 One point I wanted to ask you about: in addition to
20 the publication of papers, which is one way of advancing
21 matters, research is another way.

22 A. Mm.

23 Q. If the things are identified clinically, is there
24 a mechanism whereby research can be done, given the
25 relationship between the Trust and the university?

1 A. Yes. There's money provided from the Department of
2 Health for clinical research.

3 Q. And if you had identified hyponatraemia as something
4 that was worthy of research, how would it be progressed
5 at the university end, which is ultimately where it's
6 done?

7 A. Well, you would have to draw up a research proposal and
8 a hypothesis that you could test. I'm not quite sure
9 how you would do that. You might need to give me half
10 an hour.

11 Q. Is there any thought, given that at some point the issue
12 of hyponatraemia became a very important and significant
13 one in Northern Ireland, so important that the Chief
14 Medical Officer established a special group to develop
15 guidelines, and prior to that, of course, we had
16 Dr Sumner, who came over for all the inquests and all
17 these children bar one, register at times his maybe
18 concern, disappointment, that there wasn't more broadly
19 based knowledge about the condition. For those of you
20 who were in the Children's Hospital -- and all these
21 children, ultimately, died at the Royal -- was there any
22 thought that, leaving aside whatever the CMO might be
23 doing with guidelines, we could be encouraging further
24 research into this at the university?

25 A. I'm sure there was, but we didn't develop any specific

1 proposal. I think it's also fair to say that some of
2 the children who died in the Children's Hospital
3 developed their problems outside the Children's
4 Hospital.

5 THE CHAIRMAN: Yes.

6 MS ANYADIKE-DANES: Oh yes, it's just that the Trust
7 obviously has the knowledge of it, so it's the last
8 place one can see the incidence of it more clearly,
9 perhaps, than anywhere else.

10 A. And I don't think that Dr Sumner has been involved in
11 any research in hyponatraemia, yet he works in Great
12 Ormond Street, which has vastly more facilities.

13 Q. That wasn't actually what I was seeking to explore with
14 you; it was how it could be done if you wanted to do
15 that.

16 A. If there was a proposal, yes, it would be considered and
17 pursued within the university.

18 Q. Then I have one final question for you, and that relates
19 to the relationship between the State Pathology
20 Department and the hospital. Dr Armour had given
21 evidence when I was putting to her the guidelines on
22 autopsy practice, and I had put to her the guidance
23 in relation to intravenous IV lines and devices.
24 206-004-088, but it doesn't need to be pulled up because
25 I am not really taking you to it as a pathologist.

1 I was putting to her that the guidance was that if
2 the patient died with tubes and IV lines and cannulae,
3 et cetera, then the cadaver should come to the mortuary
4 for autopsy with all these medical devices in situ and
5 that nursing staff may wish to remove them prior to
6 transfer, but hospital clinical governance guidelines
7 must make it clear those circumstances where such
8 medical devices must not be removed and specify
9 permissible means of facilitating viewing and preventing
10 dislodgement or leaking.

11 Were you aware of the Trust having established any
12 guidelines of that sort?

13 A. No.

14 Q. Were you aware that the State Pathologist Department
15 actually wanted the lines to be left in, if possible?

16 A. No.

17 Q. Dr Armour had said that -- it's in her evidence on
18 13 June 2012 at page 41 -- the State Pathologist
19 Department did say, "Please can you leave the lines
20 in?", but that didn't always happen. Were you aware of
21 that?

22 A. No. But I believe that when children die in the
23 intensive care unit situation, where they have multiple
24 lines and tubes and so on in place and you're giving
25 that child back to its mother, as happened with Adam and

1 Debbie, and he was sitting on her knee, I would think
2 that the nurses will have thought it would have been
3 inappropriate to have all sorts of tube and things there
4 whilst she grieved.

5 Q. That I understand.

6 A. But I accept that the pathologist might feel that it's
7 important.

8 Q. I think what it says in the guidelines is if they are to
9 be removed in that way, that some facility be made for
10 viewing so the pathologist, should it turn out to be
11 significant, is actually able to see the line before
12 it's then removed. It's not that we don't appreciate
13 why you would want to remove the lines in those
14 circumstances, what I'm seeking to explore with you
15 is: what was the communication between the State
16 Pathologist's Department and the hospitals about that
17 issue so that guidance could be given to the clinicians?

18 A. Well, I mean, you've read me the guidance, but I wasn't
19 particularly aware of that and I don't remember that
20 Dr Armour or indeed any pathologist has ever asked me to
21 leave everything in situ.

22 Q. Sorry, this is the final question now. This is
23 a document that has been referred to before and you've
24 seen, which is the consent, the guidance on consent. It
25 was sent to the Heads of the Trusts on 6 or

1 7 October 1995. And I think, when you gave your
2 evidence, I think you said that you weren't aware of it.

3 A. No.

4 Q. Can you help us with two things then? One, how did you
5 receive notification that new guidance was coming in?
6 What was the mechanism whereby you received it?

