

Tuesday, 27 March 2012

1

2 (10.00 am)

3

(Delay in proceedings)

4 (10.12 am)

5 THE CHAIRMAN: Ladies and gentlemen, the written opening  
6 address by Ms Anyadike-Danes was circulated at the end  
7 of business yesterday afternoon. It's easier for  
8 everyone to follow, as Ms Anyadike-Danes completes her  
9 delivery this morning. She said there are some changes  
10 to be made, some small points to be corrected, and the  
11 final corrected version will be on the inquiry website  
12 by tomorrow.

13 Ms Anyadike-Danes, over to you.

14 Opening by MS ANYADIKE-DANES (continued)

15 MS ANYADIKE-DANES: Thank you.

16 I don't know whether it was explained as it was  
17 handed out, but the version that you had was actually  
18 a draft and the purpose of it was to assist you today.  
19 I would have liked you to have it at the start of  
20 yesterday, but I know that you'll appreciate that in  
21 trying to do that, it's not necessarily as final as we  
22 would want it to be. You will get the final version.  
23 Nothing of very great importance will change and, in any  
24 event, I'm going to give you, obviously, the correct  
25 version as I deliver it today. But if you'll just bear

1           that in mind and, when you receive the correct version,  
2           get rid of that so there's no confusion as to what  
3           actually is the correct position.

4   THE CHAIRMAN: Picking it up in the version that was  
5           circulated, we're at page 59, paragraph 212 or so;  
6           is that right?

7   MS ANYADIKE-DANES: Yes, I think we were there. I was about  
8           to set out for you the debate -- well, at least how the  
9           debate arose. Actually, setting out the debate for you  
10          is one of those things that I intend to do when we  
11          resume the hearing on the 16th and I can conclude the  
12          part of the opening that deals with the experts'  
13          reports.

14                 But I think it is important to appreciate how it  
15                 arose and the sorts of things that are involved in it.  
16                 So until the preliminary report that had been provided  
17                 by Professor Kirkham on 16 February 2012, the shared  
18                 view of the inquiry's experts was that dilutional  
19                 hyponatraemia was the major cause of the acute cerebral  
20                 oedema that led to Adam's death. That's not to say that  
21                 there weren't some differences between them, principally  
22                 in relation to the role of a possible ligation of Adam's  
23                 left internal jugular vein, as described in  
24                 Alison Armour's report on the autopsy -- we've already  
25                 gone through that yesterday and I took you to the part

1 -- and its contribution to any obstruction from the  
2 venous drainage from the head as referred to in  
3 Dr Sumner's report of 22 January 1996 and, indeed, his  
4 evidence on 18 June. I also took you to that.

5 The report of Professor Kirkham, though, signalled  
6 a change to there being a common view on dilutional  
7 hyponatraemia amongst the inquiry's experts. She  
8 introduced in her preliminary report the explanation  
9 that -- and these are her words:

10 "On the balance of probabilities, chronic venous  
11 sinus thrombosis was a likely cause of Adam's previous,  
12 rather subtle, neurological problems. It was likely  
13 that further acute thrombosis in the venous sinuses was  
14 associated with acute posterior cerebral oedema during  
15 the operation."

16 She also addressed the view that the development of  
17 PRES, for which Adam had at least three risk factors --  
18 anemia, blood transfusion and immunosuppression --  
19 contributed to the rapid development of mainly posterior  
20 cerebral oedema. I think that should read "of the  
21 mainly cerebral oedema". And Professor Kirkham then  
22 goes on to deal specifically with dilutional  
23 hyponatraemia at paragraph 54 of her preliminary  
24 report -- and you have all had that -- in which she  
25 summarises and addresses in turn the bases of the

1 argument that Adam's acute cerebral oedema and brain  
2 death was caused by dilutional hyponatraemia and she  
3 concluded with:

4 "Although it is possible that the compensatory  
5 mechanisms were overwhelmed because of the rapidity of  
6 the fall in the sodium ..."

7 And if I pause there: that was one of the issues  
8 that I had raised yesterday. Really, the three issues  
9 about the fluid were: the type of fluid it was, the  
10 amount that was administered, and the speed with which  
11 it was administered, and that's the rate issue, if you  
12 like. So the rapidity of the fall in sodium and the  
13 associated shift of water into the brain along an  
14 osmotic gradient, on the balance of probabilities, the  
15 rapid development of fatal posterior cerebral oedema was  
16 secondary to acute or chronic cerebral venous  
17 thrombosis, probably with the additional development of  
18 posterior cerebral oedema similar to that seen in cases  
19 of PRES."

20 So there is an issue there about whether she is  
21 accepting, apart from any other thing, that the rate of  
22 the fall of the sodium, which is to be -- one of the  
23 debates is how much that is associated with the rate of  
24 the administration of the dilute fluids and to what  
25 extent does that have a role in the development of

1 a cerebral oedema.

2 Since Professor Kirkham's preliminary report, the  
3 inquiry's clinical experts have had two lengthy  
4 meetings. They had one on 22 February 2012 and one on  
5 9 March 2012. Both of those were recorded and I think  
6 you've all had CDs of that. There's also a transcript  
7 that was provided of each of those meetings.  
8 Professor Kirkham's preliminary report and those two  
9 meetings have served to generate a considerable number  
10 of reports from the experts, as they explore and indeed  
11 challenge their differences and the bases for them.

12 If I go through them, it's worth knowing exactly  
13 what the extent of the expert material is that this  
14 issue has given rise to. It's by no means  
15 straightforward, as you will appreciate.

16 We first had Dr Anslow and he produced a note on  
17 18 February 2012, dealing with certain queries that  
18 Professor Kirkham had raised. She had raised some  
19 queries with Dr Squier and Dr Anslow, which she had  
20 actually wanted to receive the answer to before she  
21 provided her preliminary report. And as matters  
22 occurred, she had the answer from Dr Squier, but she  
23 didn't have the answer from Dr Anslow. She released her  
24 report or provided her report because it was felt that  
25 she really had to provide a preliminary report on the

1 16th and Dr Anslow's note didn't come in until the 18th.  
2 So that wasn't factored into her preliminary report.

3 In any event, that's the report, it deals with those  
4 queries. Then there's Dr Coulthard. He produced  
5 a report on 15 March and that report deals with the CVP  
6 and it presents his arguments as to the error in  
7 zeroing. You'll remember that the CVP measurements are  
8 a real issue as to what was happening. Was the catheter  
9 in such a place that the CVP measurements were entirely  
10 unreliable and couldn't be used at all? Could they be  
11 used for reference purposes, so we can just see relative  
12 change? And what exactly could be made of them? Or  
13 were they actually reliable? They may not have been in  
14 an appropriate place, but they were still giving useful  
15 information as to the CVP.

16 So that's the issue. There is also a question  
17 about, if you thought they were giving inaccurate  
18 measurements or readings, I should say, then what should  
19 you do? Should you fiddle about with the catheter, move  
20 it around a bit to see if you can get it into a more  
21 appropriate position? Should you, if you thought it  
22 might be the machine, re-zero it, clear it and see if it  
23 came back and started giving accurate readings? That's  
24 the zeroing issue. And Dr Coulthard's report is  
25 actually dealing with that whole CVP question and what

1 one can make of either the readings that one had from it  
2 and/or the arguments in relation to it.

3 Then there's a report on 15 March, and that deals  
4 with two papers that Professor Kirkham had cited in her  
5 preliminary report, Paut "Severe hyponatraemia  
6 encephalopathy after paediatric surgery", which was  
7 a report of seven cases, and the recommendations for  
8 management and prevention, and Sicot, "Death of a child  
9 due to post-tonsillectomy hyponatraemic encephalopathy",  
10 and also a third paper that hadn't be mentioned by  
11 Professor Kirkham, but he thought was relevant. And  
12 really that's what that report is dealing with. It's  
13 part of the literature debate.

14 So as I understand it, literature to them is to  
15 lawyers what authorities would be. That's their source  
16 for being able to say that something is a credible or  
17 not credible hypothesis or argument. So for them,  
18 in the experts' literature, it's a very important  
19 question and what that literature establishes about the  
20 studies that are going on and how relevant they might be  
21 to the particular cases you have.

22 So that's that paper. Then he produced a paper on  
23 16 March on free water balances. The free water,  
24 I should just say, if you've listened to the DVD or more  
25 probably read the transcript, you will see that there is

1 an issue between Professor Kirkham and at least  
2 Dr Coulthard, and maybe others, about the role of free  
3 water. There's a question about whether it makes any  
4 difference that you're talking about the administration  
5 of fluid which has dextrose in, the administration of  
6 fluid which has low amounts of sodium in, or just free  
7 water, the amount of actual water. That's the debate.

8 And so he produced that report that's dealing with  
9 that, and what he considers to be the amount of free  
10 water in Adam, which is part of the argument of what  
11 would have been the effect of that. In the course of  
12 that, he produced two pages of calculations that are  
13 based on Dr Taylor's statement of 1 February.

14 Then there's another report from him on 16 March and  
15 he was providing responses to queries that had arisen  
16 during the meeting on 9 March. As you will appreciate,  
17 we've seen the transcript coming out of the 22 February,  
18 there are a number of issues and queries, and they're  
19 all followed up by papers, aide memoires, notes to  
20 agenda, that the legal team sent to remind people of all  
21 the various strands that they had left that they wanted  
22 to consider and we wanted to make sure that they did in  
23 fact consider them. And a similar thing happened coming  
24 out of the meeting on 9 March, and this report is really  
25 Dr Coulthard seeking to address some of those.



1           He also deals with some things in Dr Taylor's  
2           statement and he recalculates his own table, Adam's  
3           perioperative fluid balance, and those that were  
4           originally produced by Dr Haynes, Professor Gross and  
5           Dr Taylor. And that is one of the points I think I made  
6           yesterday: that although we had produced that  
7           comparative table at the time, we had not reflected  
8           Dr Savage's position, but in any event, Dr Coulthard has  
9           gone back and relooked at the whole thing and he's made  
10          changes to his own calculations, and while he's about it  
11          on that basis, he has seen what that would do if others  
12          adopted -- I presume, I haven't been able to study it  
13          fully -- a similar basis and he's looked at their  
14          calculations and, so far as I can tell, he has just  
15          a suite of different calculations. Obviously, we have  
16          to look at it and see what the implications of it is, as  
17          do they. They need to look at it and see whether they  
18          accept that that is something that can be done with  
19          their calculations.

20                Then there's another report on 16 March in response  
21                to the queries raised and other issues, matters raised  
22                by Professor Gross and so forth.

23                Then he produced a report on 17 March, providing his  
24                final views from the perspective of a paediatric  
25                nephrologist. You'll be aware when I was addressing it

1           yesterday that he had two roles. He is a consultant  
2           nephrologist, paediatric nephrologist, so he has  
3           produced reports dealing with that role. But he also  
4           has produced reports on the appropriate fluid  
5           calculations and management. So this report of his is  
6           a sort of final view, looking at it from the perspective  
7           of the paediatric nephrologist.

8           Then there's Professor Gross. He produced a report  
9           on 18 March on the meeting of 22 February. And as  
10          I think you've already been advised or informed, he is  
11          to produce either the report coming out of 9 March  
12          and/or his final report. But in any event, whatever  
13          it is, there is a report that he has signalled to us  
14          that is coming. So far as I know, we don't yet have it.

15          Then there's Dr Haynes. He produced a report on  
16          20 February responding to the report of  
17          Professor Kirkham. That was her preliminary report. So  
18          he produced a relatively short report, just to his  
19          reaction to that report. And you'll recall that when  
20          that report was released, all the experts were being  
21          asked to provide their views on it, on the 20th, which  
22          was a relatively short period of time. And some of them  
23          were able to do that: Dr Haynes was, Dr Coulthard was,  
24          but Dr Haynes has specifically said at the meeting that  
25          he thought he had produced that rather under a rush in

1 order to get it in for 20 February, as we had asked him  
2 to do.

3 Then he produced a supplemental report on 6 March  
4 and he produced a report on 18 March on his final  
5 position, having regard to it the expert reports to date  
6 and the two meetings of experts. Unfortunately,  
7 of course, that's the reports that he'd seen to date.  
8 There are others out there. Probably, most  
9 significantly for him, is Professor Kirkham's report  
10 that is out there. But in any event, he can only do the  
11 best he can with what he's got so he's produced his  
12 final report on everything that he has had and he then  
13 helpfully produced a summary report, which really sort  
14 of -- I think, I haven't studied it sufficiently, but  
15 it's sort of like an executive summary bringing  
16 together, in summary form, his position. So we have  
17 that from him.

18 Dr Squier produced a report on 17 February 2012  
19 responding to Professor Kirkham's report of the 16th.  
20 I should have added she was another who was able to get  
21 a response in, although her response only ever deals  
22 with relatively discrete things -- she's  
23 a neuropathologist -- and she also produced a report on  
24 15 March on her final position as matters stood at the  
25 time. So that's how it is.

1           We don't yet have Professor Kirkham's report. Her  
2 first report was only ever expressed as a preliminary  
3 and she said that she had produced that in a rush. We  
4 await her report -- and it's a final report that will  
5 take into consideration, we hope, all the responses that  
6 she has had and the debate that has occurred in  
7 Newcastle.

