Tuesday, 19 June 2012

(10.00 am)

(Delay in proceedings)

(10.07 am)

DR JOSEPH GASTON (continued)

Questions from MS ANYADIKE-DANES (continued)

THE CHAIRMAN: Good morning. Dr Gaston, thank you.

MS ANYADIKE-DANES: Good morning, Dr Gaston.

I wonder if I might ask you something right at the outset because I wonder if there may have been a bit of confusion when I mentioned or you mentioned Dr Lyons. I think you referred to a Morrell-Lyons(?). I had thought of a Samuel Lyons. Actually, there's a Samuel Morrell-Lyons. But I wonder if there's something you wanted to explain about that.

A. Yes. This sort of triggered something in terms of the background to this, which I think I wanted to highlight.

Q. Yes, of course.

A. One of the things that had been apparent to me during the discussions following the death and into the period of investigation, which would have occurred ... And I said in the statement -- and I say this still clearly -- I don't remember in detail the meetings, but the one thing that became apparent to me in some of those meetings was that I felt we needed an external

opinion. I felt that it probably needed to be a paediatric anaesthetist with particular experience in fluid electrolyte balance.

There were certain sensitivities around that and having only been in Northern Ireland a relatively short time and having had very limited experience of the National Health Service, I felt that I needed to talk to someone senior. And Dr Morrell-Lyons had no role within the management of the Anaesthesia, Theatres and Intensive Care directorate, but he had been president of the Association of Anaesthetists and I ... He was a senior -- to me, conceived to be a senior person and I needed a confidential conversation.

I explained to him that I felt that this case could be quite an area where there could be some differences of opinion that needed to be cleared up and I felt we needed someone with real experience to actually advise the coroner. He agreed with me and we then went and we had a meeting. I spoke to Dr Murnaghan and he arranged a meeting with Mr Leckey, Dr Murnaghan and myself and Dr Lyons and we raised this issue.

The outcome of that meeting was that I would agree to find, on behalf of the coroner, someone who would meet the specifications that I had suggested. I didn't have any names because I just didn't know the

establishment in the same way, but I knew that Dr Peter Crean was a member of the Society of Paediatric Anaesthetists and felt he might have someone who he could suggest or could find out from London.

So I went to Dr Crean and said, "This is what we're looking -- we're looking to see if we can get a paediatric anaesthetist with particular experience in the management of fluid and electrolyte balance". He went to either the College or the Association or the Paediatric Society and he came back and said, "The name that we have been advised to submit is Dr Ted Sumner". That, I think, explains what Dr Sumner's role -- he then became adviser to the coroner.

Q. Yes. I wonder if we can pull up this -- I think to some extent Mr Leckey has rehearsed a little bit of that in a letter that he sent to Dr Armour on 13 December 1995. We can find that at 011-027-128.

If you see there in the first paragraph:

"I had a very useful meeting with Dr Murnaghan and two anaesthetists from the Children's Hospital."

That's yourself and Dr Lyons. Then he has you both saying it would be most important to obtain a paediatric anaesthetist's opinion and they both pointed out that Dr John Alexander has little, if any, experience in that specialist field. That's the paediatric side. And they

made the point that, in their considered view, the death had nothing to do with anaesthetics. We will come back to this letter later on, but from your point of view, what then goes on to be said is:

"They all agreed it was an immensely complex case. The meeting was amicable and I agreed to obtain the opinion of a consultant paediatric anaesthetist."

He goes on to say, although he doesn't say how he came by that name, he goes on to say that Dr Edward Sumner has agreed to provide him with an opinion. The upshot of all this is really for Dr Armour to make contact with him and she ultimately sends him a letter of instruction. If you look over the page to 129 you see:

"I feel he will be in a better position than I would to set out the complexities in the case."

That's exactly what she does. She sends him a letter in much the same way as she did with Professor Berry and attached documents for him. And he, in due course, produced a report for the coroner and attended to give evidence at the inquest. That's what you're talking about?

A. Yes, it is.

Q. Thank you very much indeed.

There are some matters that I have been asked also

to pick up and some that I would like to pick up with you from your evidence yesterday. I will take them in the order in which you gave it because that might help you. I hope that we can pull up the transcript. If we can, it's the transcript of yesterday, which was obviously 18 June, and if we go to page 106. I'm hoping that we'll be able to do that.

Yes, we can. If you go down to line 23. This is the whole issue that I was asking you about, whether the State Pathologist's Department had asked that the bodies could come to the mortuary with the lines out and so on. There's an issue about whether that would be standard practice. But in any event, you end up by saying:

"I think this case that we're talking about is somewhat different from usual in that there was a great effort to resuscitate him at the end."

What did you mean by that?

A. Well, I think initially -- and I'm going back a little bit. My understanding is the end, whenever Dr Taylor ended the anaesthetic, he realised that the patient had got fixed dilated pupils. In terms of his cardiac outputs, et cetera, I'm not sure where they were, but he wasn't at that point -- he was possibly clinically dead, but he still had activity. So there was -- and I think this comes from the evidence. There was some

resuscitation exercises, trying to address this possibility that this was, in fact, not a terminal event.

Q. Yes. That's what I'm trying to get at really. You're the medical person. What would that actually have meant that they were doing there in the theatre?

A. I think it would be important probably that that be taken up by Dr Taylor at that point.

Q. Well, I entirely accept that. It's just that -- it's one of those things that you have remembered and said that there was a great effort to resuscitate him and I'm trying to find out what that was.

A. There was some statement -- I think it was when Dr Taylor gave evidence originally -- that he went back to the intensive care unit and I think when I'm saying resuscitate, I'm talking about that intensive care services were provided to him, is what I'm saying.

Q. Ah. Just so that we are clear, are you talking about something that you have learned subsequently or something that you knew at the time because Dr Taylor, in that conversation you had with him, told you that?

A. It would have come out in terms -- I think probably in some of the discussions or maybe even the coroner's inquest that that had happened. I don't think Dr Taylor said to me at the time -- I can't remember the details

of that conversation, but I don't think so. I mean, what I was trying, I think, to explain at that point in time is that it was, I think, general practice that if you had -- in fact, if you had a death in theatre and it's really then the standard procedure should have been and was that all lines were remaining in place, all endotracheal tubes remained in place, so you had a static situation so that whenever you then went to investigate, there was nothing that could actually -- and I think that was what the State Pathologist felt and I think that was the appropriate thing.

I think in this case it may have been that because it wasn't declared in theatre that the patient then went to intensive care unit and I'm not sure now at what point he was declared clinically dead. There may well have been a sense in which there was a period of time there when it wasn't considered that that was an acute incident in the sense of why the lines had been pulled. That might be.

Q. So what you're positing is that because he may not have been considered to have actually died literally there in the operating theatre, but was taken to paediatric intensive care and was declared dead there, it might be in those circumstances that they would remove the lines for some reason?

A. It might possibly be, particularly if they would -- and I can't say here because I didn't work there. But it might be to actually reduce distress to the family that, in that situation, they would make it as acceptable and easy for the family to view. That might be an explanation. I don't know.

THE CHAIRMAN: In other words, when his mother's holding him for the last time, there aren't lines and tubes coming out?

A. Exactly, that might be one explanation of this because certainly with regard to death in theatre, there was a standard procedure. I knew it from my North American experience and I know Dr Murnaghan would have done it. I can't remember the exact time, but he would have said "don't touch anything". So that might explain why it was slightly different in this case.

MS ANYADIKE-DANES: I understand that and, of course, Professor Savage is going to give evidence and he's a person who's recorded as having requested the lines to be removed so obviously we can ask him. But from a procedures point of view, presumably that's just the very area that the hospital and the State Pathologist's Department might have a discussion over because on the one hand you have the consideration to be given to the families when you're dealing with the death of a child,

particularly a very young child --

A. Sure.

Q. -- and on the other hand, you have the needs of the pathologists, who are trying to have as full and complete a picture as possible to help them with their investigations. So is that not an area where one might have considered "Maybe we should have some sort of memorandum or discussion as to where the balance lies"?

A. I think it probably would, in fact -- but I would say that I don't know that it was appreciated by everyone that this was a standard procedure with regard to death in theatre. I was very aware of it, particularly because of my North American experience, but also because of -- I knew that Dr Murnaghan was very aware of this too.

Q. I understand. Then if I can -- maybe I didn't quite understand what you meant, but if I can take you to page 114. Just at the bottom, you say:

"I was part of the investigation into Adam's death."

What did you mean by that?

A. I was part of the ongoing discussions and I'm not sure at which point -- I don't remember how many meetings there were, I don't remember who or what was there, but I was part of a -- I suspect, most of the meetings that were held to actually discuss what might have happened

in this case and look for the way forward. That was part of the reason why I felt we needed an external assessor because it wasn't particularly clear right at the beginning that this was just something very clear-cut and there were differences of opinion and it needed to be, I think, clarified.

Q. No, we'll come to that. The only thing is that the use of the expression "investigation" by someone like you, who actually is peculiarly qualified to know what that means and its significance, that's why I'm trying to understand. Discussions are one thing. Part of an investigation into Adam's death could well be another thing.

A. Right. I have to, I think, have the ... I would have probably perceived and probably still would perceive that the discussions that were ongoing were part of a broader sense of investigation into Adam's death. I think that -- I feel that that would be part ... Discussions were part of the investigation, I feel.

Q. Right. That's a very helpful clarification because I am going to ask you about investigations, obviously, but I'm going to do it when we come to it in its rightful place. Thank you. Just while we have it, you mentioned there were a number of discussions. You yourself have said that the meeting -- not really a meeting, but the

talk -- that you and Dr Taylor had, you believed you did record that somewhere, or at least it would have been your practised to do that. In terms of these other discussions was anybody making a record of that? I'm thinking particularly of your experience in these matters. Is anybody making a record?

A. These meetings were chaired by Dr Murnaghan and it would have been my experience that Dr Murnaghan would have kept a minute or some information with regard to that.

Q. Thank you.

A. And that would have -- I can't be clear about it now.

Q. And because he was doing that in the role of chair, then you wouldn't be doing it for your purposes?

A. I might have made the odd note from my own point of view, but I wouldn't have made a detailed note, no.

Q. Then moving on to page 125. This is just at the time when I'm asking you about Dr Taylor coming to see you because you have recorded, as I recite at line 10, that he did come to speak to you. What you then say towards the bottom at line 21 is:

"I think I might have known a little bit, but not very much."

This is about the circumstances of the death before Dr Taylor actually comes to see you.

A. Yes.

Q. Can you help us with what you would have known? You describe it as being a devastating death, but what would you have known before he came to see you?
A. My only memory of the first time I heard about this was walking along the corridor and being approached by someone who might well have been a nurse, "By the way, did you know that there had been a death of a renal transplant in the Children's Hospital?" I don't know how long after that that was and I don't know -- I don't think it was hours. I think it was -- it would have been later than that. It would have been shortly after that that I would have had some more formal -- and it would have been a formal discussion because I didn't know anything of the circumstances.
Q. I understand that. Admittedly you're saying you are not entirely sure, but you think it might have been a nurse --
A. Could have been.
Q. -- or at least imparted to you in that sort of way?
A. Yes.
Q. What did you do when you received that information?
A. I can't remember what I did. I really don't know. I didn't go to the paediatric hospital and say, "By the way, have you had a death there? What are the implications?" I didn't do it at that point. That's

the one thing I do remember. I don't know how I then took it forward. There were three other -- two other deaths that came up. I didn't know about those deaths. I only became aware of those deaths whenever the request from the coroner came. And that comes back to what I said yesterday that in the separate directorates, I wouldn't have known -- and they were usually handled within those directorates, including the links between the anaesthetists and the surgeons and the other services. That would have happened in the cardiac directorate and I would suspect there were quite a number of deaths in cardiac surgery that I have never known about, actually, because it wasn't -- it was normally managed within those services. So I wouldn't have automatically have moved in to say," What's going on here?"