7 A. Eventually?

8 Q. Yes.

9 A. I think that was quite clearly cascaded down by the
10 Trust. We would have had e-mails telling us about them,
11 we had samples of the new consent forms circulated and,
12 indeed, I don't know that the very first one was the
13 ultimate one that is in use now, but it is a very -- and
14 it's very similar to the one in that document. So it
15 does list things like asking you to give a list of
16 common complications of a particular procedure and also
17 to identify rare, but serious complications that might
18 exist and so forth. There's a section, for instance,
19 where a child can countersign it if they wish to do so,
20 even if they're not believed to be particularly
21 competent. That's often very useful. Even a 10
22 year-old who knows they have to have their appendix out
23 or whatever can sign it, they're involved in the whole
24 procedure.

25 Q. No, what I meant was, and maybe you have answered it, is

1 routinely when such guidance, guidelines or protocols
2 came over to the Trust, what was the mechanism by which
3 you, the clinicians who were ultimately having to deal
4 with them, received them?

5 A. Well, there would have been -- as I say, those documents
6 would be copied to us, but of course they wouldn't be
7 particularly useful to copy them to you on 5 October
8 1995 if you didn't have new forms produced that you
9 could then use.

10 Q. Exactly.

11 A. They didn't exist.

12 Q. Was there any training around those sorts of things?

13 A. When they eventually came online, yes.

14 Q. There would be training?

15 A. There would be. They would be presented at the clinical
16 meetings that we had once a week. Someone would come
17 along and say, "These are the new consent forms. The
18 other ones are binned. You have to use these and this
19 is the way they're filled in", and go over the whole
20 issue of consent.

21 Q. When you produced anything like your own renal protocol,
22 is that a forum whereby you would introduce: we have
23 a new protocol here, we're going to put it in the
24 department and so on and so forth? Was that the forum
25 for it?

1 A. There's a rolling clinical meeting once a week every
2 week, and each department is given a slot every three
3 months where they can present either clinical cases or
4 advances or whatever at that. And of course, that is
5 a forum where intravenous fluid management of children
6 has been covered on numerous occasions since Adam's
7 death.

8 Q. If you didn't know about the new guidance that came over
9 in October 1995, what was the guidance under which
10 you were taking consent?

11 A. It was probably the guidance I had as a medical student.

12 Q. Well, were you aware of having been issued guidance by
13 the hospital --

14 A. No.

15 Q. -- that this is how we expect patients or their
16 relatives to have matters discussed with them, there was
17 nothing of that sort?

18 A. I think I understood at that time the best person to
19 take consent was the surgeon undertaking the operation.
20 But as I think Dr Coulthard said, obviously a paediatric
21 nephrologist knows the ins and outs of a transplant
22 procedure, therefore you might take consent, but you'd
23 always expect the surgeon to come along and make sure
24 that, from his point of view, the parents understood all
25 the issues that he had identified.

1 Q. No, I understood that, Professor Savage. The point that
2 I was getting at is: these issues are ultimately issues
3 that the Trust has to satisfy itself that the care
4 that's being provided to children and their families is
5 appropriate. So ultimately, these are the Trust's
6 responsibilities, which it will account to the board
7 for, but down at the level of the actual clinicians,
8 what I am trying to find out is what was provided to
9 you, what was communicated to you about these matters.

10 So you have said: well, I certainly hadn't had
11 the October document cascaded down to me. What had the
12 Trust provided to you in relation to how you should take
13 consent or how consent should be taken --

14 A. I don't think the Trust had communicated anything
15 particular to me, but obviously if one was to read GMC
16 guidelines or guidelines from medical defence
17 organisations, you would know the correct way to take
18 consent and what you should inform people in relation to
19 risks and hazards.

20 MS ANYADIKE-DANES: Thank you very much.

21 THE CHAIRMAN: Thank you. Are there any questions?

22 Questions from MR HUNTER

23 MR HUNTER: I have a couple of questions for

24 Professor Savage if I could.

25 The first is in relation to a matter this morning

1 when it was put to him about his attendance at the
2 autopsy and Adam's appearance as to why he didn't
3 explain to Dr Armour how bloated Adam was.

4 THE CHAIRMAN: What do you want to ask, which hasn't been
5 developed?

6 MR HUNTER: I want to ask him that, of course, he had seen
7 Adam immediately after the surgery. And Dr Armour saw
8 Adam about a day-and-a-half later. And during that
9 period, of course Adam had been receiving treatment
10 in relation to that.

11 A. Yes.

12 MR HUNTER: I would like to put to the professor could it be
13 the case --

14 A. That he wasn't as bloated then? I think you are right.
15 Thank you for drawing that to my attention. It is true
16 that Adam continued to pass 1,500 ml of fluid. We
17 restricted his fluid quite dramatically to try and
18 reduce the amount of fluid in his system and we also
19 attempted, with Debbie Strain's help, to do some
20 peritoneal dialysis. So he probably was not quite as
21 bloated by the time Dr Armour saw him as he was
22 immediately post-operatively. You're quite right.