8           The debate amongst the inquiry's experts deals with  
9 extremely complex medical issues. Some of those issues  
10 may well be being developed out of research that is  
11 still ongoing. However, even that, actually, is not  
12 accepted by all the inquiry's experts. In fact,  
13 sometimes on certain issues there isn't that much that's  
14 accepted. At other times on other issues, they do come  
15 together on certain points. But anyway, on the  
16 literature front, which is important, you have  
17 Dr Coulthard saying at page 3 of his report of  
18 20 February -- that's his report responding to  
19 Professor Kirkham's 16 February report -- that he  
20 doesn't consider that there is anything new in PRES;  
21 it's just a radiological description for acute  
22 hypertensive encephalopathy, which is something that all  
23 nephrologists know they need to manage, they've been  
24 doing that and there's nothing new in PRES. So you have  
25 him saying that. Then, on the other hand, you'll have

1 Dr Haynes, who acknowledges at paragraph 25 of his  
2 report, which is also 20 February responding to  
3 Professor Kirkham, that PRES is increasingly recognised  
4 as an entity and believes he's come across it. He also  
5 agrees in his report that PRES can be considered where  
6 there is no obvious underlying cause for the cerebral  
7 oedema, although it has to be said in Adam's case he  
8 thought that there was an underlying cause and that the  
9 underlying cause was dilutional hyponatraemia.

10 As a pathologist, Dr Squier approached the issue of  
11 PRES from a different perspective. She's examining the  
12 material. And she explains in her report of 22 February  
13 that PRES is not yet a condition that is diagnosed  
14 pathologically. And Dr Anslow states in his note of  
15 18 February, when he's responding to queries from  
16 Professor Kirkham, that PRES is a diagnosis best made on  
17 MRI. But Dr Squier nonetheless comments at paragraph 50  
18 when she's dealing with PRES:

19 "It has been a very interesting condition that is  
20 well worth consideration."

21 So they are not entirely at one with whether it's  
22 new, what it means exactly, but hopefully it will become  
23 clearer when we see all their final positions because  
24 they will know each other's arguments about that and  
25 hopefully they can reflect that -- or the ones who have

1 put in their final positions, have reflected that in  
2 their reports.

3 The ongoing research and study on the matters being  
4 considered and debated by the inquiry's experts is well  
5 illustrated by the published literature that they cite  
6 in their reports. And that's been included in the  
7 updated bibliography or will be, if it's not already  
8 there, compiled by the legal team. But you can, in any  
9 event, see the currency of the publications that they  
10 are citing, that deals with ongoing research, and the  
11 present position, the views of three of the inquiry's  
12 experts, Dr Coulthard, Dr Haynes and Dr Squier, is  
13 reflected in that raft of reports that has only just  
14 been received by the inquiry, with the reports of  
15 Professor Gross and Professor Kirkham still being  
16 outstanding.

17 So that is actually why I am not in a position to  
18 put before you, Mr Chairman, the position of the experts  
19 on the various clinical matters relating to Adam. It's  
20 something that needs to be considered very, very  
21 carefully, both in terms of their views -- some of the  
22 experts' views may have shifted, their views in relation  
23 to each other's views -- and how all that fits or works  
24 or relates to the actual evidence, what the people were  
25 actually doing, what they thought they were doing, why

1           they thought they were doing it on 26 and  
2           27 November 1995.

3           That historical perspective is also important. But  
4           it takes time and we hope that we will have that. We  
5           intend to have that worked through so that I can  
6           conclude this opening when this hearing resumes on  
7           16 April. But I hope you will understand the reason for  
8           it.

9           So let's go to putting Adam on the transplant  
10          register. If I can just recap a little bit. A large  
11          part of what I was doing yesterday was actually to set  
12          out the evidence that we had, what it related to, where  
13          we got it from and, to some extent, to try and indicate  
14          its significance. What I'm entering into now is to look  
15          at what the issues actually are, what the issues are  
16          that we may be seeking to address in the oral hearing  
17          and why they are issues. So it's not really possible to  
18          get into the issues until you survey the territory and  
19          yesterday, in large part, was about surveying the  
20          territory.

21          We now come to the issues. Let's start with putting  
22          Adam on the transplant register. I have, just to recap  
23          again for you, looked at these issues from a number of  
24          different periods. Here, we are dealing with his  
25          pre-surgical period, if I can put it that way. And one

1 of the important things in that period, apart from his  
2 general condition leading up to it, is the decision to  
3 actually put him on the transplant register, and that's  
4 where we are now.

5 So as can be seen from the timeline, reference  
6 307-001-032, that's not quite where I thought it was  
7 going to be. Right okay. If you look down to  
8 14 July 1994. This is July, this is the arrangements  
9 being made, you can see that he's admitted and his  
10 mother's going to be trained in the use of the home  
11 dialysis equipment and the arrangements are being made  
12 to have Adam's tissue typing done with a view to putting  
13 him on call for renal transplant. And in fact, the form  
14 is there -- the initial part of the process, anyway.

15 So contemporaneous with putting him on dialysis, the  
16 decision is made to put him on call for a kidney  
17 transplant. He was registered with the United Kingdom  
18 Transplant Support Services Authority, in fact,  
19 in November 1994. And I took to you that form and some  
20 of the details that are on that form.

21 The main members of the transplant team together  
22 with the inquiry's experts -- the experts in question  
23 are Dr Coulthard, Dr Haynes and Messrs Forsythe and  
24 Rigg -- were all asked to complete a template for  
25 a table for paediatric renal transplant showing the



1 involvement of personnel in the various phases. Their  
2 completed tables show who they regard should be involved  
3 at any particular stage from the first mention to the  
4 family of transplant as an option to communicating the  
5 child's death. I'm going to see if we have one of  
6 those, we may not be able to pull that up for you, but  
7 let's try 300-064-124. Yes.

8           There would have been these forms completed for, as  
9 I say, the main members. I think they were completed  
10 for Dr Savage, Dr Taylor and Mr Keane. This happens to  
11 be Dr Savage. You can see going down on the left-hand  
12 side are the phases, as we have been advised, the phases  
13 in a transplant process, starting with transplant  
14 option, first mention to the family, ending with 15,  
15 "Communicating child's death to parents". And across  
16 the top you have the various people who might be  
17 involved in that. So you have the physicians, ward  
18 staff, intensive care unit staff, the anaesthetists,  
19 medical technical officers, surgeons, scrub nurse and  
20 runner.

21           The first bit that we're dealing with is "Transplant  
22 option first mentioned to the family", and you can see  
23 that, so far as Dr Savage is concerned, we're really  
24 only talking about the physicians/ward staff and so on.  
25 And he has "MS", Maurice Savage, and there isn't an

1           indication that anybody else would be involved at that  
2           stage. And then as you go down, just while we have it  
3           here, you can see what his responses are. So  
4           "Transplant surgery consent process started, risks and  
5           benefits explained". That's Maurice Savage and ward  
6           staff. No involvement with anybody else. "Preoperative  
7           preparation on evening of the admission" and then you  
8           see he has himself involved there. And "RT", the  
9           anaesthetist, Robert Taylor. I should just say that how  
10          you indicate whether somebody is involved to  
11          a significant degree or not depends on how many crosses  
12          you have in there. So if you have two crosses, you're  
13          involved to a significant degree, and if you have one,  
14          then you have a lesser involvement, but you are  
15          involved.

16                 You can see therefore that the "Preoperative  
17          planning or preparation on the evening of admission and  
18          consent confirmed" -- so he has himself significant  
19          involvement in that, and Robert Taylor is significantly  
20          involved in that, but no one else. And in fact, you can  
21          see that he has himself significantly involved in all  
22          those -- on the first four, and then he comes in at the  
23          end, "Communicating the child's condition at the end of  
24          surgery" and, of course, being involved in communicating  
25          the child's death to the parents.

1           So that's his take on that. If we go to  
2           300-065-125. This is Dr Taylor. You can see that he  
3           himself doesn't appear to have significant involvement  
4           until you get to preparing the theatre for the start of  
5           surgery, and he has Dr Montague significantly involved  
6           in the preoperative preparation and so forth, which is  
7           phase 4. I'm not going to go through it all, just to  
8           give you the -- they are there. I will whizz through  
9           the rest. 300-066-127.

10           There we are. That is Mr Keane. He's done it in  
11           a slightly different way, he hasn't really given  
12           anybody's identity, but he's given the significance of  
13           the category of discipline, if I can put it that way, so  
14           that you can see that he regards the surgeons as really  
15           only coming into it all at 3, which is the preoperative  
16           preparation. It's there for you to see, the weight that  
17           he gives the other disciplines that were involved.

18           There are issues to be explored in the oral hearing  
19           as to the way in which the decisions were made relating  
20           to placing Adam on the transplant register. And those  
21           issues include the information options that were given  
22           to Adam's mother on the most appropriate transplant  
23           centre and also the possibility of a living donor.  
24           Dr Savage discusses in his inquiry witness statement of  
25           28 September 2011 what he told Adam's mother, and whilst

1 acknowledging that the information he provided to her is  
2 not recorded in Adam's notes, but he does set out what  
3 he told her.

4 Adam's mother refers to the particular issues of  
5 options and living donor in her inquiry witness  
6 statement of early this year, and she also addresses the  
7 issue of the transplant booklet in her witness  
8 statement. That's because there was an issue as to  
9 whether that form of information is provided to the  
10 families of all children who are to undergo renal  
11 transplants, whether they were all provided with that  
12 booklet. That booklet gives certain information and she  
13 simply says that she didn't, as far as she was  
14 concerned, ever have anything in writing. So there is  
15 an issue to be explored about that.

16 Dr Coulthard's comments on the information that he  
17 considered should have been provided to Adam's mother is  
18 at page 13 of his report, dated 7 November, and also at  
19 page 12 of his report, dated 16 February. Those reports  
20 are there for you to see and you can see the position  
21 that the expert takes in relation to that.

22 The other issue is the extent to which the decision  
23 to place Adam on the transplant register should have  
24 been informed by a multi-disciplinary team to include  
25 a transplant surgeon. Dr Savage refers in his inquiry

1 witness statement of 14 April 2011 to  
2 a multi-disciplinary team for renal transplants, and he  
3 described it as comprising, in addition to the  
4 nephrologist -- obviously, he's in it -- renal nurses,  
5 dieticians, psychologists and social workers. And he  
6 expands on that a little bit in his inquiry witness  
7 statement dated 28 September 2011 by identifying staff  
8 nurse Clingham as the senior renal nurse at the time of  
9 Adam's transplant surgery and Mrs Mercer as a dietician.  
10 So those are people he's identifying as part of this  
11 multi-disciplinary team.

12 He also makes it clear that the transplant surgeon  
13 did not participate in these multi-disciplinary team  
14 meetings, except by special arrangement, as he worked  
15 not on the Royal Victoria site, but on the Belfast City  
16 site. That's something that I had already flagged up  
17 yesterday. There may be a significance to that. In any  
18 event, that issue will be pursued from a governance  
19 perspective, but just clinically, there may be  
20 a significance to that -- and to the fact that Dr Savage  
21 doesn't regard the transplant surgeons as regularly  
22 participating as a matter of course in the  
23 multi-disciplinary team meetings.

24 The inquiry's experts, Mr Forsythe and Mr Rigg,  
25 comment on that issue of the transplant assessment in

1 their report of June 2011 at paragraph 2.1 and  
2 paragraph 3.1, and also paragraph 4.1. They are clearly  
3 of the view that a consultant transplant surgeon should  
4 be involved prior to placing the child on the transplant  
5 register for the purpose of carrying out a physical  
6 examination of the child and explaining to the family  
7 the procedure, together with the risks and benefits  
8 involved. Dr Coulthard also comments upon that phase in  
9 his report dated 7 November 2011, and the involvement of  
10 surgeons in the process, and he says:

11 "I believe that the final decision to plan to  
12 undertake a transplant should not be made by the  
13 paediatric nephrologist alone, but jointly by the  
14 paediatric renal team and the transplant surgeons."

15 Dr Coulthard develops these points at page 5 of his  
16 report, dated 7 November. Another issue is whether such  
17 a multi-disciplinary team should have developed a plan  
18 for Adam's surgery that could be implemented by the  
19 available clinicians if and when a donor kidney became  
20 available. That might be regarded as particularly  
21 an issue if you don't have a dedicated surgeon or  
22 anaesthetist who is going to carry out that child's  
23 surgery.

24 Anyway, Mr Forsythe and Mr Rigg, the inquiry's  
25 experts, refer to that at paragraph 4.1.5 of their

1 report of June 2011 to discuss options that a transplant  
2 assessment clinic and not in an emergency situation when  
3 decision-making can be pressured. And then they say:

4 "Having a plan to transfer Adam's care to a larger  
5 paediatric centre would have been a realistic option for  
6 them to consider."

7 Although they acknowledge there are logistical  
8 difficulties with such an option. But what they are  
9 saying is that's a possible option and if you're going  
10 to have it, you have to have a plan about it. It's not  
11 the sort of thing that you can decide on the evening  
12 that you get the offer of the kidney.

13 Dr Coulthard also considers that a specific plan  
14 should have been formulated for Adam's transplant  
15 surgery, and he makes a point at page 4 of his report of  
16 7 November 2011:

17 "One important role of having such a meeting and  
18 assessment by a transplant surgeon and paediatric  
19 nephrologist is to formulate a specific plan for that  
20 particular child and to record it in their case notes.  
21 The importance of this is that it may not be that  
22 particular surgeon who is available to operate at the  
23 time a kidney becomes available and it allows a calmly  
24 considered plan to be used at the time instead of  
25 considering these details under a last-minute time

1 pressure."