Q. Well, yes, except to say that these are, nonetheless, deaths happening within your overall directorate, if I can put it that way.

A. Absolutely. And I think, in the circumstances, the only way I can explain that is to go back, that there was an anomaly in the way this whole thing was set up. It wasn't actually -- it would probably have been better that the whole things had been managed within the individual service area and then anaesthetists would

have been part of that. But the anaesthetists were never at all keen on that being part of the establishment. It was some years later, before I think -- I think they now are much more integrated but it was some time later that that happened in all cases.

Q. Why did Dr Taylor come to see you then?

A. I think I was perceived as the person who understood some of the challenges that the paediatric anaesthetists faced. They had gone through -- and I alluded slightly to it yesterday. They had been through a very difficult period when, in fact, we were down to two fully-trained paediatric anaesthetists and eventually, as I said yesterday, I got Dr Rosalie Campbell and Dr Rao. We had a significant period -- and I don't know what it was, a figure of six months is in my mind -- when we didn't do any elective surgery because the consultant anaesthetists were -- they could not work. We had two specialist paediatric anaesthetists. We had two supporting, which meant that Dr Taylor and Dr Crean were on call every fourth night, but also for very difficult cases, they became the longstops, they became the people who were contacted.

So I had been working on their behalf to correct that and I think they may have perceived that I was more understanding of the difficulties that they faced and so

I would very often have been the person that they would have come to to discuss their difficulties.

Q. Is that what you meant when you said in your statement that you would have offered to give them your support?

A. My support would have been the support with how he would go through the process, yes.

Q. It almost sounded like counselling to somebody who was a bit traumatised.

A. There was a degree of that, yes.

Q. Then at page 127, line 18. After I'd asked you whether, at that meeting with Dr Taylor, he provided you with the anaesthetic record, you said, "Not at that time". When did you get it?

A. I actually think the first time I saw the anaesthetic record was actually at the coroner's inquest. I think that was the first time I saw it. But I could be wrong.

Q. But why would you wait as long as that? You're having discussions --

A. I may have seen it as part of the discussions that were going on in Dr Murnaghan's office. I didn't myself -- I think I said yesterday that I did not, after that, have a one-to-one conversation with Dr Peter Taylor [OVERSPEAKING] Bob Taylor.

Q. You did say that, but what I'm really asking is: why didn't you go and get it? I can understand from what

you have said, given the way that matters arose, that you maybe didn't have it with you when Dr Taylor came to see you because you wouldn't necessarily know he was going to come and see you and, if he didn't bring it, you wouldn't have it. But after you had that exchange with him, why didn't you go and get it and see exactly what happened here?

A. I can't answer that. I mean, I can only say that, again, it comes back to the fact that ...

THE CHAIRMAN: Sorry, doctor. You saw Mr Leckey within a couple of weeks.

A. I couldn't remember -- yes. Certainly, it was before ... It was significantly after. It was as a consequence of these meetings.

THE CHAIRMAN: But according to Mr Leckey's note, you and Dr Lyons told him that it was your view that Adam's death was nothing to do with the anaesthetics. How could you possibly have told him that if you hadn't seen the anaesthetic records?

A. Well, maybe I have -- I apologise if I've got my memory wrong. The thing that I remember, the only thing that I can remember in detail about anaesthetics, is the anaesthetic record -- was the fluid, the detail that Dr Taylor had put into his fluid balance. That was the thing. That was --

MS ANYADIKE-DANES: Dr Gaston, I promise you, we're going to come to that. The issue here is: you are expressing views as to the complexity of the matter, which you may have gained just from what Dr Taylor said, although I'm going to take you to that, but also to what the possible involvement of it is. I'm trying to find out if Dr Taylor did not bring his notes and records with him to say, "Let's have a discussion, I'm a bit worried about the outcome here". Why didn't you, with all your training on risk management and so on and so forth, do the very basic thing and say, "Let me get the notes and records myself and see exactly what's going on here. At least I can give an informed view and maybe be in a position to provide more substantive support to Dr Taylor"?

A. I cannot say other than the fact that at this point in time, I cannot remember doing that specifically.

Q. Wouldn't you have wanted to do that?

A. I think that -- I think I probably, at that point in time, felt that this was a discussion that needed to involve all aspects of the care.

Q. Quite. But before you get into all the aspects, this is an anaesthetist, you're the clinical lead for ATICS. Wouldn't you have wanted to get the very basic information yourself?

A. I'm sure I would have.
Q. Let me help you. 059-071-164. This is a memo from Dr Murnaghan, which is circulated to Professor Savage -- Dr Savage as he was then -- Dr Taylor, Mr Brown and you are there and Dr Webb and Mr Wilson are there for action.

But in any event, what this says is:

"The coroner has spoken to me ..."

And he has:

"Requested a detailed statement from the anaesthetic technical staff about the equipment used during the surgery and anaesthesia. This has been arranged."

Then:

"Referred the matter to Health and Safety Inspectorate and in order that you may prepare the requested report, I'm sending with this letter an extract copy of the recent case notes. I have to send the original of volume 10 to Dr John Alexander, consultant anaesthetist, who has been retained by the coroner as an independent medical expert."

Firstly, this seems to indicate that you obtained the recent notes and records; would you accept that?
A. Can I clarify a little bit now? Because, in fact, this has brought back, to my memory, some aspects.
Q. That's okay.

A. One of the things that I did with regard to this was that I asked -- Dr Murnaghan had asked that the technical staff went in there. The technical staff who went in there -- I think I alluded to this yesterday -- were from the Royal site.

Q. Sorry, if we can keep to the bit about the medical notes and records, otherwise we will dive off in areas and not move through it logically. Does this indicate to you that you received Adam's recent medical notes and records?

A. It does suggest that I did see them.

Q. Yes. Although it's a little bit difficult to see, it's 6 December that is actually dated. The coroner seems to have worked out that he wants an independent medical expert in anaesthesia and so he's indicated that he's going to have Dr John Alexander. And in the letter that I took you to of the coroner before, is not what's happening actually a suggestion, "No, not Dr John Alexander. What you need is somebody who's more specialist in this area", and that's how you ended up going to Dr Sumner?

A. Can I clarify?

Q. Of course you can, but in order to know that, you must have looked, I would suggest, at the medical notes and records to have appreciated that this is the kind of

case where the expertise of Dr John Alexander, whatever that might be -- actually, this is a case that might require something else.

A. That would be much more in keeping with the way that I would normally have responded. I think the problem I have at the minute -- I can't actually remember that. I think what became clear was that I needed to have someone else move -- get in to investigate very immediately afterwards. Dr Murnaghan asked me could I identify someone who we considered independent, who could move in very quickly and actually investigate this case.

I said, "I think the one person who's in Northern Ireland who would have experience of paediatric anaesthesia, major paediatric anaesthesia, and who I considered independent at that point in time was Dr Fiona Gibson". She was the person providing the anaesthesia within Northern Ireland for paediatrics and for cardiac surgery. She was also someone who would have been involved in meetings and I felt to get an independent -- and I believe it was independent because she didn't work in the Children's Hospital. I felt that, as an immediate action, I should ask Dr Gibson to actually look at this.

I'm sure in retrospect -- presumably I actually went

over the notes with Dr Gibson in advance of that, I can't remember that, I apologise. Then Dr Gibson came in, and she came back with a report, she felt that the fluid management had been good, the anaesthetic delivery had been excellent. I think there's a copy of --

Q. We have and we're going to get to that. Is what you're saying: because you received that report, you were able to reach the view that this had nothing to do with anaesthesia when you met with the coroner?

A. I can only presume that was the reason why I said that.

Q. So if we park that for a moment, leaving aside the fact that she'd looked at the report, you have looked at the medical notes and records?

A. I must have done.

Q. Exactly. Are you saying, having looked at those medical notes and records, you could be advising the coroner that this case really had nothing to do with anaesthesia?

A. I felt that, yes, it -- let's say I felt that at this point in time it wasn't apparent that it was to do with anaesthetics and I felt we needed an external -- as did Dr Lyons because I had spoken to him as someone who had a wider experience than I had. I had spoken to him and we felt that it needed someone with --

Q. I understand that. Sorry, I don't mean to cut across

you. What I'm trying to get at is -- maybe we're using terminology slightly differently. When you said this had nothing to do with anaesthesia, did you mean this had nothing to do with the anaesthetic or this had nothing to do with the conduct of the anaesthetist?

A. I think I was ... That's going back a long time, actually.

Q. But it's quite an important distinction.

A. It is an important distinction. I don't think I can give you a straight answer -- not a straight answer, I can't give you an answer to this. What was in my mind as to whether it was an anaesthetic or whether it was the anaesthetist, I honestly don't know. But the reason I felt that we needed an expert is that that needed to be cleared up. We needed to be sure of what.

Q. Well, yes, we will look at Adam's anaesthetic record. But if you looked at that record, which if you were going to look at his recent medical notes and records, would at least involve looking at the anaesthetic record --

A. Sure.

Q. -- could you have looked at that record and come to the view that whatever happened to Adam couldn't somehow involve the conduct of the anaesthetist?

A. No, absolutely not.

Q. Thank you. Then at page 128, when you -- one of the things that you suggested, I think to Dr Taylor, is that -- this starts at line 12:

"He was so upset that he needed one of the really senior people to be able to talk it through with him as well as having talked it through with me."

A. Yes.

Q. When I asked you a little while ago why was it you thought that Dr Taylor had come to see you and you explained your reason, that you were a little bit of an advocate for them in their difficulties and so forth, and a sympathetic ear as well as being a very senior person and the clinical lead. But you now have a suggestion that he go and speak to one of the really senior people --

A. Mm-hm.

Q. -- in anaesthesia; why is that?

A. I think because I had come in quite recently. I mean, I'd become clinical director in, I think, about April 1993. I felt that he needed to talk to someone else. Not just to me. I was then in a position where I was the clinical lead and I had to be aware of that. I felt at that point in time that Dr Taylor -- and this goes back a little bit to the counselling thing we were talking about. And we had ... There is within

anaesthesia -- and I think, at that time, what we called "three wise men", and that obviously is something, I think, post-Bristol, et cetera. I think that changed. And Dr -- the two names that I mentioned there were ... Dr Morrell Lyons and Dr Dennis Coppell, I think were two of those people, and I felt that --

Q. And what were they to do if he went to see them?

A. Well, that would have been another sense in which someone else other than me, who was an anaesthetist, had a -- a senior anaesthetist had an opportunity to talk to Dr Taylor.

Q. Yes, but what were they going to talk to him about?

A. I think there was -- his feeling about the anaesthetic, his feeling about what had happened, his feeling about how he was going to actually take it forward, and how he would cope with it. That was really what I was thinking about.

Q. In the sense, the coping with it, although it was my terminology -- I think you agree with it -- there was an element of counselling going on between you and he. So on that side of it, you're providing that support and he had that confidence because he came to you in the first place; you didn't seek him out. In relation to the other aspects of it, the actual anaesthetic aspects of it, you seem to have formed a view, from what you told

us yesterday -- although I will make sure about that when I take you to it -- that you were broadly seeing where he was coming from in terms of his difficulties.