23 Q. Thank you, professor. The second matter, sir, is
24 in relation to Professor Savage's expressed view that he
25 regrets that he didn't push the matter of a fuller

1 investigation with the trust at the time. I would like
2 to ask the professor -- I think you were here when
3 Dr Gaston was giving his evidence?

4 A. Yes.

5 Q. In fact, Dr Gaston had given evidence that at the time
6 he was concerned about Dr Taylor's welfare and that
7 he was concerned to support Dr Taylor. In fact, he used
8 the phrase, "If [they] had lost Dr Taylor, he would have
9 had concerns about the collapse of the paediatric
10 anaesthetic service at that time".

11 I would like to ask the professor that since, on the
12 one hand, the trust had your views about what had
13 happened to Adam and, on the other hand, presumably they
14 had Dr Taylor's views, did you get a perception at all
15 that perhaps other people within the trust may have had
16 other priorities and to some extent that superseded your
17 views? Would that be something you could --

18 A. Well, I mean, I did listen to Dr Gaston saying that.
19 I had completely forgotten that there was any pressure
20 on the anaesthetic service at that time. So no, I don't
21 think I thought that, but I did think the inquiry needed
22 to be pursued and I know that Debbie Strain felt that
23 the anaesthetist involved in Adam's care should be
24 investigated thoroughly, and she did make that point to
25 me on many occasions.

1 Q. Having heard that now, professor, is it possible that
2 the trust may have had other priorities at the time and
3 that's why your views were not picked up more forcibly?
4 THE CHAIRMAN: I think that would require the professor to
5 speculate very much, Mr Hunter. I understand your
6 general point.
7 MR HUNTER: Thank you, sir.
8 THE CHAIRMAN: Any more questions? Mr Lavery?
9 MR LAVERY: May I just make one point, Mr Chairman? It's in
10 response to something that Mr Fortune raised again after
11 the break this morning about the conflict of interest
12 between the Trust solicitor and, mainly, Dr Taylor.
13 Just in response to that, and I do hesitate to make it
14 because I do appreciate Ms Anyadike-Danes is going to
15 come back to this next week and presumably it will be
16 dealt with in the course of Dr Murnaghan's evidence, but
17 I would say that the function of an inquest at that time
18 was to establish who the deceased was, when he died,
19 where he died and how he died. It wasn't the function
20 of the inquest, Mr Chairman, to establish either civil
21 or criminal liability, and in those circumstances
22 the suggestion that Dr Taylor should have been cast
23 aside or any of the other clinicians should have been
24 cast aside and told to seek independent advice would not
25 have arisen.

1 THE CHAIRMAN: Okay. I think that will be something we'll
2 return to. Mr Fortune, do you have any final questions?

3 MR FORTUNE: I remain staggered by that proposition. I have
4 no questions, thank you, sir.

5 THE CHAIRMAN: Professor, thank you very much indeed for
6 coming back again to the inquiry.

7 (The witness withdrew)

8 Ladies and gentlemen, we'll break now. Mr Williams
9 is to give evidence this afternoon and we'll start at
10 2.15. Thank you very much indeed.

11 (1.30 pm)

12 (The Short Adjournment)

13 (2.15 pm)

14 MR NOEL WILLIAMS (called)

15 Questions from MR STEWART

16 MR STEWART: Good afternoon, Mr Williams. I'm informed that
17 you are the Co-director of Information Services for the
18 Belfast Health and Social Care Trust.

19 A. That's right.

20 Q. You have kindly provided us with two witness statements.
21 Can I take it that you are content that they be adopted
22 by the inquiry as your formal evidence?

23 A. Yes.

24 Q. Can I ask for document WS251/1, page 6 to be brought
25 onto the screen before you and if page 7 could also be

1 brought up beside it?

2 I'm told that you've been nominated by the Trust to
3 come and assist us with documentary issues and you set
4 out the context of that in the "General" section at the
5 bottom of page 6. You inform us:

6 "At this time [which I presume is the time of
7 writing], there is no individual employed by the Trust
8 who had responsibility for records management the
9 Children's Hospital in 1995. I am not currently, nor
10 have I ever been, in a role of any organisation or trust
11 where I had responsibility for the management of medical
12 or other records. I have been designated to be
13 a witness to this inquiry because of my senior position
14 as co-director in the directorate of planning and
15 performance, a directorate which has responsibility for
16 records management through the person of the Trust's
17 record manager.

18 "I have been unable to locate any contemporaneous
19 documentary evidence within the Children's Hospital to
20 support any of the questions above and my answers are
21 based on my understanding of current records management
22 practice."

23 It all rather begs the question, first of all, why
24 was the Trust's records manager not nominated? Why were
25 you nominated?