2 And he returns to that point on the following page  
3 of his report:

4 "We would see it as good practice for them to meet  
5 the transplant surgeons at least once before listing  
6 them."

7 There he means the children who it's proposed should  
8 receive donor kidneys:

9 "And for them to receive advice in that way. The  
10 paediatric nephrologist should liaise with the  
11 transplant surgeons before listing the child. At that  
12 point, any particular specific decisions about  
13 management should be recorded for future reference."

14 This is a significant point he makes:

15 "Also at that point, they should jointly decide on  
16 the level of urgency. This has major implications for  
17 the choice of kidneys that would be accepted."

18 You will recall from the registration form that  
19 I pulled up for you yesterday of November that there is  
20 a way in which you could indicate what level of mismatch  
21 you were prepared to take. So what Dr Coulthard is  
22 saying here is that, depending on how desperate -- if  
23 I can put it that way -- or how serious the need is for  
24 a kidney for that particular child, that affects whether  
25 you would take a kidney which, in other circumstances,



1           you might not. And that's the sort of thing he is  
2           saying should be recorded.

3   THE CHAIRMAN: In other words, whether you would take the  
4           kidney of a 16 year-old rather than pulled out for a 4,  
5           5, or 6 year-old.

6   MS ANYADIKE-DANES: Maybe. Whether you would take a kidney  
7           of any given cold ischaemic time. Maybe, in the best of  
8           circumstances, we wouldn't take that, but if this child  
9           is particularly desperate, we don't know when a match  
10          even approximating that child will become available, so  
11          maybe we just do and see. That's the sort of thing  
12          that's considered in a multi-disciplinary team at  
13          a meeting ahead of it, not when the actual circumstances  
14          arise. According to Dr Coulthard, that's part of the  
15          benefit.

16                So the issues for the arrangements for placing Adam  
17                on the transplant register, together with the  
18                information that was provided to his mother at the time,  
19                are all matters that are going to be considered, not  
20                just at the clinical hearings that we are going to go in  
21                to, but also from a governance perspective.

22                Then we have accepting the offer of the donor  
23                kidney. If we turn now to the period that commences  
24                with the perfusion of the donor kidney at Glasgow  
25                Southern General Hospital at 1.42 on Sunday morning of

1 26 November. Ms Eleanor Donaghy, who was a transplant  
2 coordinator at the Belfast City Hospital at the time of  
3 Adam's transplant surgery, she explains the process of  
4 donor kidney retrieval, the offer and acceptance. She  
5 does that in her inquiry witness statement of  
6 22 September 2011, and she refers to a protocol that she  
7 drew up in July or August 1992 with a senior sister of  
8 the Belfast City Hospital transplant ward. She says it  
9 set out the agreed roles between the nursing staff on  
10 the transplant ward and myself when a transplant is  
11 being arranged at BCH, Belfast City Hospital. She  
12 states that it's out of date now and no longer exists,  
13 but then goes on to say:

14 "No such protocol existed for the Children's  
15 Hospital."

16 So although the Belfast City Hospital and the  
17 Children's Hospital had decided that certainly all those  
18 children who were going to have kidney transplants, who  
19 were under the age of 14, they were all going to have  
20 them at the Royal, the Children's Hospital,  
21 notwithstanding that, there was no protocol developed  
22 for how that would work. And that's something that will  
23 be looked at from a governance perspective, bearing in  
24 mind what I outlined to you yesterday, which is you're  
25 essentially using surgeons from one hospital, taking

1           them to do a procedure in another hospital. In that  
2           hospital, you have a protocol about how it all works --  
3           at least you do in relation to the nurses. At this  
4           hospital, according to Ms Donaghy, you don't have  
5           a protocol. That's an issue we'll explore: whether  
6           she's right that there wasn't a protocol; and, if she is  
7           right, what the significance and implications are.

8           The inquiry's experts, Mr Forsythe and Mr Rigg, also  
9           describe the organ retrieval and offering process in  
10          their joint report of June 2011. I should say they  
11          always produce a joint report. They also explain  
12          in that report the significance of that period for the  
13          cold ischaemic time of the donor kidney and refer to the  
14          issue of cold ischaemic time and discuss warm ischaemic  
15          time in their joint report of October 2011. Warm  
16          ischaemic time is basically when you're handling it, so  
17          it's no longer being chilled.

18          Dr Savage's name appears on Adam's registration form  
19          and accordingly, he was the person to be notified of  
20          a possible donor kidney for Adam. And he has described  
21          in his witness statement of 14 April 2011 what actually  
22          happened insofar as, to be fair, as he can recall it.  
23          And in relation to Adam's case. He expands upon that in  
24          his inquiry witness statement of 28 September 2011 to  
25          address the role of the surgeon in accepting the donor

1 kidney as well as collecting it from the Belfast City  
2 Hospital and bringing it to the Children's Hospital.  
3 There are some issues to be pursued during the oral  
4 hearing about that because there is not entire agreement  
5 among everybody as to who was doing what in relation to  
6 the kidney or when they were doing it, for that matter.

7 The time at which Dr Savage received the offer of  
8 the donor kidney for Adam is another matter that is  
9 unclear. One would assume that it would have to be some  
10 time before 8 o'clock that evening on the 26th because  
11 that's when Adam is recorded as having been admitted  
12 into the Children's Hospital. But it may become  
13 important to know, so far as we can do it, more  
14 precisely when he knew, and that's an issue to be  
15 pursued. Dr Savage believes that he had one  
16 conversation with the UK Transplant Service when they  
17 would have informed him of a number of things: that  
18 a kidney which had a reasonable tissue match was  
19 available for Adam; that that match was 3 out of 6 -- it  
20 was a half-match, basically, it's referred to; the cause  
21 of death of the donor, the time at which the kidney had  
22 been donated; the age, blood group and tissue type of  
23 the donor; and any significant medical history; and any  
24 significant anatomical detail of the donated kidney, for  
25 example that there were two arteries on a patch, say.

1 Patch comes with the kidney and depending on how the  
2 kidney is removed, you have more or less of a patch.  
3 What is described is that there were two arteries on  
4 that patch. Most times -- well, as I understand it,  
5 a kidney normally has one artery.

6 Dr Savage has no recollection of being told that  
7 those two arteries were widely separated. He has no  
8 recollection of being told that the two arteries were  
9 widely separated. The significance of whether they were  
10 widely separated and for the surgeons is obviously  
11 something that is to be considered and has been  
12 considered by the inquiry's experts.

13 So what would he glean from all of that? He should  
14 have known that the donor was 16 years old and that the  
15 donor kidney was essentially the size of an adult. It's  
16 an adult kidney, essentially, going in to a 4 year-old  
17 child. It had two arteries and, although he is not a  
18 surgeon, he should have appreciated, so it might be  
19 said, that that could present a surgical issue, or at  
20 least something for the surgeons to think about. And as  
21 at Adam's admission, if it was appreciated when he was  
22 being asked to come in for, that the donor kidney would  
23 have a cold ischaemic time of about 19 hours.

24 On the basis of that information, Dr Savage, after  
25 speaking to Mr Keane and Adam's mother, took, so far as

1 we understand it, the initial decision to accept the  
2 donor kidney for Adam and have Adam's mother bring him  
3 in. Mr Keane states that he had no input or involvement  
4 in the decision to accept the kidney from UK Transplant.  
5 That will be an issue to be pursued.

6 There will also be an issue to be pursued on the  
7 issue of taking consent from Adam's mother and  
8 proceeding on with the transplant surgery in relation to  
9 the information that they had about the kidney. But  
10 it's worth noting at this stage that that cold ischaemic  
11 time of 19 hours, which is, as I say, what it would have  
12 been, simple arithmetic, by the time Adam was brought  
13 into the Children's Hospital, was getting quite close to  
14 that 24-hour optimal time within which to commence  
15 surgery to which Dr Savage refers in his inquiry witness  
16 statement of 28 September 2011.

17 He just referred to it as an optimal time.  
18 Of course it doesn't mean that you can't do it outside  
19 of that period of time, but that was his view of an  
20 optimal time, and you have seen what the averages were  
21 since 1998 that people were aiming for. So ischaemic  
22 time is an issue in terms of the decision-making and the  
23 information given to Adam's mother.

24 So too are really all the matters that were taken  
25 into account or should have been taken into account and

1           their significance. Those are all issues that are to be  
2           pursued and dealt with at the oral hearing.

3           Compiling the transplant team. Well, Dr Savage was  
4           responsible for putting together the principal members of  
5           the team for Adam's transplant surgery, and by that  
6           I mean the consultant anaesthetist and the consultant  
7           surgeon. It was essentially his responsibility, which  
8           he accepts, to locate an anaesthetist for it and  
9           a surgeon. Dr Taylor was the consultant paediatric  
10          anaesthetist on call over Friday 24 November 1995 to  
11          Sunday 26 November 1995. So he was on call when the  
12          offer of the donor kidney was received by Dr Savage, and  
13          it may be that that's how he came to be included: he  
14          just happened to be the consultant paediatric  
15          anaesthetist rather than anything to do with his  
16          particular expertise in relation to transplants,  
17          although I've already said something about his  
18          expertise.

19          Dr Taylor himself states in his first inquiry  
20          witness statement of 17 January 2005, ie that one just  
21          before the inquiry's work was suspended:

22                 "I only agreed to provide general anaesthesia for  
23          Adam with an experienced senior registrar,  
24          Dr T Montague, experienced theatre nursing staff, and  
25          the ready access to experienced surgeons and

1 nephrologists, who were in theatre dress and beside me  
2 in theatre for large parts of the procedure."

3           What all that means and its significance is  
4 something that we're going to address in the oral  
5 hearing. It's not clear -- if I move now to Mr Keane --  
6 whether Mr Keane, who was a consultant urologist, was  
7 contacted by Dr Savage simply because he was a surgeon  
8 on call. Dr Savage states in his inquiry witness  
9 statement dated 14 April 2011 that from the surgeon on  
10 call list for renal transplants held in the renal unit  
11 at BCH, the transplant surgeon was identified. That's  
12 how he said he found a transplant surgeon:

13           "On this occasion, Mr Patrick Keane confirmed that  
14 he was available and willing to carry out a paediatric  
15 transplant."

16           There's a matter to be explored as to exactly what  
17 that means, but from Mr Keane's point of view he doesn't  
18 think that he was on call. Rather, he thinks that he  
19 was contacted by Dr Savage because he was the only  
20 available surgeon trained in transplantation. And it  
21 seems from Mr Keane's inquiry witness statement of  
22 20 September 2011 that the other surgeons, the other  
23 two, may have been on sick leave at the time.

24           Furthermore, it also seems from Mr Keane's inquiry  
25 witness statement of 20 September 2011 that at the time



1 of Adam's transplant surgery there were only three  
2 surgeons who performed paediatric renal transplants, and  
3 that had Mr Keane -- had he been away, these are his  
4 words, "there would have been no one capable of doing  
5 the transplant". I have already referred to Mr Keane's  
6 own experience in carrying out such surgery.

7 So the implications of the statements of both  
8 Dr Taylor and Mr Keane are matters that will be  
9 addressed in the oral hearing in relation to the extent  
10 of suitable expertise that was available to Dr Savage on  
11 26 November when he was trying to put together a team  
12 for Adam's surgery. It's also something, of course, to  
13 be addressed from a governance perspective, the depth of  
14 the experience resources that are required for the  
15 provision of proper paediatric renal transplant service  
16 as at 1995.

17 In addition to Dr Taylor and Mr Savage, Mr Brown may  
18 be considered to have been a significant member of the  
19 team due to his experience as a consultant paediatric  
20 surgeon, who had operated on Adam previously. I've  
21 already referred to his experience. In fact, if you  
22 recall -- you don't have to recall it, you'll have it  
23 when the get the papers. You'll see from the schedule  
24 of surgical procedures on Adam, which identify the  
25 surgeons and the anaesthetists, you'll be able to see

1 the procedures in which Mr Brown had previously been  
2 involved in relation to Adam.

3 But coming to the point about how he got to be  
4 in the team, exactly how he got to be included in the  
5 transplant team as a surgical assistant to Mr Keane is  
6 not entirely clear from the witness statements of all of  
7 those who are relevant to comment. It's not entirely  
8 clear from the witness statement of Dr Savage or  
9 Mr Keane or even Mr Brown himself. Now, some of these  
10 things I'm sure are to do with the passage of time, but  
11 it's not entirely clear.

12 An explanation may be that his prior involvement in  
13 surgery on Adam was considered helpful. Mr Keane, so  
14 far as I'm aware, had never operated on Adam previously.  
15 So certainly Dr Savage says that it is likely that he  
16 informed Adam's mother that a paediatric surgeon would  
17 also be involved in the surgery, who had knowledge of  
18 Adam's previous surgery, who would therefore be  
19 available instantly during the transplantation  
20 procedure. The precise circumstances of why he was  
21 telling her that are something that will be explored,  
22 but the extent of that involvement can be seen, as  
23 I said, from that schedule, as for that matter can be  
24 seen the experience of the other paediatric consultant  
25 surgeons who had been involved previously with Adam.

1           The result of those early surgical procedures, some  
2           of which involved Mr Brown, is described in Adam's  
3           notes. So you see the ICU discharge summary dated  
4           20 January 1992 by Dr Craig. He was senior house  
5           officer in intensive care:

6           "He had a ureteric reimplantation on 23/11/1991 --"

7           These are the procedures with which Mr Brown had  
8           previously been involved:

9           "-- which obstructed, leading to acute renal  
10          failure."