A. Yes.

Q. So what were these two wise men going to add to that?

A. They were adding a certain seniority and a -- I think it was important that Dr Taylor had an opportunity to speak to some other people of a senior level in ... Partly as a follow-up to the counselling type situation that I had talked about.

Q. Were you concerned that there was a risk that he was in error in some way and that it would be useful for him to speak to some very experienced anaesthetist if that was the case?

A. I was concerned about his welfare.

Q. Yes. That's a different --

A. It was. And I also was concerned at the possibility there was a mistake. I didn't actually say -- I didn't highlight that to him and Dr Taylor was concerned about that himself.

Q. He was concerned he might have made a mistake?

A. Yes. He said, "Looking at this anaesthetic, I can't see what I was done wrong, but if there is --

Q. But if we leave Dr Taylor to one side -- because he is going to give his own evidence about that -- this is

you.

A. Yes.

Q. You were concerned that there was a possibility that he could be at risk, he might have made an error?

A. I think once you have a death in an operating theatre, there are a number of things that can contribute to it. And one would be anaesthesia. It is just a fact that it is. All too often it's the one that's identified as being the cause initially and I've experienced that myself in the past. All too often it's that. What I didn't do at that meeting -- and I can clarify that because I do -- I did not ask Dr Taylor to bring notes to that meeting. When I saw the notes, I cannot remember, I'll be quite honest, but it wasn't at that meeting, I do know that.

Q. That's fine. Let's just stick to this point: the extent to which you thought he might be in error, and, therefore, if that was a possibility, he actually needed some senior anaesthetic people to talk to. Is that the sort of thing that was going through your mind?

A. That's right. This was -- I had very, very little knowledge of this.

Q. I understand.

A. And I suddenly was faced with a very complex situation with a distressed anaesthetist. I had to think, not

necessarily -- in retrospect, I might have said, "Maybe this and this", but I was faced with that at that point in time and I had to look at what was the best way forward. And one of the things I felt was -- and it was important that Dr Taylor made that decision himself. I did not want to push him to go and talk to someone else, but I offered him the opportunity to speak to someone else because certainly, in terms of the follow-up to this, it would -- I didn't feel that was the exact time and maybe I should have then said, "Come back to me and we will talk over this in detail later". I have no recollection that I did that.

Q. I'm going to ask you about that. Do you know if Dr Taylor took you up on your suggestion?

A. I do not know.

Q. Sorry?

A. I don't know. The obvious person to have -- for Dr Taylor to have gone to was the senior anaesthetist at that time, who was -- in paediatrics, who was Dr Kielty, but Dr Kielty was ill and off. He was the obvious person because he was the senior paediatric anaesthetist. He was the person that he probably would have gone to first, but he was ill.

Q. Yes.

A. So I think I was probably the next person that he came

to. I felt that it needed -- he needed to talk this further, but I couldn't pressurise him to do that. I offered him the opportunity.

Q. Yes, you have said that and it may be that we've gone as far as we can with it. But I am still trying to find out whether ... You are a senior anaesthetist yourself. You are senior in the directorate because you're his clinical lead. Whatever are the anomalies in the situation, you are his clinical lead.

A. Sure.

Q. You're the person, for whatever reason, he chose to come and speak to. I'm still not entirely sure why you didn't follow that up. I have understood what you said, that you didn't think that that was the time to be getting into the details of it, but after he had left, you could have got his medical notes and records. You could have seen from a more informed basis what was going on. You could have brought in the two others so that you then formed the three wise men and the three of you could have spoken to him and seen exactly what was going on once you had informed yourself. I'm trying to understand why you didn't do something like that.

A. I'm sorry, I can't go back and -- I can't tell you the answer to that because I just don't know.

Q. Isn't that how the three wise men system, if I can

elevate it to a system, works?
A. I think it was, but it wasn't anything I'd had to activate before in the UK.
Q. Did you, in some sense, think it was better if this was going to get a little bit difficult that somehow you, as clinical lead, weren't the person having the direct personal, if I can put it that way, exchanges with Dr Taylor?
A. I felt that I did not have the experience in paediatric anaesthesia that was required to actually fully investigate that case. And that goes back to the structure of the way it was set up. I think that -- I would have not had the experience of paediatric anaesthesia that would have allowed me to take this forward in detail. And I think at that point in time, the nearest I came to someone who would have had that would have been Dr Fiona Gibson.
Q. I understand that. But in fact, you've acknowledged that in some shape or form you were part of an investigation, maybe not a very formal one, but you were part of an investigation.
A. That's right.
Q. So you felt yourself sufficiently able to be part of that investigation with Dr Murnaghan. So the question I'm asking you is: did you see a difference between

doing that and lending support and assistance to Dr Taylor that he might require and maybe, if it's going to be an issue that potentially there's a problem with what he did, it might be better that you're not the person closest to dealing with him, if I can put it that way?

A. I think that that probably was my thinking, yes.

Q. Thank you. Can we now go back to when he's meeting with you and you go through and you say you help a little bit and, with a little bit of prompting, go through what you thought were the key difficulties.

A. Using my background in adult --

Q. I understand that entirely. I'm just trying to get your sense of it. Page 131 is, I think, where you start. It doesn't actually start, but it's where we can distill it. Line 3. I summarise what you are saying by asking you whether that meant that Adam was polyuric and you said: yes, it did. I'm going to ask you about that because you have described the whole procedure, from an anaesthetic and every other point of view, as being highly complex.

I am going to ask you why you think Adam's polyuria, from an anaesthetist's point of view, made it a complex procedure.

A. Because there was -- first of all, it wasn't

particularly common actually, and I know there was -- I've read some of the advice that's come from one of the experts with regard to this, paediatric anaesthetists, and said that in his case it would have been relatively common for him. He acknowledged that in Northern Ireland the incidence was less. I think the other point was that -- and from my own experience in the past, even though I did not anaesthetise paediatric anaesthesia, there were paediatric transplants that were done by the team of which I was a member.

Q. Yes.

A. And I do not remember ever a situation where that had been considered. The ones that I knew -- and this would have been in Saudi Arabia the ones that I knew. To my memory, it would have been very rare for it to be a polyuric --

Q. Let me ask you this: at the time when he was discussing it with you, did you appreciate what the implications were for urine output of a patient being polyuric?

A. Oh, absolutely.

Q. So you knew that Adam would have a fixed urine output?

A. Dr Taylor actually said to me that he had anaesthetised this child before and he actually -- and I can't remember, but he quoted to me what his urine output was.

Q. He told you that at the time?
A. Yes. Yes, he did.
Q. And what he told you, did that cause you to have any concerns about it being at that level?
A. No, because again it comes down to that I didn't have experience with regard to that.
Q. So you knew what the implications of a polyuric condition was, you just didn't have an awful lot of experience with it?
A. Absolutely.
Q. But nonetheless, you regarded that as being a complexity?
A. I think it was complex and I think in terms of Northern Ireland --
Q. Sorry, the polyuric element of that. You regarded that as being part of the complexity?
A. I did, yes.
Q. Was it because you didn't have very much experience with it, so if it is a patient of yours, you would have regarded that as complex, or for some other reason?
A. I think I would have regarded it -- if it had ... All the cases I was doing were adult and I think they were mostly anuric, actually, but I can't remember in detail. But I would have -- I certainly didn't have experience of that commonly occurring.

Q. So that might not have been a particularly complicating feature other than to somebody who didn't know very much about it?
A. It might not have been, but I think Dr Taylor felt that that was something that was a complicating factor as well. Again, I think he didn't have all that much experience of that and there may not have been a lot of experience in Northern Ireland with that at that point in time.
Q. Did he tell you why he thought that Adam's polyuria constituted a complexity for him?
A. He just felt that it was -- I think, if I remember correctly, he felt it was like having a sink that the water poured through, that even though ... His memory was whatever this output was -- and it was high -- and I don't want ... I can't remember the figure, but he said the problem was that it was actually difficult to assess in some cases.
Q. He said something very similar to that and we can pull it up after the break, if necessary, in his statement to the PSNI. I think he actually described it as a bucket which he was desperately trying to keep full --
A. I think there certainly was a statement like that.
Q. -- something of that sort. That suggests somebody who doesn't feel that there is a fixed urine output, but

there is an urine output that can expand to cope with increasing volumes of fluid being administered?

A. Certainly at the time Bob's -- Dr Taylor said that he had anaesthetised -- I think this is true -- he had anaesthetised this child several times before. He had experience of managing the --

Q. Sorry, I beg your pardon, this is a different question that I'm putting to you. The issue that I am drawing to your attention is, from the way you have described it, that Dr Taylor was describing a situation where Adam's urine output could increase to accommodate volumes of fluid being administered. When I asked you whether you appreciated the significance of the polyuric condition, you said that you did and then I put to you -- and somebody will check it on the transcript. Maybe I'm not getting the terminology precisely right. But when I put to you, "Did that mean that you appreciated that he would have a fixed urine output?", that's the whole point about a polyuric condition.

A. Again I go back to my memory. My memory at the time was --

Q. Sorry, I'm asking you about your knowledge. Did you know that that's what a polyuric condition meant, that the patient would have a fixed urine output?

A. At this point in time, I can't say if I did or not.

Q. You don't know whether you knew that?
A. I don't now, no. I have been out of medicine for five years and I apologise.
Q. No, no. I understand.
A. I've been out of clinical medicine since 2004. What I knew then may have been somewhat different to what I know now and I apologise for that.
Q. No, no, please don't. I understand that entirely. Let me just -- one more point on this and perhaps recast it slightly differently.

When he described that problem that he experienced of Adam really having -- I wouldn't like to say an endless capacity, but in any event being like a bucket with a hole in it, even if he may not have used that precise terminology, but something like that analogy, when he described that to you and the difficulties that that presented to him in trying to calculate his fluid management, did that strike you as incorrect at the time?

A. I don't think I would have been -- at that time, I would have had the knowledge to be able to make an opinion, but I don't know --
Q. If you had thought it was incorrect, what would you have done about it?
A. I would have said, "Bob, we need to actually investigate

this further. We need to check that that was right".

Q. Did you not think that maybe you should check that anyway because that would be a fairly fundamental element of his condition if that was the case?

A. I think that was part of what I had asked Dr Gibson, to give some assessment because she wouldn't have had the knowledge that a paediatric anaesthetist specialising in renal transplantation would have had, but she certainly had very detailed knowledge of the management of both the fluids and urine output of children who would have had congenital abnormalities, which might well have included abnormalities of their kidney, their renal function.

Q. And do you think that you asked Dr Gibson to look at that element of it as well?

A. I asked her, I think, to look at the whole case, the whole aspects [sic] of the case, and I think now that actually I probably talked the case -- including the notes -- through, but I just ... I can't confirm that, I can't remember.

Q. Let's just have a look. It may be that she has dealt with it separately and we just don't happen to have that. If we go to 059-069-162. That's her report and we've got redactions because those are the other two cases. They are not of our concern.

So this is a report. Ultimately, this report was provided to the coroner. In fact, if we go just to the preceding page, 161, there it goes:

"Dear George, please find enclosed a report of my visit to RBHSC as per your request. I hope it is suitable for your purposes."

That is dated 4 December and then, when we come to the page which I first took you to, 162, it's headed "To whom it may concern", so that suggests it's a report that's going to be made available for somebody as opposed to just your consideration. That would be right, wouldn't it?

A. That would be.

Q. Let's see what she says about it:

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

If we pause there, there's no suggestion, is there, that Dr Taylor had been involved in the other two patients?