1 A. I suppose when it first -- we were first asked or when
2 my director was first asked to find someone or nominate
3 someone to attend the inquiry, I suppose at that time it
4 wasn't completely clear about what it was that they were
5 expected to answer questions on in detail. And I was
6 asked, because of my senior position, but also because
7 it was felt that I would be able to gather information
8 from various sources and across different disciplines
9 in relation to what was asked. When then the actual
10 areas of questioning became known to us, I began to
11 wonder whether that was a good idea. So therefore,
12 I tried to make it clear in my witness statement the
13 clear limitations of my expertise in this area or my
14 knowledge in this area.

15 Q. I appreciate that you're going to try to do your best to
16 assist.

17 A. Yes.

18 Q. You go on in your statement to say that you have been
19 unable to locate any contemporaneous documentary
20 evidence in the Children's Hospital. Did you mount
21 a search?

22 A. Yes. Well, I asked the current co-director for
23 paediatric services to do so.

24 Q. Yes.

25 A. And what I was asking her to do was locate evidence of

1 how the policies and procedures governing records
2 management at that time in the Children's Hospital were
3 being disseminated, whether they were being audited,
4 whether practice was being audited in relation to that.
5 And she wasn't able to find anything.

6 Q. So no documentary trail whatever?

7 A. No.

8 Q. Were you able to turn up any other documents, dating to
9 1995/96? Minutes, anything else?

10 A. Nothing from that period.

11 Q. What about a search for documents within the Trust
12 itself?

13 A. The Trust is -- unless there was a record or a system in
14 place for documenting what records were in the
15 possession of the Trust and where they were located in
16 a systematic way, looking for records in the Trust is
17 a wee bit like looking for a needle in a haystack,
18 particularly from that period. Several changes of staff
19 and changes of organisational structure have taken
20 place. When I say I couldn't find any records, it's
21 absolutely possible that some records exist, it's just
22 that we couldn't locate any.

23 Q. How many likely places might there be for you to search?

24 A. Well, I mean, the Trust's estate is vast and they could
25 have -- it's not that we could ... We looked obviously

1 in the Children's Hospital, but whenever changes took
2 place and people were moving on, whenever they were
3 starting to archive the records, they could have used
4 any facility in the Trust to find a space to put stuff,
5 or they could have destroyed the stuff, reasoning that
6 it was past the time of when it would be useful.

7 Q. And is the implication of what you say that there's no
8 formalised approach to archiving, no thought-through way
9 of going?

10 A. At this time, there is. But at that time, there were
11 the two circulars from the Department of Health, one of
12 which gives some guidance in relation to non-medical
13 records.

14 Q. Yes. We'll come to those in a moment. Sorry to
15 interrupt you. Apart from those two documents of
16 guidance, when did the Trust become more interested in
17 archiving material on a systematic basis?

18 A. I suppose in 2004, following a period of time when a lot
19 of people appeared to have -- there appears to have been
20 some confusion about the guidance and what pertained.
21 A more comprehensive records management document was
22 introduced by the Department of Health and that was
23 "Good Records, Good Management", and that was published
24 in 2004.

25 Q. I see. That's been the document which has guided the

1 approach since then?

2 A. Yes.

3 Q. Can we have document 305-035-001? This is a letter to
4 the inquiry from the DLS, responding to a number of
5 queries, and at the second paragraph:

6 "I am instructed that, prior to March 2008, no
7 formal policy in relation to records management
8 existed ..."

9 A. Yes.

10 Q. "... apart from the document provided by ..."
11 Can you assist why it took four years to introduce
12 the "Good Management, Good Records" [sic] guidance?

13 A. I can't.

14 THE CHAIRMAN: Do you think that's right from what you know?
15 Do you think there is a four-year gap between the
16 departmental guidance and the Trust's policy being
17 adopted?

18 A. I think there's a possibility that it's not right. My
19 understanding is that it would have -- as soon as the
20 guidance was introduced in 2004, the Trust began to
21 implement the guidance. So that's possibly an error.

22 MR STEWART: Very well. Were you able to find documentary
23 evidence relating to the implementation of the guidance?

24 A. No.

25 Q. In fact, could we go to page 5 of your witness

1 statement, WS251/1, page 5? At 9(a) you inform us:

2 "In 1995/1996 there was no comprehensive governance
3 framework for the management of records within the
4 Health and Social Care Trusts."

5 I ask you about that because was there not, in 1995,
6 in fact, a department, a directorate, within the Trust
7 that dealt with records, amongst other things, patient
8 records? Are you aware of the directorate of
9 development information systems and patient records?

10 A. I'm not.

11 Q. Could I ask for WS061/2, page 91 to be brought up? This
12 is a page taken from the 1995/1696 annual report. You
13 can see there a report of the Royal Hospitals. You can
14 see, listed amongst the non-clinical directorates, the
15 second one, "Development, information systems and
16 patient records, Mr Evan Bates". From that, it would
17 seem that if there's a directorate dealing with that,
18 there must have been a governance framework. Was there
19 any trace of that directorate left?

20 A. I was able to speak to people who were -- our current
21 records manager managed to speak to the person who would
22 have been the records manager in the Royal at that time.
23 She's now retired.