11          And that was one of the procedures, as I say, that  
12          Mr Brown had been involved in, and as can be seen from  
13          the schedule of serum sodium levels I showed you, there  
14          followed a period of hyponatraemia with Adam's serum  
15          sodium levels reaching as low as 111 millimoles, and  
16          when you consider that the normal range is 135 to 145 --  
17          and they didn't get back into the bottom of the normal  
18          range, that is 135, until 28 November 1991.

19          So this was the procedure that had been carried out  
20          on 23 November 1991.

21          Then there's an updated operation note by Mr Victor  
22          Boston, who's a consultant paediatric surgeon, of  
23          a procedure on Adam of 8 December 1991. He describes it  
24          in this way:

25          "Previous re-implantation of both ureters.

1           Subsequently developed renal failure necessitating  
2           bilateral ureterostomies. The left kidney, which  
3           appeared to be the best biochemically, unfortunately  
4           displaced as demonstrated by tube nephrostogram. At no  
5           stage was there drainage into the bladder and it is  
6           presumed that there was an obstruction at the lower end  
7           of both ureters. The old wound was opened."

8           So this was his procedure opening to see what had  
9           happened:

10           "And it was clear that the ureter had necrosed about  
11           two centimetres above the bladder."

12           So there's a procedure on 23 November, it leads to  
13           a difficulty, he is coming in to perform his procedure  
14           on 8 December in order to see what that difficulty is,  
15           he has to expose it, and he's describing what he sees,  
16           and that's his note.

17           The letter dated 12 May 1992 from Dr Savage to  
18           Dr Scott, who I understand was Adam's GP at the time:

19           "He was operated on at the Ulster Hospital and here  
20           in the Children's Hospital by Mr Brown."

21           I should just say: this is one of a number of  
22           regular updates that Dr Savage provided to Mr Scott and  
23           if you have the files, if you look through file 16,  
24           you will see -- they are quite useful summaries of what  
25           had been going on with Adam:

1            "He has ended up with one ureter attached to the  
2            other and then the single lower part of the ureter  
3            draining into the bladder. We are not entirely happy  
4            that this drains completely freely, but it is felt by  
5            our surgical colleagues that this is the best result  
6            that can be achieved at the minute and they are loath to  
7            interfere again because he has had five operations in  
8            this area."

9            Then there's a letter dated 2 April 1993 from  
10           Mr Boston to Mr Savage:

11           "He had a bilateral re-implant in November 1991  
12           [that's the first one I told you about] and lapsed into  
13           renal failure, necessitating bilateral T-tube drainage."

14           That's the one into the other and then one just into  
15           the bladder:

16           "In December 1991, it was obvious that the left  
17           ureter was not draining and he ended up with a left  
18           sided ureterostomy. This was followed by a left  
19           ureteral ureterostomy to try and solve the problem of  
20           drainage of his left renal tract. He had  
21           a fundoplication in 1992 for GOR ... an attempt at  
22           retrograding in January failed to identify the right  
23           ureteric orifice."

24           Adam's mother asked Dr Savage to obtain from  
25           Mr Boston -- that that's surgeon I've just read out his

1 note to -- a second surgical opinion. So by the time  
2 she gets to December 1992, she wants a second opinion  
3 and she wants Mr Boston to give it.

4 Mr Boston refers to Mr Brown having agreed that that  
5 should happen and, on 30 March 1993, Mr Boston saw Adam  
6 and his family, and it seems from Adam's notes that the  
7 last surgical procedure performed by Mr Brown on Adam  
8 was a cystoscopy on 8 February 1993 and thereafter,  
9 Mr Boston and a number of others operated on Adam, as  
10 you can see. If you look at the schedule of surgical  
11 procedures, you can see the last procedure that Mr Brown  
12 does until we get to his assisting Mr Keane, and you can  
13 see who is involved and what they're involved in. There  
14 are supplementaries on the procedures and the way that  
15 I have just spoken about them now.

16 So thereafter, Mr Brown and a number of others  
17 carried out that work. And Adam's mother states that  
18 she made it quite clear that she didn't want Mr Brown to  
19 be involved in any surgery with Adam because, "Previous  
20 experience had left me with no faith in him."

21 For the sake of completeness, the other members of  
22 the transplant team were the assistant -- I should just  
23 say, obviously, there's going to be an issue to be  
24 explored in the oral hearing as to exactly how and why  
25 Mr Brown became a member of the team and what Adam's

1 mother was told about it and when she was told about it  
2 and the significance of all that for consent and there  
3 will be an issue from a governance perspective at all.

4 For the sake of completeness, the other members of  
5 the transplant team were the assistant anaesthetist, the  
6 theatre nurses and the medical technical officer. And  
7 they were included, so far as we can, tell, from the  
8 papers at this stage, in this way.

9 On 26 November 1995, Dr Montague, senior registrar  
10 in anaesthesia was the resident on call for both the  
11 labour ward and theatres. That was 24-hour shift that  
12 was due to end at 9 o'clock in the morning of Monday  
13 27 November 1995, which of course was the morning of  
14 Adam's transplant surgery, and he was brought into the  
15 team by Dr Taylor as an assistant anaesthetist for  
16 a limited period until the end of his shift. So that's  
17 Dr Montague.

18 Dr Savage contacted the theatre and thereafter the  
19 theatre nurses for Adam's transplant surgery, who were  
20 staff nurses Conway, Popplestone and Mathewson, all  
21 seemed to be those who were on duty at that time, and  
22 specifically staff nurse Conway was on duty on Sunday  
23 26 November 1995 and handed over to staff nurse  
24 Mathewson at 8 am on Monday 27 November 1995.

25 Now, staff nurse Popplestone claims to have come on

1 duty at 8 am on that Monday. But there is an issue to  
2 be determined about that because staff nurse Conway has  
3 a different view as to when staff nurse Popplestone came  
4 on duty. She says that staff nurse Popplestone came in  
5 early to prepare her instrument set as a scrub nurse for  
6 the surgery -- and that can be seen from the witness  
7 statements -- and joined her at approximately 7 am. So  
8 there's an issue as to which nurses were there in the  
9 operating theatre, and when they were there.

10 Then we have Peter Shaw. He acted as a medical  
11 technical officer for Adam's transplant surgery and it  
12 seems that he was simply the medical technician on duty  
13 on that day. You can see from his witness statement  
14 that he doesn't particularly remember that, but his  
15 manager has been able to identify that from the records  
16 so far as we understand it. So that's the team as far  
17 as we know apart from a couple of other additions.

18 In addition to that, Dr Taylor claims that he was  
19 assisted by an anaesthetic nurse and, as I indicated to  
20 you yesterday, he said actually he would not have  
21 administered the anaesthesia without three nurses being  
22 present. He also claims that Dr Montague was replaced  
23 in the operating theatre at the end of his shift by a  
24 trainee anaesthetist.

25 So there are issues to be explored in the oral



1 hearing as to exactly how the transplant team was put  
2 together, who was in it, what information about the  
3 principal players of the team was given to Adam's  
4 mother, both prior to and following the taking of her  
5 consent for this transplant surgery, and issues about  
6 the reasons for Mr Brown's involvement, together with  
7 the significance of his particular knowledge of Adam for  
8 the transplant surgery. And you will have when that  
9 knowledge dates back to. There are issues about whether  
10 there was an anaesthetic nurse to assist Dr Taylor and  
11 if so, who she was, and if there wasn't one, why wasn't  
12 there one. Whether Dr Montague was replaced by an  
13 anaesthetic trainee and if not, why not, and if he was  
14 replaced at what stage or, more precisely, when was he  
15 and by whom. And all those issues raise questions also  
16 to be addressed from a governance perspective.

17 Then we come to Adam's care, discussions among the  
18 transplant team. Adam was admitted on to Musgrave Ward  
19 under the care of Dr Savage, who acknowledges in his  
20 inquiry witness statement of 14 April 2011 that he was  
21 responsible for satisfying himself that the renal  
22 transplant protocol was followed. That renal transplant  
23 protocol includes the measurements of his electrolytes,  
24 and he was also responsible for ensuring that Adam was  
25 properly managed and that he was fit for his transplant

1 surgery and that he was in the best condition possible  
2 when he was taken to theatre.

3 Dr Coulthard's comments in his report on  
4 7 November 2011 deal with Dr Savage's role in the  
5 management of Adam's preoperative fluids and in  
6 delivering Adam to the operating theatre in appropriate  
7 condition. Dr Coulthard also refers in his report of  
8 4 December 2012 to the Newcastle guidelines and explains  
9 why a report blood test is not included in them, and  
10 you'll recall this is -- this was a very live issue  
11 until 1 February of this year. But it may still be  
12 an issue for learning about when you take electrolyte  
13 tests for a procedure of this nature and why you're  
14 taking them at that stage. He also responds to the  
15 different view expressed by Mr Koffman in his report for  
16 the PSNI of 5 July 2006 on that question. There's  
17 a difference of view between those two experts.

18 Mr Koffman thinks it would have been helpful to have had  
19 an electrolyte test done; Dr Coulthard is not so  
20 concerned about it, largely because of what he thinks is  
21 the effect of the peritoneal dialysis overnight. But in  
22 any event, he says when he returns to that issue -- he  
23 deals with whether it's desirable or mandatory in his  
24 report on 7 November 2011, and it ultimately comes down  
25 to whether the nephrologist thinks it's something that

1 should happen and you will see Dr Savage's view about  
2 whether he thought that such a test should have  
3 happened, and if it didn't happen in the evening,  
4 whether it should have happened first thing in the  
5 morning when Adam had been anaesthetised and there was  
6 ready access, without troubling him, to his blood and  
7 you will see that, in a way, what Dr Coulthard is really  
8 doing is deferring to: if the consultant anaesthetist  
9 thinks it would be useful, probably, unless there's some  
10 very good reason why not, it should happen.

11 The issue as to whose responsibility it was to have  
12 carried out the repeat blood test that is referred to in  
13 the renal protocol. Of course, it is in the protocol so  
14 it's not just a matter of people exercising judgment  
15 without a guidance at all; it's in the protocol that  
16 there should be a check of the electrolytes. Whether  
17 and when it should have been done and its significance,  
18 those are all things to be addressed fully at the oral  
19 hearing.

20 The management of Adam's peritoneal dialysis  
21 overnight was also a matter for Dr Savage's  
22 responsibility, which he concedes in his inquiry witness  
23 statement. In fact, one way of looking at it is, to  
24 a large extent, it is Dr Savage's responsibility to get  
25 Adam through the evening of 26 November and to the

1 operating theatre on 27 November in as good a shape as  
2 he possibly could, for that surgery to give him his best  
3 chance of having a successful outcome, both in terms of  
4 obviously surviving the surgery, but also a successful  
5 outcome in terms of the transplant. And that's  
6 essentially what I think one can take from what  
7 Dr Savage says and what some of the other experts say as  
8 well.

9 So the condition of Adam is really something that is  
10 his primary focus. And that, therefore, means it's part  
11 of the peritoneal dialysis that's part of maintaining  
12 Adam's condition the evening before.

13 However, having said that, he does acknowledge that  
14 there are no dialysis records. At least, if there are,  
15 none have been identified. And we look at  
16 Dr Coulthard's comments in his report on 7 November 2011  
17 on Dr Savage's role in the management of Adam's  
18 preoperative fluids and dialysis. And then one should  
19 also look at the report of the nursing expert for the  
20 inquiry, Ms Ramsay, on record keeping generally, and  
21 then there's Dr Haynes in his report. He states that  
22 the nursing staff on the ward should have kept  
23 meticulous details of Adam's fluid balance while he was  
24 being dialysed: the volume of urine produced, precise  
25 details of all fluid administered to or taken in by

1 Adam. And the anaesthetist should have reviewed that  
2 information before Adam's transfer to theatre. But  
3 clinical examination would have given a guide as to  
4 whether Adam was hydrated, dehydrated or fluid  
5 overloaded and Adam should have been weighed at the end  
6 of dialysis and the ward nurses would have been  
7 responsible for recording all that information under the  
8 direction of the nephrology team. And Dr Haynes states  
9 that the adequate information in this respect does not  
10 appear to have been made available to Dr Taylor.

11 So whilst Dr Savage is responsible for the condition  
12 of Adam coming in, there are tests and results being  
13 produced that are necessary or useful for the others who  
14 will be involved in his renal transplant, the  
15 preparation for his surgery and actually conducting his  
16 surgery. That's where this area is moving into: whether  
17 there is proper and adequate testing done and, if there  
18 was, whether it was properly recorded and what was the  
19 quality of the information that was being provided to  
20 other clinicians who were going to play their part  
21 in the renal transplant for Adam.