A. No.

Q. In fact, I think she says that somewhere down in the report part of it.

A. There weren't common anaesthetists. I think there weren't common operating theatres either from what I remember.

Q. In fact, it says that in the penultimate paragraph. It says:

"Each case was performed by a different surgeon and each anaesthetic conducted by a different anaesthetist, all of consultant standing."

But nonetheless, is that first statement that she's made correct, that you and Dr Murnaghan had asked her to discuss with Dr Taylor the three cases which, of course, would have included Adam's?

A. I don't remember, but since she has said that, I presume we did.

Q. Yes. And then she deals in the next paragraph with Mr Wilson and Mr McLaughlin. She talked about the technical checks, what they demonstrate. If we come down to case 3, she sets out her views on Adam:

"A four-year-old child with polyuric renal failure was brought to theatre for renal transplant. A very thought out and well monitored anaesthetic was delivered with great care to fluid management in a child whose normal urine output was 100 ml per hour."

Do you have any idea how she formed that view?

A. I don't, no. It is possible that she had got ...

I don't know if she got it from the notes or she got it from Dr Taylor, I don't know. I can't answer that, sorry.

Q. But if you saw his notes, you could have formed the same view as to what his normal urine output was.

A. I might well have done at that time, but I don't remember.

Q. If you saw that, and on the other hand you record your conversation with Dr Taylor, who describes him as like a bucket with a hole that he was pouring fluid in, that might be something you might be a bit concerned about.

A. I think I should be clear, actually. I think at what point I heard about the bucket element -- I'm not sure it was that first meeting, you know. It may be that at that first meeting, what he said was, "This is what his urine output has normally been when I have anaesthetised him".

Q. Like a bucket with a hole normally?

A. I'm not sure that that was -- in fact, he may have said to me at that stage, "This is what it normally is", and I think it might have been that he said 100 ml and that the phrase came out later. I honestly can't be clear about that and I just can't.

Q. So he could have said 100 ml when he was meeting with you?

A. He could have done. He could have done.
Q. And of course, if he had said that, that wouldn't have caused you any concern at all, the fact that --
A. No, because at that point in time, he would have known what had been Adam's standard urine output, yes.
Q. Yes. We will come to that because you'll know that actually one of the difficulties in this is -- and one of the errors that Dr Taylor has now conceded is that he didn't calculate Adam's fluid management on the basis of 100 ml an hour.
A. I'm not aware of what the developments were because I've been in England since. I don't know how -- I don't know --
Q. You would have known that because you would have been part of the discussions investigating how --
A. Sorry, I'm referring to the fact that Dr Taylor has said that he didn't do that. I wasn't aware of that at that point in time. That is something which has come recently.
Q. I understand. Then she goes on to say:
"This child was well-known to the anaesthetist as he had anaesthetised the youngster very many times in his short life. Full records of all monitored parameters are available on this case and show that no untoward episode took place and that a very stable

anaesthetic was given. At the end of the operation, the child was found to have fixed and dilated pupils and a CT scan showed it to have gross cerebral oedema."

Then she goes on to summarise:

"In relation to all three cases, all of significant complexity ... substantial increased risk of morbidity and mortality ..."

And then the part that I told you before:

"Although they were all in the same room ... used the same suite ... nonetheless different clinicians involved ... all extensively monitored. The protocols for monitoring anaesthetic set-up and drug administration in this area are among the best on the Royal Hospital site and I can see no reason to link these very sad cases into any pattern."

Was that your concern that there might be actually be a pattern here because there'd been three paediatric deaths?

A. It was the coroner's concern. I came into this without knowledge of the other two cases. I think one of the things I knew from my past was that if there was a trend, if you want -- in other words, if you had three deaths together, you needed to look to be sure that there wasn't a common element, whether it be a piece of equipment, whether it be the anaesthetist. It wouldn't

have been the surgeon because it was in different things. One needed to look at that. I didn't know about the other two cases and I asked Fiona to look and Dr Gibson did, at the behest of the coroner that she consider all three cases to rule out, first of all, was there a common element. And from what I had seen in the initial -- it didn't seem to me there was, but it was important that we at least look at that.

THE CHAIRMAN: So having done that, Dr Gibson in effect saying there's no common pattern, you then revert to trying to understand what went wrong in Adam's case?

A. Yes. In a sense, that was one of the important elements of what she was doing.

MS ANYADIKE-DANES: Sorry, can I just ask you about that last paragraph?

"The protocols for monitoring anaesthetic set-up and drug administration in this area are amongst the best on the Royal Hospital site."

What did you understand the protocols to be?

A. At that point in time, I don't know because I didn't work there. They wouldn't have been the same. I think what you would have found is that in paediatrics, as in cardiac, they had more detailed protocols than would have been true in the other clinical services, and I think that's more or less in keeping with what

Dr Gibson says.

Q. Well, did you ask to look at them?

A. Sorry?

Q. Did you ask to look at them, the protocols that she's talking about? Because if they are, then as part of your general interest in quality and standards, that's something that you could adopt.

A. We were adopting policies and procedures that were, I think, in line more with the anaesthetics that we were giving on the Royal site. And that would have developed more, probably, after Adam's death. To what degree that influenced, I don't know. But the policies and procedures that were there were largely ones that I had inherited.

Q. Sorry, did you ask to see the policies and procedures that --

A. No, I didn't. But I would have seen them, I think, because I had done the -- I had been involved in the King's Fund preparatory team investigations and one of the things that I did form out of that was that there was very good practice in terms of record keeping in the Children's Hospital. They had better standards of protocols, et cetera, than I felt were true across the site.

Q. I understand.

A. And we were in the process, as part of the King's Fund, to try to do that. Did I look as to whether I picked those up and brought them to the main site? I don't think I did --

Q. Did you see them at any point?

A. I think I probably would have done.

Q. So they did exist?

A. Yes, I think so. I'm pretty sure there would have been, yes.

MS ANYADIKE-DANES: Mr Chairman, I wonder if this might be a good moment?

THE CHAIRMAN: Okay. We'll take a break for a few minutes.

(11.05 am)

(A short break)

(11.25 am)

MS ANYADIKE-DANES: Dr Gaston, you referred, when we dealt with the polyuria issue, to the fact that you have read somewhere that others had differing views, if I can put it that way, about the incidence of polyuria -- not its implications but the incidence.

A. I think there was a statement, if I remember correctly.

Q. Let me quickly take you to that. It arises in the evidence of Dr Coulthard, who's the inquiry's expert. The transcript of 8 May of this year, page 64 is where it starts at line 18.

This is actually a quote from something that Professor Savage said, recalling a report of Dr Coulthard:

"I think you'll remember Coulthard has said that some 60 per cent of children requiring a transplant have dysplastic kidneys and they are likely to be polyuric."

Then there was an issue as to whether the incidence of dysplastic kidneys in Northern Ireland is as high as it might be in the rest of the UK.

But in any event, when it comes to the complexity of Adam's case, if one goes to page 99, line 19, he's being asked about that directly. He says:

"There's a spectrum. There's no child who's going to have a transplant that isn't in some way going to have some complexity or component."

Then he talks about some children having complexities that are vast:

"I would consider Adam to be kind of average."

And over the page because he's invited to expand on that. He says:

"There would be children that would be much more complex than him because their blood vessels were congenitally abnormal or something like that. So within that, and there's always a degree of complexity, he's kind of run-of-the-mill."

And he apologises for using that sort of term:

"But he's kind of -- he's kind of a degree of average complexity for a child of that age coming for a transplant."

So for those who carry out paediatric renal transplants on children of that age, Adam presented no great complexity. He was sort of average; would you accept that?

A. Yes, absolutely.

Q. Thank you. Then in relation to the protocols, when you said -- to be fair, you didn't go and look for the protocols when you received Dr Gibson's report, but you have in mind that they did exist and you had seen them at some point.

A. Yes. I have the picture in my mind of the paediatric hospital having one of the best, in terms of protocol and in terms of their documentation, simply because having been in the -- done the King's Fund pre-visit schedule, that was an area that was of high quality.

Q. So you were looking at that as part of your mock surveys for --

A. Yes, I would have seen the picture across the trust in different services.

Q. Thank you. Let's go to reference 305-014-001. We were trying to find those protocols. This is a letter from

DSL dated 21 July 2011. And so the inquiry entered into some exchange with the DLS about them and the upshot is:

"I confirm that it is the Trust's belief that the protocols referred to by Dr Gibson did not exist in written form. I would also confirm that Dr Gibson's statement request --

I'm sorry, that's another matter. We don't need to get into that.

The important bit was that so far as the Trust was concerned, and they had asked or conducted their own inquiries for us, the protocols did not exist in written form.

So your observation on that?

A. At this point in time, I'm sorry, I cannot answer that.

Q. That's okay. Can we go back to your transcript at page 131? In addition to the polyuric element that was one of those things that arose in your discussion with Dr Taylor, you said that there was another key issue, which was the central venous pressure.

A. Yes.

Q. And this is to be found at line 6. When I asked what was the issue, you said:

"He was concerned that it wasn't an accurate reading."

Did he explain to you why he had that concern?

A. I don't remember, actually. I've seen some transcripts where he has said information -- but in terms of my own recollection of that, I can't remember why. I think there were difficulties about inserting it, but I'm not sure.

Q. In a way, you weren't just passively listening to what he had to say; you were trying to tease out from your experience and knowledge what some of the difficulties might be. Were you able to gain any appreciation for the significance of that error for him or the inability to perhaps get an accurate reading?

A. Again, I'm coming from a clinical -- having been a long way away from it.

Q. Yes.

A. So central venous pressure would have been something that you would have wanted to know accurately. You could make some calculations if you didn't think it was in the right place, as to what it might be -- you might expect it to be.

Q. Yes.

A. But at this point in time I can't actually enlighten on that, but I would have known at that point in time there were some ways in which you could assess possibly what a realistic figure was.

Q. In any event, this was a concern for him.

A. I think the point there is that these were the things he felt were making it difficult for him during the case.
Q. Exactly and I'm trying to explore with you why he thought that because you're having this exchange with him, why he thought that and how you were responding to that.
A. I think that was one of the issues that made it difficult for him to assess the fluid loss that was going on during the surgery.
Q. Right. Then his other point was that it was longer surgery. Did he explain to you what he meant by that, how much longer, what he thought had contributed to the length of it?
A. I can't tell you now how long, I can't remember, but he did say -- and very reasonably, actually -- that this was technically difficult for the surgeon. This patient had had several abdominal procedures in that area. You would expect adhesions, you would expect difficulty in terms of the operative site, in terms of bleeding, and that -- I would know that from my own experience. So he said these were issues that made it, he felt, a longer surgery. It had made it slightly more difficult to -- he felt there was slightly higher blood loss than usual. That was his feeling at that point in time and he felt that these were contributory factors and actually

I think very reasonably.

Q. If we go over the page to 132, just so that we tease out exactly what he meant by "using quite a lot of irrigation fluid". Did he explain why that was an issue for him, why that had made things difficult?

A. I presume that that would have gone -- would have been ... I mean, in any operation whenever there's irrigation fluid, it gets taken into the suction bottle and so it will add an increased volume to that suction bottle, which makes it sometimes difficult to assess what is related to the actual loss of fluid from tissue and what is related to the irrigation fluid. And I think that was the point he was making.

Q. So he has that discussion with you and he's very upset during it. What happens immediately after that from your point of view?