24 Q. Can I ask her name?

25 A. Her name is ... It'll come back to me.

1 Q. When it does, please blurt it out.

2 A. Yes. Ashlyn Carlisle(?).

3 Q. Thank you.

4 A. I suppose if I could compare it with the current
5 governance framework for records management. At this
6 point in time, the records management is part of our
7 controlled assurance framework, which involves, every
8 year, a self-assessment questionnaire against a range of
9 standards. It's completed, it's picked up by internal
10 audit. Internal audit will then visit the departments
11 and test some of the assertions made in the
12 self-assessment and produce a report. There's a score
13 given. That score goes through the controls assurance
14 framework within the Trust, so there's a very systematic
15 approach to that led by internal audit.

16 In 1995, this wasn't the remit of internal audit at
17 that time. They had purely a financial remit. So at
18 that time, there may well have been local efforts made
19 to assure the standards of records management, but
20 I wasn't able to find any documentary evidence as to
21 what that was.

22 Q. I see. Can I ask if we can go to WS061/2, page 116?

23 This a little further on in the same report from
24 1995/1996. This is, in fact, the page of the Corporate
25 Affairs Directorate and Development, Information Systems

1 and Patient Records Directorate, which tells us really
2 not very much about what was going on, but "Patient
3 records", which is the paragraph on the bottom right of
4 the page:

5 "Work in benchmarking patient records services
6 against cross-channel teaching hospitals was started and
7 is likely to lead to further improvements. An improved
8 format for medical charts developed by the
9 multidisciplinary Medical Records Committee is expected
10 to be introduced next year."

11 It would seem, at first blush, from that that there
12 certainly was work in benchmarking patient records
13 services, which would suggest an audit.

14 A. Not formal internal audit. I do agree that -- and
15 certainly the evidence from my conversation with the
16 former medical records manager from that time, who --
17 just to be clear -- didn't have responsibility for
18 children's, but just for the adult Royal.

19 Q. Yes.

20 A. What I'm trying to say is there was activity like that
21 going on, benchmarking local audit activity, the setting
22 of local standards for the availability of records at
23 outpatients, that sort of stuff. But it wasn't
24 a formalised approach and it wasn't as integrated as
25 it is now with the Trust's formal governance

1 arrangements as I understand it.

2 Q. As I understand it, benchmarking is a comparative
3 exercise where data taken from one place is compared on
4 a like-for-like basis with another to see how they are
5 faring against each other.

6 A. Yes.

7 Q. Would it be possible to conduct a benchmarking exercise
8 unless you have an audit of the services, unless you
9 actually have marked them, as it were, against a --

10 A. Of course that's true. All I'm saying is that the audit
11 system of medical records now is a much more formal
12 process and it is quite closely integrated with the
13 general governance arrangements within the Trust. And
14 in fact, reports through to the governance committee of
15 the Trust board.

16 Q. Yes. Have you been able to identify it the successor to
17 this particular directorate? The succession from the
18 Development, Information Systems and Patients Record
19 directorate through to your own department, your own
20 directorate?

21 A. Right. That's quite a torturous development.

22 Q. Perhaps don't take up too much of our Friday afternoon
23 on that torturous development, but in terms of the
24 documentation that's been left, where did that end up?

25 A. I can't answer that question.

1 THE CHAIRMAN: Sorry, can I -- Mr Williams, so you
2 understand what our concern is: as I understand it,
3 if we came to you now looking for 2011 patient records,
4 or other Trust records, it'd be a fairly straightforward
5 task to find those with any luck at all?

6 A. With luck, yes.

7 THE CHAIRMAN: The Trust was formally established in 1993.
8 It had been set up in shadow form before that -- at
9 least from 1992, if not a year or two earlier -- and it
10 looks rather as if this was one of the areas which was
11 identified as being important enough to have its own
12 directorate. And it looks from this report as if, by
13 the standards of the time, some thought was being put
14 into how we are going to look after patient records, and
15 we're going to have to look at them more carefully and
16 in a more coherent way than we have been to date.

17 A. That's right.

18 THE CHAIRMAN: If that's what was happening from about 1992
19 onwards or 1993 onwards formally, it becomes a little
20 difficult for us to understand how patient records
21 just -- some patient records disappear. We have some
22 patient records and we've other records which are
23 missing. Some are more important than others. That's
24 in the patient record side. On the other side, on the
25 governance side, again we have some documents, but we

1 don't have other documents and we are trying to work out
2 two things. First of all, how this can be and,
3 secondly, where else they might possibly be found.

4 A. Yes.

5 THE CHAIRMAN: We are not going back to a time, as is quite
6 clear from the name of this directorate, where no
7 thought was given to these things, we're not back to the
8 70s or 80s where there was no such thing as a patient
9 records directorate.