22 Then if one looks again at Sally Ramsay's report,  
23 she states that the record keeping fell below the  
24 expected standards, more elements of Adam's care  
25 required more detailed documentation. Perhaps if one

1 goes back to the idea of having a plan: if you don't  
2 have a plan, then there is an issue as to whether you  
3 should at least maintain very detailed records so that  
4 those who are coming who have no prior knowledge  
5 necessarily of the child have an opportunity to learn as  
6 much as they can of that child before they embark upon  
7 the process of major surgery on him. And for example,  
8 she gives examples of what she regards as deficiencies:  
9 there was no nursing care plan, the dialysis records  
10 were not recorded, including the number of cycles, the  
11 volume of fluid removed post dialysis and post-dialysis  
12 weight. There was no prescription for dialysis  
13 detailing the type of fluid, the volume for each cycle,  
14 the number of exchanges, the dwell time. The  
15 prescription chart nursing and medical records did not  
16 make clear any intention to administer the fluids at  
17 75 ml an hour. They're on the prescription, you can see  
18 that they're prescribed, if you look at the  
19 documentation, but what Ms Ramsay is saying is that  
20 the nursing records don't make clear any intention of  
21 administering that or when the feed stopped at 5 am, so  
22 there's no plan in relation to that, and there's no  
23 prescription for the initial infusion of the rate of  
24 20 ml, of which 18 ml were delivered, despite the  
25 cannula having been inserted by a doctor who would have

1           been able to write the necessary prescription. There's  
2           no record of the actual type of gastrostomy feed or  
3           whether there were bolus feeds, no individual hourly  
4           recordings, merely a running total which is incomplete.  
5           she says:

6                    "If 'clear fluids' meant 'Dioralyte', there was no  
7           prescription written for that fluid. Prescriptions for  
8           medicines should have been signed to confirm they had  
9           been given. Vital signs were not recorded  
10          post-dialysis. Adam's height had not been measured  
11          contrary to the admissions protocol."

12                   His height, of course, is one of those things that  
13          enables you to estimate the surface area and that forms  
14          part of what his insensible losses might have been. And  
15          Sally Ramsay goes on to state:

16                    "Renal nurses, as nurses working in a specialist  
17          area, would have been able to initiate urinary  
18          measurement or ask a doctor whether urine was to be  
19          measured. Adam's nappies could have been weighed to  
20          estimate his urine output as a child in chronic renal  
21          failure about to undergo major surgery."

22                    And her overall impression is that:

23                    "The care given to Adam preoperatively lacked  
24          structure and this resulted in omissions in his care."

25                    And then if one goes to Dr Coulthard's reference in

1 his report of 4 December to the effect of dialysis on  
2 imbalance in biochemistry and Adam's condition when  
3 arriving at theatre. He says:

4 "The effect of Adam's dialysis on his fluid balance  
5 and serum sodium levels, including the fact that he  
6 received only 8 of his usually 15 cycles, that is  
7 a matter that was the subject of discussion during the  
8 experts' meeting of 9 March."

9 We can see that from the transcript and we'll wait  
10 to see what their views of that are, but that is  
11 certainly an issue, what consideration was given as to  
12 whether that would have any effect.

13 There is a recent statement in from Dr Savage on  
14 that very question and his view would appear to be very  
15 much that of Dr Coulthard's, which is that the effect of  
16 the peritoneal dialysis may have been to have corrected  
17 any of those imbalances, but those obviously are issues  
18 and they're issues to be developed further in the oral  
19 hearing.

20 Dr Savage also liaised with Dr Taylor in relation to  
21 his particular requirements for clear fluids and the  
22 cessation of fluids in relation to safely anaesthetising  
23 Adam and ensuring that what was prescribed by junior  
24 staff -- and that was doctors Cartmill and O'Neill --  
25 ensuring that they had actually prescribed and had



1 administered what he wanted.

2 In addition, Dr Savage describes himself as liaising  
3 with Mr Keane and Dr Taylor to formulate a plan for the  
4 arrangement and conduct of Adam's renal transplant, but  
5 that, of course, would necessarily be something that was  
6 happening on 26 November.

7 And then, if one looks to Dr Coulthard on the fluid  
8 management information that Dr Savage provided to  
9 Dr Taylor, it deals with that in his report, and he also  
10 deals with matters that Dr Savage should have discussed  
11 with Mr Keane.

12 It seems that Dr Savage took the decision to accept  
13 the donor kidney once the transplant cross-matching  
14 process was complete at some time in or around  
15 1 o'clock, and that indicated a half match. And  
16 Dr Coulthard indicates or comments in his report:

17 "A child who was thriving happily on dialysis would  
18 be listed to have an especially well-matched and, in  
19 some ways, extremely suitable kidney."

20 And then he goes to:

21 "The range of issues to consider include the size  
22 and age of the donor, their medical condition before  
23 retrieval, the time since the organ was harvested, any  
24 anatomical issues such as multiple arteries and the  
25 degree of tissue type mismatch."

1           So essentially he's saying those are the things we  
2           think about, but if we have a child who's doing well and  
3           is healthy, then in his view you list that child to have  
4           an especially well-matched and, in other ways, extremely  
5           suitable kidney, and there will be an issue as to  
6           whether the donor kidney that was ultimately accepted  
7           for Adam fits that description of especially  
8           well-matched and, in other ways, extremely suitable  
9           kidney.

10           Then, compliance with the 1990 Children's Hospital  
11           guidelines on paediatric renal transplant. Those are  
12           quite often called the renal transplant guidelines. The  
13           protocol for paediatric renal transplants that was  
14           operating at the time of Adam's surgery was called  
15           "Renal transplantation in small children". That had  
16           been introduced by Dr Savage in September 1990. The  
17           examinations and investigations on admission included  
18           a chest X-ray. Adam's notes include a request by  
19           Dr O'Neill for such a chest X-ray, but in the evidence  
20           part of this opening that I was going through yesterday,  
21           you will appreciate that although there is a request for  
22           it and you can see the request form in these notes,  
23           there's absolutely no record of the corresponding  
24           radiological report. In fact, there's no direct record  
25           that a chest X-ray was actually carried out. There are

1 references to whether Adam's chest was clear or not, but  
2 there's no reference in the notes to that being related  
3 to or derived from a chest X-ray. In fact, that's  
4 exactly what has happened and what I've just explained  
5 is recited in a DLS correspondence.

6 The implications of that are that the post surgical  
7 X-rays that were taken at 13.20 and 21.30 on 27 November  
8 could not be considered by Dr Landes, who was the  
9 radiologist instructed by the inquiry, but more  
10 particularly by the radiologist at the time by reference  
11 to Adam's pre-state. So if one was trying to see what  
12 the effect of what had happened over the surgery had  
13 happened, you didn't have a before X-ray. What you had  
14 was two afters, 13.20 and 21.30. And so there was no  
15 way to look at what the implications of what they were  
16 seeing were or how any of that reflected the  
17 administration of 1,500 ml of hypotonic fluids during  
18 his surgery. That doesn't, of course, mean that the  
19 X-rays weren't useful; they were trying to see whether  
20 there was any pulmonary oedema and, if there was, if  
21 there was a gradual progression of it. So of course,  
22 they had clinical utility. But for this particular  
23 point, to see whether you could see the implications of  
24 what had happened during the surgery to him, they were  
25 missing an X-ray beforehand.

1           That is an issue that will be pursued, as I say,  
2           firstly, as a matter of fact, so we can find out what on  
3           earth happened about it, and also from the point of view  
4           of record keeping and protocol, compliance with  
5           protocol.

6           The absence of a pre-surgical chest X-ray is only  
7           one issue in relation to record keeping that's going to  
8           be pursued during the oral hearing. And I had indicated  
9           another one that we will also pursue and this is this  
10          matter of the record of his serum sodium levels. At  
11          2300 hours, 11 o'clock, Dr O'Neill records Adam's serum  
12          sodium level from bloods taken at approximately  
13          9 o'clock as 139 millimoles. However, there is no  
14          corresponding laboratory report, so we don't know how  
15          that result was actually got, except for it's just  
16          written there in his notes.

17          In the absence of a printout, his handwriting was  
18          misread by Dr O'Connor, and she recorded Adam's serum  
19          sodium level as actually 134 millimoles on the  
20          transplant form. Subsequently, the inquiry received  
21          a set of laboratory results from the DLS and that  
22          included a laboratory report dated 27 November 1995 in  
23          respect of blood specimen taken at some time on the 26  
24          November 1995. That report records Adam's serum sodium  
25          levels at 133 millimoles, as I've already told you

1           yesterday.

2           There's no reference to that at all: not to the  
3           laboratory report, not to the values that it shows in  
4           Adam's notes and records, and it's not clear whether at  
5           any time anyone appreciated that, over that evening of  
6           26 November, that Adam's serum sodium levels had fallen  
7           to a level that was just below the range of 135. So  
8           in the mid-evening, it's 139, perfectly within the  
9           acceptable range of 135 to 145. Then, if it is the case  
10          that it's from bloods taken at about 11, then it's now  
11          fallen just below that range. Well, we simply need to  
12          see whether anybody knew that had happened and if they  
13          did know that it happened, what, if any, significance  
14          they attributed to it.

15          I think I'm being indicated ...

16   THE CHAIRMAN: If you finish this section and then we can  
17          break.

18   MS ANYADIKE-DANES: I think one of the other matters to be  
19          explored is not just from a clinical point of view that  
20          we don't know how these matters arose, but we don't know  
21          what effect, if any, they had on anything. From  
22          a governance point of view, which we will look at later  
23          on, that might be potentially quite significant. As it  
24          happened, his serum sodium level had fallen to 133. If  
25          it had fallen to even more than that, unless anybody was

1 looking at any other factors that would assist them in  
2 appreciating that, that might be something of quite some  
3 significance. But the junior doctors who were  
4 looking -- who were in Dr Savage's team and looking at  
5 these things have no knowledge of that. They wouldn't  
6 know that something serious had started to happen before  
7 he went into his transplant surgery. We know they  
8 didn't test them before that, so we know the opportunity  
9 to check whether any such thing had happened wasn't  
10 there. So, yes, I've identified the clinical issues,  
11 but from a governance issue, how that could happen and  
12 what you ought to put in place to make sure that that  
13 sort of thing doesn't happen, that is something that we  
14 are going to look at.

15 There might be some very obvious explanations for  
16 it, but we haven't seen them on the face of the medical  
17 notes and records yet and we haven't seen them recited  
18 in the witness statements yet, so it is something we're  
19 going to pursue.

20 The protocol did provide for electrolyte tests, as  
21 you know, and that didn't happen, and the witness  
22 statements of Dr Montague and Dr Taylor provide the  
23 explanation for that. And they say that Adam was upset  
24 and that a decision was made to leave him alone until  
25 the morning. I don't think any of the inquiry's experts

1           have taken issue with leaving him alone. I think where  
2           the issue turns is having decided they are leaving him  
3           alone, should you then be carrying out the test before  
4           he embarks on the surgery. Thereafter, Dr Taylor just  
5           didn't seem to consider that the pre-surgical  
6           electrolyte check was a priority. In fact, he said so  
7           in a number of his statements.

8                     His reasoning is not always clear, nor always  
9           entirely consistent, but in his most recent statement of  
10          1 February 2012, he accepts that he should have sent  
11          a sample to the laboratory for electrolyte analysis  
12          before surgery commenced. So he accepts it now. There  
13          is still an issue as to what he has said about it  
14          previously and how he came to say those things. That  
15          will be explored in the oral hearing.

16                    So Dr Haynes is of the view that serum electrolyte  
17          measurement was strongly indicated at the completion of  
18          dialysis and that, as an absolute minimum, once Adam was  
19          anaesthetised. So we will see how they finally resolved  
20          themselves in their expert reports. And whatever it  
21          might be that peritoneal dialysis was doing over the  
22          evening, Dr Haynes was strongly of the view that it was  
23          indicated at the completion of dialysis. He says that  
24          there could be abnormal results and that, if there were  
25          abnormal results, that would have guided the fluid and

1 electrolyte administration, and that is a principal role  
2 of the anaesthetist during surgery.

3 Dr Coulthard, as I've just indicated to you before,  
4 took a different view. He takes a different view, as  
5 I've said, because of what he thinks is a consequence of  
6 the process of dialysis. The basis of the explanations,  
7 as I've mentioned, that Dr Taylor gave about his conduct  
8 in relation to the serum sodium tests, those are going  
9 to be explored, as is the question of the likely effect  
10 of the peritoneal dialysis on his hydration and serum  
11 sodium levels. And not just the likely effect, but what  
12 people thought at the time was going to be the likely  
13 effect because those are the people making decisions  
14 at the time and, whatever they thought, what should they  
15 have thought at the time.

16 I recognise that we are dealing with things from  
17 very much a time remove: we're in 2012 with our experts,  
18 and they were in 1995 with their patient. So it is  
19 important to make sure that we are addressing things  
20 from what people should and could have appreciated at  
21 that time.

22 THE CHAIRMAN: Okay. That's a convenient point. We'll  
23 break for 15 minutes and, after the break,  
24 Ms Anyadike-Danes will finish. Mr McBrien will present  
25 his address and then we'll cover any outstanding issues



1           which have to be dealt with today. Thank you very much.

2   (11.40 am)

3   (A short break)

4   (12.02 pm)

5   MS ANYADIKE-DANES: The next phase that I want to move to is  
6           the timing of the surgery and the cold ischaemic time.  
7           It seems from Adam's notes and records that before the  
8           results of the tissue matching were received at about  
9           1.42 in the morning of the 27th, a decision had been  
10          made for the transplant surgery to start at 6 am on  
11          Monday 27 November.

12                    It's not clear exactly when that decision was made,  
13           but it should have been known by those making it that at  
14           6 am, the cold ischaemic time of the donor kidney would  
15           be approximately 29 hours. In fact, the start time of  
16           the surgery was put back to 7 am and there are issues  
17           about that, and we'll explore how that happened and why,  
18           and the donor kidney was not perfused with Adam's blood  
19           until about 10.30 on the 27th, following an anastomosis  
20           time of 120 minutes. That makes the total cold  
21           ischaemic time approximately 32 hours.