A. I don't remember exactly after that, actually. I don't remember what the sequence of events were. I would have certainly had interacted with Dr Murnaghan. Whether I had interacted before that, I can't remember. At what point I would have had an interaction with Dr Murnaghan, I don't know. I didn't, to the best of my knowledge, have any further detailed conversations with Dr Taylor. I don't remember having them. I may have.

Q. What happened is quite a serious thing and it's

certainly not a particularly common thing.

A. No.

Q. Firstly, a child has died. That's not particularly common. Did you know that another child had died in relation to a renal transplant procedure?

A. In the hospital?

Q. Yes.

A. No.

Q. You didn't know that?

A. No.

Q. But in any event, this is the third child who has died -- not related symptoms, but the third child who has died. Did you know that at the time you were speaking --

A. Third child from a renal transplant?

Q. No, the third child who has died.

A. No, no I didn't know that. The first I knew about that was when I was asked to contact someone to set up --

Q. I understand.

A. I go back that ... I wasn't -- and I know this is very hard to understand. I was not -- and it goes back to the way things were set up. I was not privy in a sense to the day-to-day workings of the paediatric set-up and the cardiac set-up and I would actually probably have known more about paediatrics than I did about cardiac

because paediatrics at that stage, as I said, were actually -- I became, in a sense, more close to them because they were going through a difficult period.

Q. I appreciate that. So what has happened, though, leaving aside that at that stage you don't know that this is the third, but you do know that a child has died in surgery, which is not a common occurrence.

A. Yes.

Q. And you have had the anaesthetist before you, who's been very upset. He's explained certain things that are concerns to him. You have in the back of your mind the possibility that maybe something went awry that he might be involved in and maybe he really ought to go and speak to somebody more senior and experienced. So that's your mindset if you like. When he leaves, leaving aside what you can remember you actually did, what from the point of view of the organisation would have been the appropriate thing to do at that stage?

A. Well, I would normally have taken forward enquiries, I would have spoken, say, to Dr -- and I don't know, I can't recollect. I would have spoken to somebody like Dr Peter Crean. I would have obviously discussed with Dr Murnaghan and I would have -- and I think I followed up with some discussion with Dr Gibson. I can't remember, but that would have been the way. I would

have looked at the people who were part of that. I probably wouldn't -- in fact I'm sure I wouldn't because of the fact that I wasn't ... I wouldn't have discussed this further within the paediatric directorate in terms of the other personnel.

I saw that -- that actually happened as part of the discussions that would have happened in Dr Murnaghan's office. So I would have had some -- and I did have some -- I would have been prepared for that discussion for those meetings and I would have obviously had discussions with a number of people who prepare for that. I don't remember the sequence or the details of that, I'm sorry.

Q. I very much appreciate that point. So I think what I have from you is that you would have had some discussion with Dr Murnaghan?

A. Yes.

Q. And you would have possibly had some discussions with another anaesthetist, maybe Peter Crean, who was having the day-to-day management of matters.

A. Sure.

Q. Would you have thought, given at that stage even Dr Taylor considered that Adam's death was unexplained, would you have thought to involve the medical director?

A. That normally -- I can't imagine that that -- the normal

mechanism in a death like this would have been, to the best of my memory, Dr Murnaghan reporting to Dr Carson.

Q. So you wouldn't do that?

A. I wouldn't normally have done. If I felt that the mechanisms that were normally in place had fallen down, I would have gone and spoken to Dr Carson, but I wouldn't otherwise have done so, no.

Q. Can I ask why you wouldn't? Because you are -- he's your medical director. Why wouldn't you raise an issue that has clinical concerns, if I can put it that way, with your medical director?

A. I cannot say that I didn't have a conversation with Dr Carson.

Q. No, but you said that that wouldn't necessarily be the normal way.

A. The normal way would have been --

Q. I'm asking you why it wouldn't have been the normal way. Why wouldn't it be normal for you to raise an issue of that sort of thing, raising clinical concerns with your medical director?

A. I think the thing that -- actually the structure, the way it was at that point in time was that Dr Carson, like me, was actually undertaking a significant amount of clinical work. And the one person who ended up as the link in this would be Dr Murnaghan because he

didn't -- he was available unless he was off ill. He was the person who was available and would have actually ended up as being the person that one would have talked to first because he was available.

Did I speak to Dr Carson later? I'd be surprised if I didn't, but I don't remember.

Q. We'll get to that. What it looks like then, and it's in some ways perhaps helpful that you're the witness helping us with this, given your background, is that when one lays out the organisational structure that emerges from the documents and one sees the lines and what one assumes would be the reporting lines, that all looks fairly straightforward. But what in fact happened wasn't that at all.

A. I think actually, again, coming back to my experience with the King's Fund, that didn't happen in a lot of organisations.

THE CHAIRMAN: Sorry, doctor. I have a fairly clear picture between yesterday afternoon and today that when an event like this happens, to take this event, when Adam dies in unexpected circumstances, to put it neutrally, there is a report made to Dr Murnaghan --

A. Yes.

THE CHAIRMAN: -- who's in charge of medical administration. He, in effect, takes charge.

A. Yes.
THE CHAIRMAN: Is that right?
A. Yes.
THE CHAIRMAN: He's the one who liaises with the coroner, at least initially, and he then takes charge so that, for instance, you expect him to speak to Dr Ian Carson and you expect him to speak to you.
A. Yes.
THE CHAIRMAN: So this is, in fact, arguably -- if it works out well -- it should be better because the responsibility for this has been taken at the top by Dr Murnaghan rather than people feeding it bit by bit up to the top to Dr Murnaghan. How that then works out in practice is another matter which we're looking at, but your point is, I understand that -- well, why would we possibly complain if Dr Murnaghan is brought in as the person in charge at the start; is that right?
A. Yes.
THE CHAIRMAN: Okay.
A. It wasn't -- again, I go back a little bit. This was a developmental process. And nothing was perfect with regard to structure. People were adjusting to a completely new system. So there would have been difficulties. But the one person who would have been generally -- unless he was off ill, would have been in

a position to respond immediately, which the rest of us who were doing clinical work wouldn't, was Dr Murnaghan. So the sensible thing, in a way, was the way it was set up.

THE CHAIRMAN: And you are free to go to speak to Ian Carson or you're free to speak to anyone else if you want?

A. Absolutely. Ian Carson was an anaesthetist as well and a very close friend, so I would certainly not feel in any way inhibited about speaking to him.

MS ANYADIKE-DANES: Can we just deal with after you had had your discussion with Dr Taylor, at some point, although I don't think you said that you could remember exactly, at some point you go and seek or suggest that Dr Gibson is brought in?

A. Yes. That was, I think, quite soon after the incident, I think.

Q. Have you already had any discussions with Dr Murnaghan at that stage?

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

Q. Well --

A. I would have had some discussion as to why he felt that we should do that and the fact that the coroner had identified these three cases, so in that sense there would have been -- and it would have been prior to meeting Dr Gibson, yes.

Q. Is it you who recommends Dr Gibson?
A. Yes.
Q. Can I pull up one of Dr Taylor's witness statements. 008/3, page 43? It says there in answer to question 119:

"I would have reported to Dr Gaston and Dr Murnaghan in relation to the inquest following Adam's death."

And then:

"State whether you were required to: (i) formally report Adam's death and the circumstances thereof; and/or (ii) explain what happened to Adam to a senior manager or clinician within the Trust. If so, state to whom and when you reported it."

He says:

"I reported to Dr Gaston and Dr Murnaghan in relation to the inquest following Adam's death."

Then in relation to the nature of the report/explanation he says:

"The deposition to the coroner."

I want to pull something up and perhaps you can help me as to whether you actually saw this: 011-002-003. This is written from Dr Taylor to Dr Murnaghan on 30 November -- it's dated 30 November. This provided the basis for his deposition to the coroner; did you see this?

A. I don't remember seeing it, but I would anticipate I probably did see it, but I don't actually rather seeing it.
Q. Yes. Why I ask you that is since this happens really quite quickly, I'm trying to see what information you had when you, at the early stages, were forming your views as to matters -- so could you have seen this before you form a view that maybe we'll get in Dr Gibson?
A. I wouldn't have thought so, no. I don't think -- I mean, first of all, I can't remember seeing it. Secondly, I would have thought that I would have seen it, but I don't remember. As to when I would have seen it, I have no idea. I am sorry.
Q. So in these discussions that you're having with Dr Murnaghan, up until the time when we have identified a memorandum, which is Dr Murnaghan referring to copying documents to you -- the medical notes and records -- is it possible that until that time you hadn't actually gone to seek out any of Adam's notes and records?
A. It is possible and I suspect that those notes and records were with Dr Murnaghan, which would have been the normal procedure. So whenever I would have spoken to Dr Murnaghan, he -- I think he had the notes and records at that point, which he then forwarded to

Dr Gibson. Was I involved in that discussion? I can't remember.

Q. So if I can take you then to what might have -- I'm so sorry, can we go over the page? It looks like you did get it, "cc Dr Gaston".

A. I obviously did get it. I'm not sure of the time frame. As I say, I do not remember this document, but ...

Q. If it's cc'd, are you likely to have got it?

A. Oh yes.

Q. Then --

THE CHAIRMAN: It would make sense for Dr Taylor to send it to you?

A. Absolutely.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: This is what's going to form the basis of his statement to the coroner. Let's see whether he addresses the things that he raised with you as concerns. Let's go back to the first page.

THE CHAIRMAN: Can we put the two pages up, please?

MS ANYADIKE-DANES: Thank you very much, chairman.

So the first paragraph, he's describing the general anaesthetic:

"He was in polyuric renal failure [the date of admission] ...made aware of his perioperative problems of fluid administration. Usually received night feeds.

Couldn't be given two hours prior to surgery. Encountered no difficulties following his arrival in theatre, accompanied by his mother."

It gives his weight:

"General anaesthesia induced uneventfully."

Then:

"IV access, arterial access and a central venous catheter all placed without undue difficulty. Lumbar epidural. Administered IV fluids as usual, calculated to correct his fluid deficit, to supply his maintenance and replace operative losses."

Then it says what he gave him and how much.

It totals over 4 hours, so you don't get an appreciation of the rate, which of course you would get if you looked at the anaesthetic record, but in any event, over 4 hours. Then:

"There was a substantial ongoing blood loss from the surgery. Packed red blood cells were given."

It gives his haemoglobin. The nurse is asked to weigh the blood soaked swabs. Then it says how much blood he indicates was lost in the swabs, how much in the suction bottle and an unknown amount in the towels and drapes. And it gives what the total loss he estimated to be was and how he replaced that and:

"The infusion of fluids was titrated against CVP and

BP to ensure that the blood volume was more than adequate and at maximum perfusion for the donor kidney."

Then it refers to the low-dose dopamine infusion:

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

Of course, if one had looked at his records, one would know that he also had, with that blood gas report, he had a serum sodium level of 123.

"In view of the CVP, heart rate and BP, I did not consider the fluids to be either excessive or restrictive. Indeed, I regarded the fluids to be appropriate and discussed this with the other doctors present in the theatre. At the end of the case, I reversed the neuromuscular block. I anticipated the child waking. No sign of this. I examined the pupils and found them to be fixed and dilated. Extremely concerned that he had suffered brainstem injury. Transferred him to paediatric intensive care."

Then he was on hyperventilation and mannitol:

"IV fluids restricted. Spoke with Dr Savage, spoke to Adam's mother, offered her my sympathy for the loss of her child. Could not supply her with a clear explanation. Accompanied Adam to the CT scan room later in the day. Informed by the neuroradiologist that

he had gross cerebral oedema and herniation of his brain. Extremely perplexed and concerned that this happened to Adam and cannot offer a physiological explanation for such severe pulmonary and cerebral oedema in the presence of normal monitoring signs.