10 A. Yes.

11 MR STEWART: It is likely that a directorate like this would
12 have left minutes of its meetings and so forth.

13 A. Yes.

14 Q. Would those still be kept or would those have been
15 destroyed?

16 A. Well, according to, certainly, current guidance and
17 guidance from the 1962 circular, which would be the only
18 formal guidance on the retention of records of that
19 kind, they would not have needed to be retained. I've
20 said in my statement that individual managers may well
21 have made their own judgments about whether to retain
22 documents for longer than that. But in the end, they
23 may well have been forced just through constraints of
24 space and storage to dispose of some of them.

25 Q. I wonder, now you mention that particular advice, can we

1 go to it? It's at WS251/1, pages 9 and page 10. This
2 takes us back to an earlier era, 1962. This is
3 a memorandum of arrangement for the preservation and
4 disposal of hospital service records, which I suppose is
5 quite distinct from patient records. The covering
6 letter advises in relation to it at page 10:

7 "Selection and disposal of records. The lists
8 contained in appendices A and B shall be observed as the
9 guide for selection and disposal of hospital service
10 records. Appendix A lists classes which shall not be
11 destroyed at all."

12 Appendix A is then at page 12. The very top, you
13 see "Classes of documents which are not to be
14 destroyed":

15 "1. Minute books, including minute books of
16 governing body and their subcommittees. Minute books of
17 hospital committees and subcommittees are included in
18 this category and must not be destroyed."

19 I read that as meaning that minutes of committees,
20 especially of directorate committees, should be
21 preserved.

22 A. Yes.

23 Q. Do you differ?

24 A. No.

25 Q. So when earlier, for example, we were discussing that,

1 the minutes of any committee within the hospital would
2 be caught by that. Whether it's a medical records
3 committee, whether it's an audit committee, whether it's
4 a directorate committee, they would all be caught by it.

5 A. It would seem from the wording, yes.

6 Q. So when the annual report that I referred to just
7 a moment ago referred to the multidisciplinary medical
8 records committee, those minutes of that committee
9 should also be with us still.

10 A. Yes.

11 Q. Is there an explanation as to why they're not?

12 A. Either they were destroyed in contravention of the
13 guidance at that time or the committees that you're
14 referring to were not considered to be committees of the
15 trust or major sub-committees.

16 Q. Well, can I --

17 A. I'm only speculating. Yes, they should be there. No,
18 they're not.

19 THE CHAIRMAN: On the face of it, they should be and it's
20 a bit hard to see why they're not there?

21 A. It is, or else they are there and we can't find them.

22 MR STEWART: Would it be correct to assume that
23 a directorate of patient records or a medical records
24 committee would be responsible to ensure that records
25 guidance is, in fact, adhered to?

1 A. Yes.

2 Q. So if the body responsible to ensuring the guidance is
3 adhered to has its own minutes destroyed, contrary to
4 its own guidance, then you have a situation where
5 nothing remains.

6 A. I'm not saying they were destroyed; I'm saying they were
7 either destroyed or they still exist, but are not
8 retrievable.

9 Q. I do understand your position. The inquiry has found it
10 frustrating following a trail of documents which hasn't
11 always been helpful.

12 Can I ask for document 305-035-001? This was an
13 earlier advice given to us by the DLS. The third
14 paragraph down commencing:

15 "Prior to December 2004, we were informed
16 in September of last year that there was no specific
17 guidance on destruction or retention of records other
18 than medical records and social care records."

19 We now see that is incorrect. Were these requests
20 for information about records coming back to your
21 department?

22 A. I am responsible for that misunderstanding.

23 Q. You are, I see.

24 A. And that's why I issued the correction to my statement.

25 I based that -- the information that Wendy Beggs was

1 using there was based on interviews with records
2 manager -- our current records manager and the former
3 records manager in the Royal. It's only when I read the
4 actual guidance in detail that I realised, which
5 I should have done before making my first statement,
6 I realised that the 1962 circular did indeed, as
7 you have shown, cover the non-medical records.

8 Q. Yes. Because this issue has, in fact, cropped up over
9 the years from time to time. I see from the documents
10 exhibited to your answers that at least in July 2000 --
11 I don't need it to be called up, but it's WS251/1,
12 page 19 -- advice was being sought as to whether or not
13 this guidance that we've been discussing was current and
14 the advice came back that it was, at least in part,
15 still current.

16 In relation to the last paragraph here of this
17 letter:

18 "You will note that previous correspondence as
19 regards document retention/destruction prior to 2004
20 makes reference to Trust policy and hospital policy and
21 this may have led to some confusion. I understand that
22 perhaps reference to a practice rather than policy would
23 have been more appropriate."

24 That refers back to the letter we were discussing,
25 Mr Chairman, this morning, which, if it could be brought

1 up alongside it, is 305-029-001. This is the letter
2 that has been the subject of discussion. This is where
3 the inquiry was informed that Adam Strain's death --
4 this is at the end of the first line -- would have been
5 discussed at the paediatric directorate clinical audit
6 meeting in December 1995. Well, might have been,
7 I think, is now the most recent advice, but nobody
8 knows:

9 "The minutes of this meeting have not been retained.
10 All the Trust audit meetings from that period should
11 have been destroyed by now in accordance with Trust
12 policy."