22                    The warm ischaemic time, there be an issue that will  
23           be discussed as to its significance, but anyway it is  
24           clear from Dr Savage's inquiry witness statement of  
25           14 April that he incorrectly believed when making this

1 statement that putting back Adam's surgery to 7 would  
2 constitute only 16 hours after the kidney had been  
3 donated, and his inquiry witness statement shows that he  
4 had assumed that the kidney had been donated at 1.42 pm  
5 on Sunday the 26th, as opposed to early in the morning,  
6 1.42 am. Thereafter, he states in his inquiry witness  
7 statement of 28 September that this error in regards to  
8 the time was in the statement, not at the time of the  
9 surgery, and that he:

10 "... would have been unlikely to accept the kidney  
11 if I believed we were unlikely to be able to perform the  
12 transplant within 24 hours of it being donated."

13 In other words, what he was saying is it was  
14 unlikely that he would have accepted it if he had  
15 thought that, by the time they got around to being in  
16 a position to be able to perform the surgery, that would  
17 have been after or in excess of 24 hours of it being  
18 donated. So he was really therefore envisaging the  
19 surgery being completed at 1.42 on Monday morning.

20 Cold ischaemic time of the donor kidney is referred  
21 to by Mr Koffman in a letter to the inquiry dated  
22 7 July 2010, and he notes that the average cold storage  
23 time in the UK is about 20 hours, but he goes on to  
24 state that he had been involved in transplanting organs  
25 with cold storage times greater than 48 hours with

1 a great deal of success. The particular circumstances  
2 of those surgeries have not been provided to the inquiry  
3 and that's a matter that we might explore in the oral  
4 hearing. But he goes on to state that the longer the  
5 cold storage time -- and this is really the significance  
6 of it -- the more likely there is to be acute tubular  
7 necrosis, which can affect the blood circulation of the  
8 kidney and might explain the description of the donor  
9 kidney not looking so well perfused in the later stages  
10 of the operation. It will be recalled that Dr Taylor  
11 expressed the view in his deposition at the inquest that  
12 the new kidney did not work leading to a re-assessment  
13 of the fluid given.

14 The significance of the cold ischaemic time of the  
15 donor kidney is also expressed by Messrs Forsythe and  
16 Rigg in their joint report of June 2011. They  
17 associate:

18 "A prolonged cold ischaemic time with delayed kidney  
19 function, which can increase the risk of thrombosis in  
20 children."

21 They also refer to the seeming two hours of warm  
22 ischaemic time involved in the preparing and  
23 transplanting the donor kidney, which they consider  
24 overlong and likely to have caused it irrevocable  
25 damage.

1           The cold ischaemic time of the donor kidney,  
2           especially in relation to the decisions that were made  
3           by Dr Savage, Dr Taylor and Mr Keane during the  
4           pre-surgical period and its infarction are issues that  
5           will be addressed in the oral hearing.

6           It's probably worth noting that nobody -- in the  
7           same way as none of the experts have thought that  
8           anything to do with the condition of kidney or the way  
9           in which the transplant surgery, from the actual  
10          surgical point of view, caused Adam's death. That's not  
11          the issue that we're exploring here. We're exploring  
12          this as a significant element of his care, which is also  
13          part of the terms of reference. And so we are looking  
14          at the surgical care he received, and that is its  
15          significance. So we will be exploring in the oral  
16          hearing actually what they had appreciated about the  
17          donor kidney's cold ischaemic time and, when they were  
18          making the decision, the basis on which they appreciated  
19          that, and what they actually weighed up, whether they  
20          turned their minds to the risks of the successful graft  
21          of the kidney and whether they weighed up those risks  
22          and obviously decided to proceed, why they did and what,  
23          if any, of that they communicated to Adam's mother.  
24          Those are the sorts of issues that will be pursued. And  
25          also what, if any, of that can be related to the

1 condition as observed of the kidney during the surgery  
2 and its condition as observed during autopsy. How is  
3 all that related to these factors? Those are the sort  
4 of things that we will be exploring.

5 In fact, just as I talk about that, the condition  
6 of course of the kidney was examined and has been  
7 commented upon by at least two experts. It was examined  
8 at autopsy and Dr Armour made a number of histological  
9 slides. She provided those to Professor Berry. He was  
10 engaged by the Coroner specifically to provide  
11 the Coroner with an expert report, a report to the  
12 inquest. Of course, at that time, nobody knew what the  
13 effect of the kidney might or might not have been to  
14 Adam. He examined those slides and he expressed the  
15 view in his report of 23 March 1996 that the transplant  
16 kidney was infarcted, dead. That's if you look at his  
17 report. He puts it as bluntly as that:

18 "The extent of change suggested that this occurred  
19 at or before the time of transplantation and this could  
20 be resolved by enquiries about the fate and function of  
21 the donor's other kidney after transplantation."

22 And we did make those enquiries.

23 Dr Armour concluded then, because her report of  
24 autopsy come after his report, that:

25 "There was complete infarction of the transplanted

1 kidney."

2 The PSNI, when they were conducting their  
3 investigation, they gave Professor Risdon -- you can see  
4 his qualifications -- a number of tissue samples from  
5 the transplanted kidney to examine for the purpose of  
6 advising on the likely time of its infarction. That's  
7 what they wanted to know. When was it dead,  
8 effectively. And he concluded that the changes seen  
9 in the transplanted kidney were more advanced than would  
10 be expected after only 24 hours of non-perfusion.

11 The starting point for that calculation would be  
12 some time after the completion of the vascular  
13 anastomoses at 10.30 and the perfusion of the  
14 transplanted kidney with Adam's blood and would extend  
15 to the removal of ventilatory support. So that's the  
16 time when the donor kidney is hooked up to the time when  
17 ventilatory support is removed. So then you have  
18 a period of time when the kidney is simply there and  
19 reached to round about 11 o'clock, I think, when it's  
20 being examined the following day at autopsy. So he's  
21 taking that into consideration, factoring that in, but  
22 he's saying even if you factor all that in, he says he  
23 sees more advanced changes in that kidney than you would  
24 otherwise expect, unless of course the kidney was  
25 infarcted at or some time before its actual

1 transplantation.

2 So he goes on -- it's a very short report and he  
3 says:

4 "In my opinion, the transplanted kidney must have  
5 suffered significant ischaemic damage prior to its  
6 insertion for this degree of ischaemic damage to be  
7 apparent at post-mortem."

8 It's really as blunt as that. He also referred to  
9 the other kidney from the donor and he drew support for  
10 his conclusion from the fact that that kidney had also  
11 failed. So we made enquiries, as I said we did, about  
12 the fate of that kidney and we had a response in  
13 a letter in June 2010 from NHS Blood and  
14 Transplant, and they explained that the other kidney,  
15 which had been transplanted on 26 November 1995 --  
16 obviously they were both removed at the same time --  
17 that kidney actually was transplanted that day, the same  
18 day. That had failed, but the explanation for the  
19 failure was poor recipient arteries, which is obviously  
20 something to do with the recipient. It can be addressed  
21 by the experts, but my understanding of that is that the  
22 poor recipient arteries meant the blood supply to the  
23 donor kidney wasn't sufficiently good to sustain it.

24 What would have happened if there had been good  
25 recipient arteries, nobody knows because we're not

1 in that situation, but that's as much as we know about  
2 what happened about the other kidney.

3 So there are issues to be addressed during the oral  
4 hearing in relation to the timing of the transplant  
5 surgery, the cold ischaemic time of the donor kidney  
6 transplanted into Adam, whether its condition had any  
7 effect during the transplant surgery as well as the  
8 ultimate cause of its infarction. Having said that,  
9 it is important to note that the experts have all formed  
10 the view that the infarction of the transplanted kidney,  
11 whenever and however it occurred, that did not  
12 contribute to Adam's death. But as I said, it's  
13 an important issue from the point of view of his care.

14 If we go then to taking consent for Adam's  
15 transplant surgery. Dr Savage assumed the sole  
16 responsibility for taking consent from Adam's mother for  
17 his transplant surgery. He also states that in 1995, it  
18 was not uncommon for initial consent to be obtained by  
19 someone other than the surgeon carrying out the  
20 procedure. That's commented upon by Professor Koffman  
21 in his report of 5 July 2006, which he carried out for  
22 the PSNI during their investigations; he was their  
23 expert. It appears from the records that consent for  
24 the operation was not performed by the surgeons, but  
25 probably by the paediatric nephrologist, Dr Savage. And



1 this would be normal accepted practice in the mid-1990s.

2 He then goes on to state:

3 "It will be important to view the consent form and,  
4 if possible, the topics that were discussed with Adam's  
5 mother, including the risk of death and serious adverse  
6 events from the procedure."

7 Well, you can review the consent form and there's  
8 not a lot in it that will tell you or help you with what  
9 was discussed with Adam's mother. Of course, you know  
10 from Dr Savage that whatever was discussed with Adam's  
11 mother, it wasn't recorded. So it is an issue at the  
12 oral hearing of what was discussed, what he informed her  
13 about it, the circumstances and context, what she would  
14 be expected to appreciate about it and what she herself  
15 understood about it at that time. Those are all issues  
16 to be addressed.

17 Dr Coulthard expresses the view that, in 1995, it  
18 was common for the final written consent for a child's  
19 kidney transplant to be undertaken by the consultant  
20 paediatric nephrologist. However, that is put in the  
21 context of a surgeon having previously been involved and  
22 he explained that.

23 "In our local arrangements, the parent will always  
24 have met a transplant surgeon in advance of the surgery  
25 and will have covered the relevant issues then."

1           Then Mr Forsythe and Rigg, they note in their report  
2           of June 2011 that consent was taken by Dr Savage, who  
3           they say was not capable of carrying out the transplant  
4           operation himself, and they then express a different and  
5           very firm view to that of Mr Koffman and Dr Coulthard  
6           and that it is the role of the transplant surgeon to  
7           gain consent from paediatric patient's parents and this  
8           was the case in 1995 as well as now.

9           I'm simply, in this opening, reading out certain  
10          extracts from all these expert reports. Of course  
11          you'll read them yourself in full and we will address  
12          them in full with the experts. But what I'm identifying  
13          is some of the critical issues that they identify about  
14          these things. So there are a range of matters that  
15          Dr Savage believes he communicated to Adam's mother  
16          prior to or at the time consent was taken, although as  
17          I say, he acknowledges that he didn't record it. He  
18          says he communicated to her the donor kidney was an  
19          adult kidney, effectively, that a paediatric surgeon  
20          would be involved who had knowledge of Adam's previous  
21          surgery, who would therefore be available instantly  
22          during the transplant procedure, that several units of  
23          blood would need to be cross-matched because of the risk  
24          of blood loss during surgery, that Adam's normal  
25          overnight feeds would need to be changed so that his

1 stomach was empty at the time of receipt of anaesthetic  
2 and that once Adam's tube feeds had ceased, some  
3 intravenous fluids would be given to him up until he got  
4 into the operating theatre.

5 The issues relating to consent which will be dealt  
6 with at the oral hearing that will include the  
7 information that should have been provided to Adam's  
8 mother, particularly in relation to risks, and those who  
9 should have been involved in explaining that information  
10 to her for the purpose of obtaining her consent for  
11 Adam's transplant surgery. And then, of course, the  
12 information that actually was provided to her and the  
13 explanation for what that information was.

14 The issue of consent is an important issue that will  
15 be looked at from a governance perspective as well,  
16 including the consideration of the extent to which the  
17 consent form that was used complied with any current  
18 requirements as to consent forms. If it didn't, why  
19 didn't it?

20 I move now to the information gathering by the  
21 transplant team. I mentioned some of this, a little  
22 before, the importance, when I was discussing record  
23 keeping, of recording those results precisely so that  
24 those who are going to be involved in Adam's surgery  
25 could appraise themselves of his condition, as it were,

1 and as part of their own planning for what they were  
2 going to have to do.

3 So the value of the information gathering for the  
4 transplant team rather depends on the quality and  
5 accessibility of the information that had been compiled  
6 on Adam once he was placed on the transplant register.  
7 That goes right back to the issue that we discussed  
8 before about the planning for that. Dr Haynes states  
9 that as Adam was such a complex patient, a medical  
10 summary should have been prepared when he was placed on  
11 the transplant waiting list, and placed in a prominent  
12 place in the case notes. That was important because the  
13 surgeon involved in that initial assessment may not be  
14 the actual surgeon performing the transplant operation.  
15 That's something that I've already said that is  
16 mentioned by Coulthard in his report.

17 The depth and efficacy of the information gathering  
18 process at the initial assessment stage to go on to the  
19 transplant list and therefore on any reviews prior to  
20 the offer of a donor kidney lay the foundation for  
21 a well planned and successful transplant. And it's this  
22 information, together with Dr Savage's briefing to the  
23 surgeon and anaesthetist preoperatively, which forms the  
24 basis of the actual plan for the particular transplant  
25 surgery that's going to happen that day or whenever

1           it is going to happen once they get the offer.

2           So of course you've got a plan -- according to the  
3           experts, there should have been a plan starting from  
4           when he was put on the actual transplant list and that  
5           tells you all about how you're going to manage him and  
6           what information you're going to collect and where  
7           you're going to put it for convenient use. But then he  
8           talks about this phase just before -- once you've  
9           actually got an offer of a donor kidney and how you use  
10          that information that you hope has been accumulated so  
11          that they can prepare for the surgery.