Did that, as a description of what happened, accord with what Dr Taylor had told you when he came to see you?

A. No, it doesn't entirely. As I remember it, it doesn't. As I remember what Dr Taylor spoke to me -- it doesn't entirely, no.

Q. When you received that, what was your reaction?

A. I don't remember. I don't remember my reaction to it. I'm only realising now as you put this up that actually I have seen this at some point. I did see this. I couldn't remember. But I have seen it.

Q. What do you think your reaction should have been, given that it doesn't accord with what Dr Taylor told you?

A. My reaction would have been, as I think I did, which was to broaden the input of information, which was why I -- if and I'm not sure that this was -- this may well have been prior to Dr Gibson, I don't remember. Dr Gibson was brought in because, again, this wasn't my area of expertise. And secondly, we had then asked Dr Sumner to become involved.

Q. Sorry, I beg your pardon, doctor. I really don't mean to cut across you, but that's a different point. This point is that as soon as he feels able to do so, Dr Taylor comes in some state of concern and upsettedness [sic] and, with you, goes through what for him were the main issues, the things that made it complex, difficult, the things that he was world about.
A. Sure.
Q. And in fact, you form the view that really he would be better placed going off to talk to somebody more experienced or with greater expertise. So you then get his narrative, if you like, of what he says is happening. And this is something that's going to go further, actually going to go to the coroner.
A. Sure.
Q. And this, as you can read it now, does not identify any of those matters really that were relayed to you as his concerns as to what had happened during that procedure?
A. That's correct.
Q. Yes, and what I'm saying to you is: when you received that, what should be your response to it?
A. My response would have been that that was something that needed to be taken through. There were two elements there.
Q. Yes.

A. I did not feel that I was in a position -- I would not have felt I was in a position to actually take that further. I had one set of things that Bob talked through with me. I had this. I think at that point in time I would have felt that this needed to be discussed at a further meeting, which would have been part of the investigation.
Q. Well, did you raise with anybody that, "This actually isn't quite how Bob Taylor put it to me when he was explaining matters to me"?
A. I don't know.
Q. Well, do you think you should have done that?
A. I might well have been. I don't know. I can't answer that at this moment in time.
Q. Do you think you should have?
A. I should have, yes.
Q. Yes.
A. Did I? I don't know.
Q. I understand that. If you had appreciated that this was going to go forward as a statement to the coroner, what do you think your response should have been?
A. Well, first of all, I don't know that that hadn't gone to the coroner first. I don't know that.
Q. Then if you had thought it had gone to the coroner, what do you think your response should have been?

A. My response would have been to -- there were clearly some issues that were in conflict from what I had. I do not feel that at that point in time I had the expertise on that particular area to come down and say what were the issues that needed --

Q. These are just factual differences. Just factual differences.

A. There were factual differences, but in terms of someone who has come distressed, at that point in time, my conversation with Dr Taylor would have been in a somewhat more informal way than this because he was a distressed person and we were talking through in broad outlines what were the challenges that you saw in this case --

Q. Yes, but --

A. -- and then he has put this letter in.

Q. Absolutely. But he says nothing --

MR UBEROI: Can I rise at this stage? Because my recollection of the witness's evidence yesterday was that, firstly, he couldn't remember the meeting with Dr Taylor, but secondly to the extent that he was trying to assist by speculating as to what would have been said, Dr Taylor was effectively racking his brains going through what happened in the surgery and was unable to explain what had gone wrong, which is in fact exactly

what he's doing in this letter.

THE CHAIRMAN: Well, Dr Gaston also said yesterday that some of the conversation which he had with Dr Taylor, he thinks was him prompting Dr Taylor. I think he used the word "prompted" yesterday in relation to that conversation.

The difficulty, Mr Uberoi, is this. We will come to it I'm sure very, very soon, because we have a child who's died unexpectedly. We have Dr Taylor being upset and distressed about that, and of course that doesn't mean it's his fault. You can be distressed and upset because some event has happened even if you're not to blame for it.

MR UBEROI: Of course.

THE CHAIRMAN: But Dr Gaston has said this morning that in this scenario, one of the things that immediately springs to mind because it's happened to him himself is: were there mistakes with the anaesthetic? Right? So it must be one of the issues to look at is: did Dr Taylor do something wrong? And you also said before the break this morning, doctor, that when you were asked by Ms Anyadike-Danes -- it's on today's transcript at the bottom of page 22 and into page 23:

"Could you have looked at the records and come to the view that whatever happened to Adam couldn't somehow

involve the conduct of the anaesthetist?"

And your answer to that was:

"Absolutely not."

A. I think once you have a death in this situation, I don't think you can come to the conclusion early on exactly who was responsible. And I think that -- when I say -- but one thing you can be -- it will be in the equation -- is the possibility that the anaesthetic or the anaesthetist contributed in some way. That has to be something that is in the discussion.

THE CHAIRMAN: We need to clarify this because I understood the answer you gave earlier on to go somewhat further than that. You were asked by Ms Anyadike-Danes:

"Could you have looked at the records and come to the view that whatever happened to Adam could not somehow involve the conduct of the anaesthetist?"

And you said:

"Absolutely not."

And I understood that to mean that when you look at the records and when you see how much fluid is given, you must conclude that what happened to Adam somehow involved Dr Taylor. There's been a bit of toing and froing about when you first saw the records.

A. Sure.

THE CHAIRMAN: But as I picked up your answer earlier, once

you look at the records, there is a real concern about whether Dr Taylor has made mistakes; is that not right?

A. I'd like to clarify that because I think what -- there are two points. The first is that once a child dies in theatre, anaesthesia has to be in the frame.

THE CHAIRMAN: Right. And that's --

A. That's just a general comment. The second one is ...

THE CHAIRMAN: If your second point comes back to you, great, but my second point was going to be --

A. It's going back to what you said actually.

THE CHAIRMAN: My second point is if you then think that it may involve the anaesthetist, then at some point fairly early on in the investigation, you look at the anaesthetic record.

A. Yes.

THE CHAIRMAN: And if you look at the anaesthetic record in Adam's case, your concerns that this may have something to do with the anaesthetist must increase.

A. That is, I think, the one thing that was clear throughout this case, until certainly Dr Sumner's evidence, and that was that there was a debate about what was the appropriate fluid balance. And that was something which would have come up at the -- some of the meetings. So there was some debate of which I wasn't in a position to be -- not at that point, but at some point

there was. I felt I would have -- I would have felt that this was something that was an area that was open to some debate because -- and I go back to the fact that he has -- that he had said to me and [inaudible] here was the fact that there were contributory factors that made it difficult for him to assess the fluid balance.

THE CHAIRMAN: Okay.

A. And I think that is actually -- that was partly in prompting with him and talking through the case. I think that then developed at a later stage whenever -- at the later stage in the investigation, during discussions, that was an issue that came up.

THE CHAIRMAN: Okay. If you just pause for a moment. Mr Uberoi?

MR UBEROI: I entirely understand why that general issue is being pursued and the specific question of when the record was seen is being pursued. The point I was making was more focused on the characterisation of the content to the best of the witness's recollection of the oral conversation, set against the content of this letter. Because my note about the content of the oral conversation is -- I think it was about the challenges that he met:

"High output renal failure, the fact that [Adam Strain] was polyuric, issues around the CVP,

[et cetera]."

And then moving on to basically conclude that Dr Taylor, going through these checklists, couldn't actually fathom what had gone wrong. So the point of my interjection was to point out that that is in fact what he's doing in this letter.

MS ANYADIKE-DANES: Well, Mr Chairman, it'll be --

THE CHAIRMAN: Up to a point.

MS ANYADIKE-DANES: It'll be a matter for you to determine. What I was seeking to develop, and I must say I hadn't appreciated that the witness would have the feeling that this letter could actually have gone and then he might have had the rest of the discussions but pulled together those half a dozen matters, or --

A. I --

Q. If I may just conclude -- that caused Dr Taylor concern. My only question is at some point in time when he did have a number of matters from Dr Taylor that caused Dr Taylor concern, and in fact when I asked him about that, because I was anticipating that Dr Gaston may not recollect these things accurately, and it's at page 130, I say:

"Question: Do you recollect what they were? I'm not asking you to recollect the terms he used or even all of them, but do you recollect what they were?

"Answer: I do recollect them because I think I would have made these points."

I appreciate that maybe they didn't all come in the first conversation, although you did say that you only had one conversation with Dr Taylor.

A. I think I had only one one-to-one conversation with Dr Taylor. I think that's true.

Q. Right. So if these matters are being raised and you're hearing them from Dr Taylor, it's all happening in that one conversation. And my only point is at whichever time you see the letter that was just up -- maybe we can pull it back up again in the two pages side by side. At whatever point you see that, you would appreciate that the terms of that letter do not entirely -- and I think you yourself fairly said so -- accord with the points that were being canvassed with you or you were teasing out as having caused Dr Taylor difficulties.

A. Yes.

Q. If you read that, you wouldn't, for example, have any appreciation that the CVP might have caused anybody any difficulty because that's not expressed there in any way.

A. No, but it was expressed at --

Q. I entirely appreciate that. Nor would you have appreciated that, for example, there was a potential

problem with the extent of irrigation fluid because that just doesn't feature there at all.

A. I think he does mention that there were difficulties in here in terms of assessing blood loss and part of it was the fact that the drapes were soaked, that there were -- and there were issues as to why the drapes were soaked. Part of your assessment of blood loss would have been looking and -- and fluid loss, would have been what were in the drapes ... So part of his assessment that there were higher levels of irrigation fluid -- and I think this came out a little bit more at a later date -- was actually not just the bottles, but there would have been thing like drapes being -- which I now see here and I'm coming -- I apologise. My memory of this -- it's obviously a very long time ago and I may not be absolutely certain of what event occurred at what time.

Q. No, that's entirely to be understood, except for what he seems to be talking about on the second page is all to do with blood and his calculation of blood and how heavily soaked he thought the towels and so forth were.

But leaving that point aside, of the matters that you described to us, and if one takes the CVP, which was a very important one, and you have explained why the CVP would be such an important matter, that is not raised at all. In fact, if you read where he talks about it, it's

over on the second page, he says:

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

A. I can't answer why that statement was in there. But it's certainly my understanding that there had been an issue with the CVP.

Q. Yes. I have understood you to be saying that.

THE CHAIRMAN: The very last line is:

"In the presence of normal monitoring signs."

MS ANYADIKE-DANES: Exactly, Mr Chairman.

THE CHAIRMAN: And if there's one thing that's absolutely clear, it's that there were not normal monitoring signs in Dr Taylor's or Dr O'Connor's evidence.

A. I can't explain why that is not in that letter, I'm sorry.

THE CHAIRMAN: It's not just that it's not in that letter. The very last line of that letter says that what were present were normal monitoring signs. You were being told something quite different, weren't you?

A. Not about the monitoring signs, but I certainly had the perception from Dr Taylor, from what I remember of that conversation, that it had been challenging. And some of the areas that were challenging were around the CV [sic], were around the fluid loss, were around the fact that the surgery took longer. To what extent my

prompting as we went through that conversation would have been, I don't know.

THE CHAIRMAN: The CVP -- well, even if you prompted the CVP, it's a point which Dr Taylor made, and it's also a point that Dr O'Connor found when she arrived in towards the end of the operation. She saw the CVP readings were askew and she was given an explanation for that by Dr Taylor, which she accepted. There's endless further debates about that, but the one thing which is clear, relatively clear from the evidence, is that there was not a normal monitoring sign from the CVP. But that letter, written by Dr Taylor to Dr Murnaghan, says that there was in terms.