13 So we can now read that as saying: all the Trust
14 audit meetings for that period should have been
15 destroyed by now in accordance with Trust practice; is
16 that right?

17 A. The current Trust policy would allow for records of that
18 age to be destroyed. The 2004 guidance allows for
19 records of that nature to be destroyed, I believe, after
20 two years.

21 Q. Clinical audit meetings records, if they are contained
22 within the minutes of a clinical audit committee,
23 should, of course, be retained; would you agree with
24 that, if it's a hospital subcommittee?

25 A. I'm not sure if that's what the 2004 guidance says.

1 I would need to check that document.

2 Q. Very well.

3 THE CHAIRMAN: I think the witness is saying that that might
4 be right under the 1962 guidance, but not under the 2004
5 guidance.

6 A. Yes.

7 MR STEWART: Very well. Can I ask for document 305-018-001,
8 which is another letter from the DLS in a series of
9 letters that have been exchanged? Perhaps you can help
10 with the last paragraph:

11 "In relation to the Trust board subcommittee
12 meetings dealing with issues relating to quality of
13 patient care, a search in the registry office in the
14 Royal Victoria Hospital has taken place and there are no
15 minutes on file for the audit committee for the period
16 preceding 1999. These minutes were held within the
17 finance department during the time in question and, from
18 an accounting perspective, as the professional code
19 stipulates retaining papers for a seven-year period,
20 these minutes would not have been retained."

21 A number of questions arise. Why would minutes
22 relating to a subcommittee dealing with quality of
23 patient care be consigned to the finance department?

24 A. I can't answer that question. Except to say that the
25 internal audit department is part of the finance

1 department.

2 Q. Is that confusing financial audit with perhaps clinical
3 audit?

4 A. Well, internal audit traditionally was financial audit.
5 But more recently, they have audited, not from
6 a clinical point of view, but non-financial matters,
7 including medical records management.

8 Q. This letter claims that the minutes would have been --
9 they would not have been retained beyond seven years by
10 reason of professional code. Would that be in relation
11 to financial documents that are kept for seven years?

12 A. I understand there is a financial records circular, but
13 I haven't studied that, so I can't comment on that.

14 Q. Because if we were to turn to the schedule attached to
15 that earlier guidance we were looking at in relation to
16 preservation of records, and we could turn to WS251/1,
17 page 14, we see "Classes of documents which may be
18 destroyed". At number 2, we have:

19 "Audit reports. Six years after the end of the
20 financial year to which they relate."

21 Which sounds like a seven-year period.

22 A. Yes.

23 Q. Could that be the basis upon which these patient care
24 quality reports were destroyed, do you think?

25 A. I don't believe so because the 1962 -- in 1962, audit

1 reports, financial audit reports, would have been
2 restricted, as I understand it, to financial matters and
3 not non-financial matters.

4 Q. Yes, well, we have a confusing picture, which seems that
5 records relating to patient quality, patient care, have
6 ended up in the finance department. And if they were
7 destroyed under the professional code for the financial
8 department, that might be under this particular area,
9 which would, if we go back earlier in the guidance,
10 require a registration and a certification of
11 destruction. So it seems, as though it's a confusing
12 picture, that we may assume that the guidance is simply
13 forgotten about.

14 A. I mean, a lot of people I've spoken to -- and from my
15 own experience, the retention and destruction of records
16 principally relating to medical records would have been
17 well-known abroad in the Trust. The guidance
18 in relation to non-medical records, possibly less
19 well-known.

20 Q. Yes.

21 THE CHAIRMAN: Sorry, could I go back one page for a moment
22 to the previous document? I'm not sure, maybe I just
23 didn't pick it up quite clearly. Three lines up, when
24 it says:

25 "The professional code."

1 What professional code -- I think Mr Stewart
2 suggested that would be a financial code. If it's not
3 a financial code, what professional code is it?

4 A. I assume it's financial, but I can't answer.

5 THE CHAIRMAN: It's the only apparent answer, isn't it, that
6 it's financial?

7 A. I don't know.

8 THE CHAIRMAN: Okay, thank you.

9 MR STEWART: This morning, we were discussing where we might
10 go to find the minutes of the paediatric directorate
11 clinical audit meetings for the period of 1996. Having
12 been present this afternoon and listening to this
13 debate, can you think of any further places you might go
14 back to and search to see if the inquiry can be
15 assisted?

16 A. Well, if I can just describe ... Recently, we had
17 occasion to audit some disused facilities within the
18 Trust, just to check that they were properly secured and
19 whether the information and the records contained in
20 them were properly looked after and under a proper
21 security. And just from the experience of that, you
22 could find records of any nature, given the transition
23 from directly managed units through to the Royal Trust
24 through to the now Belfast Trust. You can find records
25 relating to finance, clinical records, personnel

1 records. They've been stored, for want of a better
2 expression, everywhere in the Trust.