12          By 26 November 1995, Adam's medical notes were been  
13          contained in 10 files, so if there wasn't a ready  
14          summary that had started to be compiled once he was put  
15          on the transplant register, then there's an issue to be  
16          explored as to how those who were coming in to perform  
17          the surgery were to glean the information that was  
18          important for them to have along with whatever briefing  
19          they were given from those ten files.

20          I hope, when we have the oral hearing, that we'll  
21          have them here, the actual files, so that one can see  
22          the volume of material that anybody coming in would have  
23          had to work their way through to find whatever they  
24          thought was the important information that they needed  
25          to prepare themselves for such a procedure.

1           Dr Haynes would have expected the anaesthetist to  
2           have sifted through Adam's notes to gain an  
3           understanding of the pathology involved and to identify  
4           particular problems as well as introducing himself to  
5           Adam and his mother and to examine Adam, as required.  
6           That's part of what Dr Haynes considers is an  
7           information gathering exercise for the anaesthetist.  
8           Dr Haynes says that the preoperative assessment is an  
9           integral part of the anaesthetist's duties and, if not  
10          performed adequately, mistakes will inevitably be made.  
11          And he would have expected Dr Taylor to have ascertained  
12          the nature of Adam's renal pathology, noted Adam's  
13          current normal fluid balance and electrolyte  
14          requirements, including his fluid intake, normal  
15          insensible fluid losses, usual volume loss during  
16          peritoneal dialysis and Adam's average urine production  
17          and also noted that Adam required sodium supplements to  
18          maintain normal sodium serum levels and that he could  
19          not regulate urinary sodium losses. That's what he  
20          would have expected Dr Taylor to have had by way of  
21          information on Adam.

22                 He states that the anaesthetist should have realised  
23                 that sodium had to be given as a constituent of all  
24                 fluid administered and that repeated tests on Adam were  
25                 required to ensure that the sodium serum concentration

1 was acceptable, ascertained the detail of the  
2 post-operative course following major surgery. For  
3 example, December 1991 to January 1992, ascertained the  
4 details of Adam's normal peritoneal dialysis regime,  
5 read the medical correspondence after the nephrology  
6 outpatients visits, noted any difficulties arising in  
7 previous anaesthetics and to have noted any other  
8 features regarding Adam's health.

9 Mr Forsythe and Mr Rigg say that the transplant  
10 surgeon ought to have met Adam and his family when Adam  
11 was first assessed for transplant and prior to going on  
12 the transplant list and that the operating surgeon  
13 should see the patient and parents again before surgery,  
14 preferably early in the preoperative period, to reassess  
15 the patient and become fully aware of all active  
16 problems and any relevant past medical and surgical  
17 history. In other words, he may have been seen and  
18 certain notes made of him, but things may have changed.  
19 There needs to be a period before the donor kidney is  
20 offered, and so the surgeon coming in to perform the  
21 transplant should meet and assess the patient, satisfy  
22 himself -- which is how matters lie -- and also meet the  
23 patient's parents. They also state that the transplant  
24 surgeon should have been aware of Adam's current  
25 position, active problems, past medical and surgical

1 history and recent and current results of investigations  
2 and should have examined Adam's abdomen. There appears  
3 to be no record of a transplant plan of Adam. That's  
4 what they note.

5 The timeline that I went through yesterday, or at  
6 least introduced you to yesterday, and which will  
7 you will see, is a very long document -- I accept that  
8 because it is dealing with about four years and I have  
9 really only described one or two pages in it for  
10 illustrative purposes. But I do suggest that you look  
11 at it because it does try and provide some sort of  
12 running chronology of the things that were happening to  
13 Adam and when they were being done and when they were  
14 happening.

15 But anyway, it highlights a number of factors from  
16 Adam's notes and records that they may have been  
17 relevant for the transplant team to have known or  
18 appreciated before embarking on the transplant, for  
19 example, Adam's previous fluid balances. It's something  
20 that the experts feel they ought to have been aware of:  
21 his episodes of hyponatraemia, the level to which his  
22 serum sodiums fell, and the way at which they did so  
23 and, if it's disclosed in the records, why.

24 You can see the rate at which that was happening  
25 from the actual schedule of the results and you can see,



1 graphically, when he had his loads from the actual chart  
2 that I took you to yesterday. The details of his  
3 previous surgeries, especially those involving central  
4 lines and urethral catheters. And you can see those  
5 from the schedule of previous surgical procedures that  
6 I provided. But they, as the clinicians, will have  
7 access to that information from his medical notes and  
8 records and they would be able to see, just as we have  
9 distilled them out, the descriptions of those surgeries  
10 and what was happening.

11 Dr Savage was familiar with Adam's notes and records  
12 as he'd been in charge of Adam's care since his  
13 admission to Musgrave Ward in 1991. Both Dr Taylor and  
14 Mr Keane say they read Adam's notes and records prior to  
15 surgery. The inquiry's expert Dr Haynes refers in his  
16 report of August 2011 to the central importance of  
17 Dr Taylor knowing about Adam's past history of  
18 hyponatraemia with serum sodium results below  
19 120 millimoles and its implications for his fluid  
20 management.

21 The inquiry's experts, Forsythe and Rigg, also deal  
22 in their report of June 2011 with the importance of  
23 Mr Keane being aware of Adam's history of hyponatraemia  
24 and of his current condition as well as being aware of  
25 Adam's active problems, past medical and surgical

1 history and recent and current results of  
2 investigations. Pausing there: from their point of  
3 view, it's not just Dr Taylor as the anaesthetist who  
4 needed to know that he had a history of hyponatraemia.  
5 From their point of view, the surgeon needed to know  
6 that as well and they say that Mr Keane should have seen  
7 the following documents before commencing surgery: the  
8 operation consent form; kidney donor information form;  
9 the admission notes from the 26th and 27th, including  
10 results of investigations; an investigation summary  
11 sheet to know what the trend for results of  
12 investigations had been in the preoperative period;  
13 recent clinic letters; and knowledge of Adam's previous  
14 abdominal surgical procedures.

15 When I said that Dr Savage was familiar with Adam's  
16 notes and records, he's their initial point of contact,  
17 so he's contacting them and inviting them to be part of  
18 the transplant team. So there is an issue as to the  
19 quality and extent of the information he gave them.  
20 They have, so we understand it, their own obligations to  
21 satisfy themselves that they understood about Adam, that  
22 he was a person who knew Adam best, so there may be  
23 an issue as to exactly what was conveyed and how  
24 adequate it was in the time that was available to  
25 communicate with those people, over and above the

1 quality of the investigation that Dr Taylor and Mr Keane  
2 made as to Adam's own condition.

3 So those are issues to be explored. An important  
4 one is: if they had the time, what would they have  
5 learned from Adam's medical notes and records,  
6 configured as they were, assuming they're contacted some  
7 time in the evening of 26 November? And if those notes  
8 were not in a form which was easily accessible to them  
9 so that they could get the relevant information, then  
10 there may be questions: why weren't they?

11 The timeline highlights from Adam's notes and  
12 records periods of his dehydration and polyuria -- those  
13 were one of the red-line issues I read to you -- anemia,  
14 iron deficiency -- that's another red-line issue -- and  
15 the administration of erythropoietin -- another red-line  
16 issue -- and whilst there's agreement amongst the  
17 inquiry's experts that they actually are all risk  
18 factors for the chronic venous thrombosis that  
19 Professor Kirkham thinks is a possibility for Adam, they  
20 disagree that any of them actually operated to expose  
21 Adam to the risk of developing that condition. But they  
22 do say that those are risk factors, so there's an issue  
23 to be explored whether those, as risk factors for  
24 anything in particular, were identified or recognised by  
25 the clinicians, and if they were, what did they do about

1           them. We'll see.

2           The issue of whether Adam was likely to have or did  
3           develop chronic venous thrombosis and its relevance to  
4           the development of his cerebral oedema obviously is  
5           something to be addressed during the oral hearing. It  
6           obviously has quite significant implications.

7           I have, Mr Chairman, for this opening largely dealt  
8           with the span of the period from when it was decided to  
9           place Adam on the transplant register until the morning  
10          of his transplant surgery, which is the preoperative  
11          stage and the preoperative planning stages. There are  
12          other issues leading up to the end of where I wanted to  
13          get to with the opening, the end being the report on  
14          autopsy, and they can be categorised into the remaining  
15          three periods. I have previously told you there were  
16          four, I've dealt with one. That's the perioperative  
17          period: that deals with that period from the start of  
18          his anaesthesia for his transplant surgery until he's  
19          transferred to paediatric intensive care. So that's  
20          when the transplant's going on, basically, and deals  
21          with all that was happening, both from a number of  
22          different perspectives, all that was happening in terms  
23          of who was there. That's one question. All that was  
24          happening in terms of what people were doing, who were  
25          there. So if you look at it from the point of view of

1 the anaesthetist, Dr Taylor, what was he doing in terms  
2 of Adam's fluid management? If you look at it from the  
3 point of view of the surgeons, what were they doing in  
4 terms of the actual transplant itself? And if you look  
5 at it from the point of view of the nephrologist -- and  
6 we know that Dr Savage was not there for the entire time  
7 and that Dr O'Connor came in and out -- but there'll be  
8 an issue as to what the nephrologist should have  
9 appreciated about what was going on and what they should  
10 have been doing as well as, of course, what actually was  
11 happening to Adam and why was that happening.

12 So that's a very big area and it is no surprise that  
13 that is the area that the experts are most concerned  
14 with, particularly that latter point, which is what  
15 actually was happening to Adam and why was it happening  
16 to him.

17 Then there is post-operative period to deal with.  
18 That really is the period from his transfer to  
19 paediatric intensive care up until his death. There are  
20 issues to deal with that as to, what, if you look at  
21 that period, might explain or help to have a better  
22 understanding of what was happening to him actually  
23 during the surgery or rather why it was happening to him  
24 if one looks at that period there.

25 And then, of course, there's the period following

1 his death, which deals largely with the autopsy up until  
2 the verdict on inquest and how that autopsy was  
3 conducted: what was the information that was obtained  
4 and what is one to understand from that information?  
5 Those events that took place in those periods are all  
6 deeply associated with clinical matters of evidence and  
7 the debate that I've already said about the experts and  
8 are therefore not a matter that I can address with you,  
9 Mr Chairman, today, but will be addressed, so far as it  
10 can be, when we get all these reports in, on 16 April.  
11 So those are matters that I will have to leave over.

12 THE CHAIRMAN: Thank you very much indeed.

13 Mr McBrien?

14 Opening by MR McBRIEN

15 MR McBRIEN: Thanks to the inquiry team's sterling efforts  
16 to date, Adam's family now has a fairly good idea of  
17 what happened. However, there are still gaps. They  
18 hope that the relevant witnesses will provide  
19 informative answers to the following: did a desire to  
20 increase their transplant statistics play any part  
21 in the fact that neither Dr Savage nor Mr Keane  
22 suggested to Adam's family that in view of all the  
23 issues arising, Adam's surgery could or should have been  
24 cancelled?

25 On a more specific basis, bearing in mind the

1 desirability of having a donated kidney in place within  
2 24 hours of it being harvested, why did Dr Savage not  
3 make it clear to both Dr Taylor and Mr Keane that the  
4 clock was running from 1.42 am on the morning of Sunday  
5 26 November 1995? Was it because he confused 1.42 am  
6 with 1.42 pm as he had indicated to the police in his  
7 statement at 093-006-016?

8 As the clinician who knew Adam best, why did  
9 Dr Savage not take a more active role in theatre to  
10 protect Adam's health and well-being? Why has Dr Savage  
11 never realised in a period of 16 years that the  
12 calculations were wrong and that Adam was not in a fluid  
13 deficit situation when he went to theatre?

14 Why did Dr Taylor make so many mistakes? Why did it  
15 take Dr Taylor 16 years to recognise the fact that he  
16 made so many mistakes? Why did Dr Taylor not have  
17 adequate anaesthetic assistance for the whole of the  
18 operation? Why was there such poor communication  
19 between the clinicians?

20 Will Mr Keane answer the following questions put to  
21 him by the inquiry? For the avoidance of doubt, these  
22 are:

23 First, what would he have said or done if he had  
24 been told of a CVP reading of between 20 and 25,  
25 approximately 15 minutes before the completion of the

1           vascular anastomosis?

2           Secondly, what would he have said or done if he had  
3           been told of a serum sodium reading of 123 at 09.32?

4           Thirdly, whether he thought a chest X-ray should  
5           have been taken to check the line position in respect of  
6           the CVP.

7           The family also want to hear Mr Keane's views on who  
8           he considers has the final say as to whether fluid is  
9           administered in a situation where the surgeon requests  
10          more fluid is given, for example, to increase kidney  
11          perfusion and the anaesthetist present believes this to  
12          be inappropriate.

13          Using the expression "knife to skin", did this  
14          actually happen at 0800 or some other time? When was  
15          the donated kidney actually put into Adam? In other  
16          words, when did anastomosis occur? When did the surgery  
17          actually end? At the moment, the family are bewildered  
18          by all the conflicting evidence. For example, the  
19          experts say that it should only have taken 90 minutes  
20          from knife to skin. On such a view, it should,  
21          therefore, have ended at about 9.30.