A. I'm sorry, I can't comment on the conflict of what I remember of the conversation with Dr -- and what's on there, I'm sorry.

MS ANYADIKE-DANES: That I understand. My question to you is: what should you have done about it when you appreciated that discrepancy, particularly when you gave evidence that you might actually have been seeing that letter once it had already gone to the coroner?

A. Basically, I think I would have wanted these things to come out in a discussion, at a further discussion, because there were issues there which would have involved the surgical opinion with regard to that.

Q. No, these are different questions from the opinion. These are factual matters, which, if what you are told was correct, are factual inaccuracies in a document which you have just now -- I know that you can't say whether or not it had or had not gone to the coroner -- but it was destined for the coroner.
A. Absolutely.
Q. So these are factual inaccuracies and all I'm asking you is: what do you regard as your duty once that had become clear to you?
A. Well, first of all, Dr Taylor was distressed when he came to me at that point in time.
Q. Yes.
A. And I think he may well have presented information at that time, which is in conflict with what he's saying here. My perception would have been that this needed to be set out and discussed in another forum.
THE CHAIRMAN: What would that forum be?
A. That was the forum that would have been, I believe -- would have, I think, taken place, which would have been Dr Murnaghan's office when these opinions came together.
MS ANYADIKE-DANES: Right. Well, if we just start off with where it starts --
A. I think, again, I go back to the structure. I wasn't normally directly involved in these investigations.

I would have had opinions, but the person who would be leading the investigations is Dr Murnaghan. So in a sense, all of this information would have come out in those debates or in these discussions. So that's when I would have felt that actually, a lot of these conflicts of evidence would have come out.

Q. Okay. Well, the first thing that gets done, so far as you seem to recall, is that -- not necessarily the first thing that gets done, but a thing that gets done -- is that Dr Gibson is brought in to go and have a look at the anaesthetic equipment, consider the anaesthetic and Mr Wilson and Mr McLaughlin are also brought in; is that right?

A. That's right.

Q. You have said in your witness statement that you would have been aware of PEL9336. That is 210-003-1132.

MR SIMPSON: [Inaudible: no microphone] and it's this: when the letter was first addressed, only the first page was put up. And we spent a couple of minutes back and forward with Dr Gaston: do you remember receiving this, I don't know, if you did get it, when did you get it. It's most unfair to the witness when over the next page is the CC to Dr Gaston, which my learned friend must have known about. This type of ambush questioning, in my respectful submission, is neither fair nor helpful to

the witness. If the letter had been put in its full extent, then there would be none of this nonsense, I respectfully say, about, "When did you get it? Did you get it? I don't remember", and that is not fair to a witness who's having clear difficulties remembering contemporaneous events.

MS ANYADIKE-DANES: Firstly, Mr Chairman, I apologise. It certainly wasn't intended to be an ambush. In fact, I wasn't going to come to that letter at that time. I only came to it because of something that Dr Gaston said and I didn't actually have my own hard copy to appreciate that that was that letter. There were a number of letters that were written at that time and I'm not aware of all of them or where their ccs went to. So I apologise. There was no intention whatsoever to confuse or mislead and certainly not to ambush Dr Gaston.

MR SIMPSON: I absolve my learned friend of any deliberate intent, but if that kind of situation arises [OVERSPEAKING].

MS ANYADIKE-DANES: We will try and do better. I will try and do better.

A. I think it is. And I can't stress this enough: for me, having been out of anaesthesia since 2004, completely out of medicine in every aspect from 2008, trying to

remember these things accurately, and I have difficulty.

THE CHAIRMAN: Doctor, I accept that, but I should also say, even if you were still involved, I'm not sure how easy it is for you to remember the events of 1995 and 1996.

A. Quite.

THE CHAIRMAN: It is a long time ago.

A. Yes.

THE CHAIRMAN: There's a general caution I have about the evidence, which is that people are doing their best to remember what happened 15 and 16 years ago, 17 years ago, and that some of these documents will jog your memory and some of them will not at all.

A. Yes. This one did jog my memory.

THE CHAIRMAN: We'll do the best we can.

MS ANYADIKE-DANES: This is not the right reference, it's 210-003-1132. That's dated 27 July 1994. It's "Reporting of adverse incidents and reactions and defective products" and so on. But anyway, when you were asked in your witness statement request whether you were aware of this document, you said at witness statement 013/2, page 5:

"I would have been aware of PEL9336 since the information was wildly publicised at the time."

Would you accept that?

A. Yes. Can I clarify that slightly?

Q. Yes.
A. In that I wouldn't necessarily have been aware that it was called PEL9336, but I was aware. And as I said yesterday, those critical incident recordings had been a key element in us identifying several areas where we were at risk.
Q. Thank you. So then if we just look at this:
"General managers and chief executives are responsible for ensuring prompt reporting of adverse incidents and reactions and defective products relating to medical --"
That's the only bit that we are interested in. If we go down to "Action":
"Adverse incidents, reactions and defective products are reported promptly."
Over the page to 1133:
"For medical devices, a liaison offer officer is appointed at facility level to take the responsibility for reporting."
Then if one goes down, one sees annex C:
"Reports relating to all medical devices, equipment, hospital laboratory equipment and medical supplies."
That's a particular annex that deals with that. If we go over the page to 1134, we see, I think it's the second sentence of the first paragraph:

"Every Health and Personal Social Services employee has a duty to see that all safety-related incidents and potentially harmful products are reported, even if on suspicion only. Adverse incidents occurring in local units may often have implications for the rest of the HPSS."

Annex C, which occurs at 1139, there we are:

"Reportable cases. Adverse incidents in medical devices may arise due to shortcomings in the device itself, user practice, device service, maintenance, modifications or adjustments, management procedures, instructions for use or environmental conditions. You should report if a device is involved in one of the following."

Not surprisingly, (a) is "death".

So did that, so far as you're concerned, mean that given that there was no firm view as to what had happened to Adam and why, at the conclusion of his surgery, his pupils were found to be fixed and dilated, but on the range of things that may have been implicated, the anaesthetic equipment would be in there? Would that be a fair way of putting it?

A. Yes.

Q. And does that mean that you would then have to be reporting it?

A. No. Because I wasn't responsible for that area.
Q. I'm sorry. I beg your pardon.
A. Apologies. I wasn't responsible.
Q. No, no, it's my incorrect framing of the question. Not you, it would have to be reported?
A. Yes, it would be, and I think that is raised by Mr Jim Wilson in regard to -- and I didn't know the piece of equipment, but it was a Siemens ventilator which had a problem with the pins, not something that I remember now. And he picked this up and actually said in his report he was surprised that this had not been actioned.
Q. Yes. Well, let's go to your witness statement, 013/1, page 3. That is:

"I arranged for a report on the equipment used during the operations in the theatres in RBHSC."

And the report was prepared by Mr McLaughlin and Mr Wilson and Dr Gibson. We'll come to those references for the report in a sec.

So that was you arranging for that to happen.
A. As to whether -- and I think this is actually unclear in a number of the statements and I'm unclear, whether I asked Mr Wilson and Mr McLaughlin to do that or whether ... Certainly there were discussions between Dr Murnaghan and I. I don't remember whether it was he

who would have gone ahead and asked the technicians and said, "Dr Gaston, by the way, I've asked Mr Wilson and Mr McLaughlin to do this in regard to the anaesthetic equipment", or whether he said, "Would you mind speaking to them?". I can't remember, actually, and my appreciation is that there was may be some confusion. Because the time frame is so far back, it is hard to tell whether it was him asking first or me and I personally don't know.

Q. Well, we can go to what Dr Murnaghan says about it. His witness statement 015/2, page 3. That might clarify it. It's the answer to (ii)(2)(c):

"Did you arrange for Dr Fiona Gibson to accompany the medical technical officers and, if so, why? This was done on the recommendation of Dr Gaston to ensure that there was a consultant anaesthetic input to the reporting requested by the coroner."

At that stage, the coroner had really only asked for a report on the equipment. That's correct, isn't it?

A. That's what it says there. I can't comment.

Q. So your suggestion is: well, let's have Dr Gibson go along with them.

THE CHAIRMAN: Sorry. First of all, do you accept that that was your suggestion? Dr Murnaghan is saying that the reason why Dr Gibson was involved was because you

suggested that she should be involved; is that right? Do you agree with Dr Murnaghan on that or can't you remember?

A. This would have been a discussion between Dr Murnaghan and I as to what we did with regard to it.

The suggestion that I remember is that Dr Murnaghan had suggested that we have an anaesthetist who would go.

I suggested that the most appropriate person within the organisation and not working in the Children's Hospital was Dr Gibson, and it was -- I think it was appropriate that she would be there at the same time as the technical people. That would be, I think, what happened.

THE CHAIRMAN: So it's a combination of the two [OVERSPEAKING]?

A. I think so. And as to what did what ... I'm not sure.

THE CHAIRMAN: It doesn't really matter because the two of you agreed.

A. Absolutely.

THE CHAIRMAN: So [OVERSPEAKING].

A. I would have suggested Dr Gibson's name. That would have come from me.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: And then if we go back to your witness statement, WS013/1, page 3. Sorry, I thought this was

going to pull up the reference for the report that you actually get. It's an 011 number. I beg your pardon. It's an 059 number. 059-068-157.

This is the report that's actually produced by Mr McLaughlin and Mr Wilson; is that correct?

A. That's right.

Q. Are they both of equal standing or is one in charge of the other, if I can put it that way? Can you remember?

A. Again, this is slightly complicated.

Q. Right.

A. Dr Wilson or Mr Wilson was the most senior MTO or technician in the hospital. But he was within the ATICS directorate and Mr McLaughlin was the technician within the cardiac directorate. And in terms of years of experience, Mr Wilson would have been the most senior one in terms of years, but they did not work in the same directorate, and this goes back to the structure again. One of the reasons that we would -- and I think this was at my suggestion, was that I would have said to Dr Murnaghan, "I think it's important that it's not just from our directorate that this person comes, that we have one from our directorate and we have one who understands paediatric equipment", because that would have been within the cardiac directorate.

So they were not in the same line management, they

were not in the same management structure at all. I felt that that was actually adding value to the information we got.

Q. You said in your witness statement, the second witness statement at page 5, that you thought that they were independent because they didn't work for the Children's Hospital?

A. That's correct.

Q. But they're all employed by the same employer?

A. Yes, but these organisations were still, in a sense, operating as separate -- there wasn't the cross-integration that I think ... Maybe if you look at the structure ... And that was particularly true between the paediatric hospital and the Royal. The paediatric hospital, I think, had been -- it was before I came and I had never worked there at any time. I think that the paediatric hospital would have been largely a stand-alone unit and managed itself. It had been integrated into the Royal Trust. Whenever services are integrated, there is a sense in which they maintain a certain degree of their own identity and that's one of the challenges of bringing them together and this was very early stages.

Q. Does that mean that the Children's Hospital was under the paediatric directorate?

A. Oh yes.
Q. And when you said "essentially managed itself", do you mean in any way different than another directorate is managed?
A. I think it would have been slightly different in the way it perceived -- I think that it was different from my directorate. It had a much wider remit in terms of -- it was encompassing a whole lot of services and would have had a bigger budget and a whole different --
Q. What about paediatric surgery?
A. Paediatric surgery --
Q. Where did that come under?
A. I honestly can't answer that, but I don't think it came in under the surgical directorate. I think Mr Hood says that. I think that the surgeons were actually managed within the paediatric directorate.
THE CHAIRMAN: Is that in the same sense as the paediatric anaesthetists --
A. No.
THE CHAIRMAN: -- were formerly under your remit but actively not?
A. I think it was different, actually. I think the paediatric anaesthetists were actually, as an anaesthetic group, part of the anaesthetic directorate, but to all intents and purposes, they functioned within

the paediatric hospital, but they wanted to maintain their identity.