3 THE CHAIRMAN: Is that the Beaver Park experience you're
4 referring to?

5 A. I'm relating to that, I'm alluding to that, but then the
6 subsequent actions beyond that. Records storage has
7 been a problem for this Trust and its predecessors for
8 many years. And there's no registry of where all the
9 records are stored. I will go back to my earlier phrase
10 that it would be looking for a needle in a haystack. If
11 you said to me, "Can you try and find for me the minutes
12 of the audit committee in July 1995?", if they're there,
13 I don't know if they're there. If they're there, it
14 could take me years to find them, possibly.

15 MR STEWART: That's helpful, if discouraging. So really,
16 the picture you're drawing for us is one of a confusing
17 and fairly unstructured archive system, if it is
18 a system at all.

19 A. Yes.

20 MR STEWART: Thank you, Mr Williams.

21 THE CHAIRMAN: So it's your job to try and pull it together?

22 A. I'll try and sort it out.

23 THE CHAIRMAN: Lucky you!

24 Any questions? No? Mr Williams, thank you very
25 much for coming along. You're free to go.

1 (The witness withdrew)

2 Timetabling discussion

3 THE CHAIRMAN: Ladies and gentlemen, that brings us to an
4 end for today's hearing. Could I look forward with you
5 over the next two weeks? Because we've been looking
6 at the schedule. We are going to hear from Dr Murnaghan
7 on Monday. He's the sole witness on Monday.

8 On Tuesday, we're scheduled to have Ms Duffin, who
9 was the director of nursing and patient services from
10 1993 to 1997. As you will have seen from her statement,
11 she was not involved in Adam's case, but she has some
12 evidence which will not probably be very lengthy to give
13 about governance issues.

14 We were also scheduled to call Dr McKaigue on
15 Monday. We've been considering that on the inquiry team
16 over the last day or two. Dr McKaigue's relevance
17 is that he was a paediatric anaesthetist and he was
18 involved, to some extent, in the preparation of the
19 statements that we've been referring to over the last
20 few days.

21 My own view is that at this stage we've already
22 heard from doctors Gaston, Crean and Taylor and the
23 value of hearing from Dr McKaigue is not obvious to us.
24 Does anybody have any contrary view on that or do you
25 think we have heard enough on that? We've heard from

1 the head of ATICS and we've heard from two of the three
2 paediatric anaesthetists.

3 MR McBRIEN: Do you need an immediate answer, sir?

4 THE CHAIRMAN: If we're going to cancel Dr McKaigue, which
5 you now know is my inclination, I'd like to give him
6 notice of that rather than do it at some point on
7 Monday, Mr McBrien.

8 MR McBRIEN: Could you give us 20 minutes?

9 THE CHAIRMAN: Well, does anyone else have anything to say
10 on that? Okay. I'm going to be here anyway, so I'll
11 let Mr McBrien come back.

12 Then on Wednesday, we're having Mr McKee and
13 Dr Carson. I should say, there's a possibility that
14 that evidence will spill into Thursday. Otherwise,
15 we will not be sitting on Thursday, except to finish the
16 evidence of Mr McKee and Dr Carson if it isn't finished.
17 It might be, with luck. We won't be sitting on Friday.

18 Then the final two days -- Monday 2 July, Tuesday
19 3 July -- we have Mr Ramsden and Mr Mullan. We had
20 obtained a report from Mr Ramsden and then we obtained
21 a more developed report from Mr Mullan. Again, looking
22 at this now, our instinct is that the value of bringing
23 over Mr Ramsden to add orally to his written report is
24 questionable. But our inclination is that we should
25 bring over Mr Mullan on Tuesday. Does anybody have any

1 thoughts on that or any objections or reservations?
2 If we don't call Mr Ramsden, he's like other witnesses
3 who have provided statements: their evidence is not
4 ignored, it is just that we don't bring witnesses to
5 give evidence unnecessarily or we try not to do it
6 unnecessarily, and we will still have Mr Mullan to give
7 governance evidence on Tuesday the 3rd. There are no
8 objections to that? At least at this stage?

9 I think some of the representatives have left
10 already, so what we might do is we might -- I will lay
11 down that marker and we'll finalise the position about
12 Mr Ramsden on Monday. That's Monday the 25th. Unless
13 anybody else has anything to say, we'll finish now. My
14 inclination, unless I have some persuasive reason from
15 the representatives of Adam's family, is that we will
16 not bring Dr McKaigue on Tuesday, but we can confirm
17 that later on.

18 MR LAVERY: Sir, can I say this in relation to the request
19 earlier in respect of further documentation regarding
20 the clinical meetings of July, August and September?
21 I should say that my solicitor has just informed me that
22 the offices of the Eastern Board have been evacuated
23 this morning because of flooding, so it may take
24 a little longer to obtain that documentation than might
25 otherwise have been the case.

1 THE CHAIRMAN: Well, I won't get into conspiracy theories!

2 Thank you.

3 (3.00 pm)

4 (The hearing adjourned until 10.00 am on Monday 25 June)

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