22          Dr Taylor has said on one occasion that he put in  
23          more fluid at 09.30 to pink up the donated kidney.  
24          Dr O'Connor recorded the anastomosis time as being  
25          10.30. Mr Keane said he left after the anastomoses.



1 Adam did not leave theatre until noon. Who was doing  
2 what during the period from 0800 until noon?

3 Bearing in mind that they were said to be there to  
4 learn, Adam's family want to hear what both Dr Montague  
5 and Mr Brown have to say about what they actually  
6 learned from the operation.

7 Adam's family want a definitive answer to  
8 questions: how did Mr Brown come to be involved and why  
9 did Dr Savage, as a matter of common courtesy, not tell  
10 Debra that Mr Brown was going to be involved? Adam's  
11 family want to know why Mr Brown has proved so evasive  
12 in some of his answers to the inquiry. This can best be  
13 seen in one of his witness statements, where he has  
14 answered that he does not understand the relevance of  
15 the questions in relation to the list of surgical  
16 procedures and his role and involvement, the fluid  
17 management regime employed in each procedure and the  
18 lessons learned about Adam's fluid management for  
19 surgical procedures.

20 Adam's family want definitive answers as to who was  
21 present and when, notwithstanding both an inquest and  
22 a police investigation, the following issues still  
23 arise. Who were the nurses present in the theatre  
24 between 0700 and 0800? Nurse Conway was there, she's  
25 referred to nurse Popplestone. However, nurse

1 Popplestone stated she only arrived at 0800. When  
2 precisely did Dr Montague leave? He was still present  
3 when Dr O'Connor arrived. When did Mr Keane leave? At  
4 what time did Eleanor Donaghy arrive? She said she saw  
5 him in theatre. Adam's family also want to know why was  
6 there no anaesthetist to replace Dr Montague? Who wrote  
7 up the blood loss figures between 0700 and 0800? And  
8 whether Dr Campbell will remember anything about what  
9 happened.

10 The overall position is best summarised by  
11 Dr Coulthard, a document at 200-022-272. He has  
12 written:

13 "Adam's death was an avoidable tragedy. I am  
14 pleased that Dr Taylor has recently been able to  
15 recognise that his decision to infuse a massive volume  
16 of hypotonic into Adam was a mistake, as it may now  
17 finally allow important lessons to be learned and  
18 shared. Any tragedy should be used to learn from, so we  
19 may be able to build ways of doing better in the future  
20 and avoid repeated mistakes in other children. It is  
21 a shame that it has taken so many years for the lessons  
22 to be learned in this case."

23 For the sake of all our children, how such  
24 a situation should be avoided in future will have to be  
25 addressed in both the clinical and the governance parts

1 of this inquiry. Thank you.

2 Housekeeping

3 THE CHAIRMAN: Thank you, Mr McBrien.

4 In the absence of any other opening addresses, let  
5 me move on to a few more issues before we finish for  
6 today.

7 As you know from what you've heard from  
8 Ms Anyadike-Danes, she will complete her opening on  
9 16 April. That has been brought about because of the  
10 reports which are still coming in from the Newcastle  
11 meetings. We have, this morning, received  
12 Professor Gross' report and we can arrange for that to  
13 be circulated tomorrow. We understand that  
14 Professor Kirkham's report will be available later  
15 today, so we will arrange for both of those reports to  
16 be circulated tomorrow.

17 We will also ask our advisors to update the  
18 consolidated report which was circulated in  
19 late January/early February to you in light of what has  
20 been discussed since they wrote that report and we will  
21 ask the peer reviewers to comment on the advisors. The  
22 advisors' report, I hope, should be available by the end  
23 of this week so that you then have an idea not only of  
24 what the further expert reports say, but also what the  
25 advisors have highlighted to the inquiry as outstanding

1 issues of concern.

2 The fact that the opening has to be completed on  
3 16 April means that we may have to tweak the witnesses  
4 who are giving evidence that week. Professor Savage is  
5 due to start on Monday 16th. Can I ask, I think, Mr  
6 Fortune, you represent Professor Savage; is that right?

7 MR FORTUNE: I do, sir.

8 THE CHAIRMAN: If Professor Savage's evidence didn't finish  
9 on Monday 16th, could he run into Tuesday 17th? Is he  
10 available on Tuesday 17th?

11 MR FORTUNE: Yes, he is, but my first question would be how  
12 long my learned friend in completing her opening is  
13 likely to take on that Monday because, listening to my  
14 learned friend, I anticipate that she has still a great  
15 chunk of opening to deliver. If so, Professor Savage is  
16 not likely to start his evidence until some time around  
17 the midday adjournment, and that may be hopeful. More  
18 realistically, it may be that I ask for Professor Savage  
19 to start his evidence cleanly first thing on Tuesday  
20 morning because there may be matters that we need to  
21 reflect upon in the course of that day, following my  
22 learned friend's completion of her opening.

23 THE CHAIRMAN: Okay. What I was going to say, what I was  
24 coming to is that we're due to sit from Monday 16th to  
25 Thursday 19th. We can actually sit on Friday the 20th

1 as well. What I wanted to check was whether, if your  
2 client is available on the Monday going into Tuesday, if  
3 Dr Taylor, who was due to be Tuesday/Wednesday, if he is  
4 also available on the Thursday, if his evidence runs  
5 over, and if Mr Keane is then available on Thursday into  
6 Friday, we could still have at least four days to hear  
7 their evidence that week, even if we started late on the  
8 Monday or didn't start on the Monday at all.

9 MR FORTUNE: Sir, can I deal with that matter in two ways?

10 Firstly, Professor Savage has made himself available  
11 throughout the whole period with which clinical issues  
12 are to be addressed.

13 THE CHAIRMAN: That's very helpful.

14 MR FORTUNE: There is a matter about his availability during  
15 the period relating to governance, but I needn't detain  
16 on you that matter at the moment. However, looking at  
17 the witness list, and looking at the days that have been  
18 assigned to each of the witnesses, at this stage is it  
19 more in hope that each witness will be completed within  
20 a day or, in Dr Taylor's case, two days? Because the  
21 timetable will come under great pressure unless a tight  
22 rein is held to all the witnesses. We're not at this  
23 stage suggesting a guillotine of any questioning, but  
24 clearly there must be concerns with slippage.

25 THE CHAIRMAN: Well, a tight rein has to be kept,

1 Mr Fortune. That's why I'm suggesting that for that  
2 opening week, we try to keep Fridays free for a variety  
3 of reasons, but it's also there as a runover day if  
4 needs be, and it may be that we need it in that week.  
5 But in any event, I think you're confirming that your  
6 client is available that week and if his evidence starts  
7 late on Monday or doesn't start until Tuesday, he can  
8 accommodate that and I'm grateful for that indication.  
9 Thank you.

10 Mr Uberoi?

11 MR UBEROI: I don't know the answer off the top of my head,  
12 sir, but we could certainly make enquiries this  
13 afternoon and let you know straightaway.

14 THE CHAIRMAN: Thank you very much. Can I ask you, it would  
15 be helpful -- I'm not asking for an answer on the spot  
16 unless you can give it. But in his statement of  
17 1 February, Dr Taylor clearly changed his position in  
18 a number of fairly significant ways, which have been  
19 highlighted. One of the fundamental points which he had  
20 made previously was that he didn't believe that  
21 physiologically Adam could have dilutional  
22 hyponatraemia.

23 In his statement, which was volunteered to the  
24 inquiry, he says that, I think in effect, he now  
25 recognises that the administration of excessive volumes

1 of hypotonic fluids can produce a movement of water and,  
2 in particular, lead to cerebral oedema, known as  
3 dilutional hyponatraemia [sic]. So he's now accepting  
4 that in fact in that can happen. It's not clear from  
5 that whether he also accepts that that is what did  
6 happen to Adam. Can you consider, can you confirm  
7 whether he -- he has moved from saying this couldn't  
8 have happened to saying it can happen. Does he move  
9 further and say it did happen or -- can you answer that  
10 immediately?

11 MR UBEROI: I think, sir, it's difficult for me to answer on  
12 the hoof now. I also don't have the statement in front  
13 of me. I recognise it's a potential middle path that  
14 arises from the extracts you have quoted to me and  
15 I recognise it's something Dr Taylor may well be  
16 questioned on.

17 THE CHAIRMAN: Okay, thank you very much.

18 Mr Millar for Mr Keane?

19 MR MILLAR: I'm sure he will be available on Friday if  
20 required. I think, sir, it's useful to point out that  
21 we seem to have used all of the Fridays during the  
22 clinical period. We did have Fridays as back-ups  
23 previously, but on this schedule all of the Fridays seem  
24 to be used except that first one.

25 THE CHAIRMAN: Well, yes.

1 MR MILLAR: On the schedule, sir, I think this was sent as  
2 a draft, the schedule. It'd be surprising if some  
3 people hadn't come back to the inquiry and indicated  
4 that a day doesn't suit, for example. I'm just  
5 wondering, is there to be a revised schedule which  
6 reflects the up-to-date position?

7 THE CHAIRMAN: I will confirm that whatever the up-to-date  
8 position is, it is circulated generally later on.  
9 Thank you very much.

10 Let me move on from that to refer to Claire's case  
11 because Claire's case is the next one scheduled to be  
12 heard, I think starting on 11 June. I think you'll  
13 understand how the inquiry's operating. We get advice  
14 from the advisors, we get expert reports, and then we  
15 get witness statements from those who are involved in  
16 the care and treatment of the various children.

17 In Claire's case, we have, although we haven't  
18 shared it with you, a battery of expert reports and  
19 witness statements. We have been troubled by two  
20 particular problems, which I'm afraid are unavoidable.  
21 The first is that one of the doctors who was separately  
22 involved in looking after Claire has been very ill and,  
23 as a result of that illness, was unable to provide the  
24 detailed witness statement which you were looking for  
25 without some considerable delay. That has knocked back



1           our preparation to some extent.

2           Secondly, on our side of the house, one of the  
3           inquiry expert witnesses has had to withdraw from the  
4           inquiry due to illness; he simply cannot continue.  
5           Those reports will be circulated and shared, even though  
6           that witness will not be available to give evidence.  
7           We are resolving at the moment how that void will be  
8           filled and we'll come back to you on that as soon as  
9           possible.

10           The result of that is that although we have made  
11           very, very substantial progress in Claire's case, we are  
12           not yet ready to distribute either form of witness  
13           statements, that is the witness statements from those  
14           who were involved in her care or the expert witness  
15           statements. And I think, as you know from the way that  
16           we've dealt with Adam's case, we prefer not to do that  
17           until we have received -- we prefer not to distribute,  
18           for instance, the expert witness statements until  
19           we have received the witness statements from those who  
20           were involved in looking after one of these children  
21           because, frankly, we would prefer the people who are  
22           giving us information about their role in the care and  
23           treatment of a child not to see what the experts are  
24           saying until we have received a report from them.

25           Our original intention was to distribute those

1 reports before Easter. That is not achievable, but  
2 I haven't missed the fact that Claire's hearing will be  
3 starting on 11 June and we will report back to you on  
4 16 April on what further progress we've made in Claire's  
5 case to advance it. It is substantially advanced, but  
6 it's not quite at the stage that we needed it to be  
7 because of the illnesses to which I've referred.

8 Beyond that, I have nothing further to say to  
9 anybody here. Unless there are any issues which anybody  
10 wants to raise, can I say that we'll adjourn now and  
11 resume with the evidence and the resumption of  
12 Ms Anyadike-Danes' opening on Monday 16 April.

13 Thank you for your time.

14 MR McCREA: Mr Chairman, just before you do rise, for the  
15 purposes of the record, my name is Michael McCrea, I'm  
16 instructed by Ferguson Solicitors on behalf of the  
17 Roberts family. Mr Chairman, you indicated that you've  
18 got problems in relation to the combination of witness  
19 statements and the matter is going to be reviewed.

20 Is that my understanding, reviewed 16 April?

21 THE CHAIRMAN: No, we will report back to you on 16 April to  
22 tell you what further progress we've made.

23 MR McCREA: Does that mean therefore that no documents will  
24 be released prior to 16 April?

25 THE CHAIRMAN: I understand the concern that you have about

1           seeing the documents far enough in advance of 11 June.  
2           But I think you'll understand our point that if we are  
3           still seeking some -- as a result of witness statements  
4           we have received, we sometimes go out and ask for either  
5           a supplementary statement or a witness is identified,  
6           about whom we were previously unaware. We are very,  
7           very reluctant to distribute the witness statements  
8           including the expert statements we've received,  
9           which frankly could tip off a witness from whom we're  
10          seeking a further statement. But there's a balance here  
11          between providing you with the information and us  
12          keeping the system as pure as we would like.

13   MR McCREA: I appreciate that, Mr Chairman. The problem,  
14          of course, is in Claire's case there's a considerable  
15          overlap, not only in time but also in terms of personnel  
16          and issues between Claire and Adam's case. And the  
17          problem arises that if documents are released so late in  
18          the day, as far as Claire's case is concerned, we may  
19          not be in a position to properly prepare both Claire's  
20          case and also deal with the commonality in Adam's and  
21          Claire's cases.

22   THE CHAIRMAN: Okay. Well, I'm not sure if I can say much  
23          more, but I understand the concern because I think it's  
24          been raised by your Mr Quinn, before. We'll do  
25          everything we can to facilitate you, but we have to get

1 round this problem of the illnesses. Thank you very  
2 much.

3 (1.00 pm)

4 (The hearing adjourned until Monday 16 April at 10.00 am)

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