THE CHAIRMAN: Okay.

A. That didn't apply to surgery, to the best of my knowledge. So surgery -- I think the surgeons in the paediatric hospital were part of the paediatric directorate. They were not part of the surgical directorate.

MS ANYADIKE-DANES: You may not know the answer to this and, in any event, we do have the benefit of Professor Savage. But the Paediatric Renal Transplant Service, which is the thing that is in issue here with Adam, was that therefore -- given that that involves surgery, anaesthesia by definition, and children, did that come within the paediatric directorate or did that in some way involve other directorates?

A. Within the Trust?

Q. Yes.

A. First of all, until this incident, I knew nothing about the paediatric -- the transplant service. I didn't know anything about it at all. This was completely new to me. The only other areas where there would have been some cross-involvement might have been, say, with pathology. It certainly wouldn't have been with surgery because my perception -- and I'm sure I'm right -- was

that the surgeons within the paediatric hospital, of whom one would have been Mr Stephen Brown, he would have been part -- in fact he had been, at some point, clinical director of paediatrics. Whereas -- and I didn't know him, but Mr Keane would have been part of the surgical service of the City Hospital. And I don't know what their structure was.

Q. That's all right, Dr Gaston, we'll take that up perhaps with Professor Savage.

Anyway, you were saying that you regarded them as being independent because they were from the Children's Hospital, as it were, and not ATICS?

A. Yes. Absolutely.

Q. Let's have a look at this report; do you remember when you saw it?

A. I don't remember when I saw it. I would have seen it fairly early on, but I don't remember when.

Q. What did you understand by it when you did see it?

A. I understood ... Well, I'm seeing it now and I'm seeing it -- and you know, what I understood with the report was that barring this issue with the -- which I know is not the Siemens but the ... I'm not sure. Barring that one incident, which would have been reported, I presume, to the paediatric directorate and the paediatric service --

Q. You mean --
A. The rest of the equipment as it applied would have seemed to be normal, yes. And it wasn't within my remit to actually follow that up. This was on behalf of Dr Murnaghan and also on behalf of the paediatric directorate.
Q. Sorry, let me just be clear on this. When you say "barring that one incident", do you mean the incident of the pins?
A. Yes, and we wouldn't have had anything to do with that. It looks on that, as [sic] the face value, that the only area that was identified was that there had been problems with these pins. To the best of my knowledge, they didn't feel it was an issue in any of the cases, but they were surprised that given the reporting -- they were surprised that this had been reported three times and they were surprised nothing had actually happened.
Q. But this is equipment that is in the -- for use for anaesthesia, part of anaesthetic equipment. It's in an operating suite, it's within ATICS.
A. No, it's not.
Q. Sorry, is the anaesthetic equipment not part of ATICS?
A. No.
Q. Who is responsible for the anaesthetic equipment?
A. That is the responsibility of the paediatric service.

I think that's again a -- I will try to clarify that actually. It didn't maybe come through in what I said yesterday. ATICS had responsibility I think for 13 operating theatres, which were based in what was A block, which were based on main theatre block, which were based in the eyes and ENT clinic. The responsibility for the purchase and maintenance, et cetera, of equipment in maternity and dental and the paediatric directorate and the cardiac directorate was the responsibility of those directorates.

Q. I understand.

A. Now, we would have worked quite closely with maternity and the paediatric directorate -- sorry, maternity and dental. We would have actually worked quite closely. They had the responsibility. They decided what money could be spent, but we would have been involved with them and advised with [sic] them. The only role that we would have had -- and it wasn't a role as part of ATICS management -- is that some of our anaesthetists -- and Dr Peter Crean, probably -- would have been the person most ... They would have been involved in assisting the paediatric directorate purchase the equipment, service the equipment and follow up, and they had their own technical service to do that. And same with cardiac; cardiac was completely separate. We had

nothing to do with that. Sorry, that might not have been clear yesterday.

Q. I'm sure I didn't pick it up properly, but I understand now. But in any event, you did get this at some point and what you would have seen by the fourth paragraph in relation to the Siemens patient monitor --

A. That's the one I was talking about yesterday.

Q. This isn't the pin point; this is a different point. This point is that this monitor is currently out for repair. A new display screen is being fitted, so the monitor that was actually used for Adam's surgery is not the monitor that is being inspected.

A. That would appear from that report, yes.

Q. And it would seem that Mr Wilson and Mr McLaughlin are only looking at things from the perspective of Adam? In their evidence, they don't appreciate that there are two other cases.

A. I can't answer that now. I'd be very surprised if that was true given the remit that they went with.

Q. Yes. We will go to their witness statements if we have to to show it. But in any event, when you read this, you would appreciate that whatever else they were looking at and were being satisfied about, they couldn't be satisfied about the performance of the Siemens patient monitor because they are not looking at the

right Siemens patient monitor?
A. That I know now from this report. I don't remember that issue. I don't remember back knowing about that issue.
Q. Well, that means you don't remember anybody picking that up.
A. I don't remember either they didn't or they did, yes.
Q. Given what you said about you wanted it to be an independent, firstly, why did you want it to be an independent investigation?
A. I'm trying to think. Are we referring to whenever I brought Dr Gibson in?
Q. No. Well, you were asked in your witness statement about whether you considered them to be independent; you said that they were. Was that relevant to you that they were independent?
A. Yes.
Q. And why was that?
A. Because I felt that if a team went in to look at any sort of incident like that, it was important that they didn't have prior knowledge or prior commitment to a particular directorate. It had to be someone looking at it who --
THE CHAIRMAN: There's what you said a few minutes ago about they didn't have the same line management.
A. Neither of the two who went in had the same line

management and they had nothing to do with the technical service in the paediatric -- or they may have met them. I mean, one of the things that did happen is that in terms of their own continuing professional development, et cetera, I think as a group they would have met. But as an organisation and as an operating -- they were completely separate operating units.

MS ANYADIKE-DANES: So at some point you would have got this report and Dr Gibson's report?

A. I would have done, yes.

Q. Did you feel, when you got those reports, that you now had a clear view of the anaesthetic equipment position?

A. Well, I presume I did, but I don't know. This report actually, I think, went back to Dr Murnaghan and I think I -- I'm certain I got it actually. I probably got a CC, even though it doesn't say that. That's where I would imagine I got that. I certainly -- looking at it now, I remember this report and I don't remember, I must admit, the issue around the Siemens monitor, actually. I don't remember that at all.

Q. Okay.

A. But I clearly see it now. I certainly didn't know that --

Q. If it's any help, Dr Gibson doesn't appear to have picked it up either. If we go to 059 --

A. It may well have been that that wasn't picked up at the time and I have a ... It may well be that this was information that came after they had done their visit. It may possibly be.

Q. Sorry?

A. It is may be a possibility -- and thinking back now, again, my memory's being triggered a little bit by it -- that the issue -- the reason they didn't see it at the time was that they were unaware that that was the other monitor and was not the monitor that had been used in Adam's case or -- yes, I think, Adam's case -- and that it had been returned to Siemens to correct problems.

Q. I understand you're doing your best with recollecting something. If you weren't directly involved in that, then it may not be helpful for you to try and speculate on that. We do have the witness statements of Mr McLaughlin and Mr Wilson. They seem, by their report, to have been aware at the time that they weren't looking at the relevant Siemens monitor. If one pulls up their witness statements very, very quickly, it's witness statement 110/2, page 8. This is the second witness statement and if one looks at (j), just above question 21. This was a point I had asked you before and you said you would be surprised:

"Were you investigating more than one incident?

I was asked to check equipment and was not aware of the incident or if there was more than one incident. My role was to verify that the equipment was functioning correctly."

That's what he said that he was asked to do. And he was simply, it would appear, noting -- although how he knew what the given day was -- that was not the same monitor.

A. I would have taken from his statement that they were asked to look at -- and I suspect they were asked to look at the equipment in all the paediatric theatres. And I would suspect that might well have been the case.

Q. Well, we certainly haven't received anything to that effect.

A. Sure.

Q. But in any event, what I was asking you is, at whichever point it came to you, you got those two reports. Whether you now thought you had a clear picture on the anaesthesia -- and I think you said you thought you had -- did you consider that Dr Gibson's report was an adequate report for your purposes?

A. That initial report, I did, yes.

Q. We'll look at 059-069-162:

"High degree of vigilance. Found nothing at fault in relation to the cases in question."

Well, if the monitor is not there to be viewed and that's something that the technicians themselves can see, then it's -- doesn't that call into question whether you can know whether the monitor was functioning appropriately in any of those cases?

A. First of all, you have to make the premise that that monitor was -- that same monitor was used for all three cases, which I don't think was the case. In fact, I think that was [inaudible].

THE CHAIRMAN: That's what makes it worse, doesn't it?

A. In terms of?

THE CHAIRMAN: Does anybody really know what monitor they're talking about?

A. Well, that would have been the link that Mr --

THE CHAIRMAN: You see, the monitor which was out, it wasn't out for service, it was out for repair according to the technical report.

A. That's right.

THE CHAIRMAN: So it's out for repair because there is something wrong with it.

A. Yes.

THE CHAIRMAN: So how then is Dr Gibson reliably telling you that:

"The technical checks demonstrated a high degree of vigilance and found nothing at fault in relation to the

cases in question."

When the monitor which was used in Adam's case is out to be fixed?

A. I just don't have the memory to be absolutely -- to clarify that point.

THE CHAIRMAN: Well --

A. I can see --

THE CHAIRMAN: It doesn't make sense to me.

A. That?

THE CHAIRMAN: That you can say there was nothing at fault found in relation to the cases in question when the monitor, the Siemens monitor used in Adam's case, is out for repair.

A. I think it might be useful for my memory to look at Dr Gibson's report. Does she mention the monitor at all?

THE CHAIRMAN: This is her report.

A. Right, sorry.

THE CHAIRMAN: The bit that's highlighted in yellow is the technical checks. She's saying in the previous paragraph it was Messrs Wilson and McLaughlin who carried out the checks on the equipment. She then says:

"The technical checks demonstrated a high degree of vigilance in this area and found nothing at fault in relation to the cases in question."

We now know, because we've just looked at it, that the Siemens monitor which was used during Adam's operation was out to be fixed. Not to be serviced, but to be repaired.

A. I have no memory of the details in regard to this.

THE CHAIRMAN: Okay.

A. And I have no knowledge now as to whether Dr Gibson knew that.

MS ANYADIKE-DANES: I understand. If we just stay with her report there, the bit that we can see is the only bit that's really relevant to us, which is Adam's case that she summarises. It says pretty much along the lines that the chairman read out in Dr Taylor's letter:

"Full records of all monitored parameters are available on this case and show that no untoward episode took place and that a very stable anaesthetic was given."

One way of reading that is if you looked at the records, you wouldn't able to tell anything was amiss, but two things follow from that. One -- and we're going to look at it now -- his anaesthetic record. The inquiry's experts -- and not just the inquiry's experts but the nephrologist at the time, Professor Savage and Dr O'Connor -- were all able to conclude that something was awry in relation to the amount of low-sodium fluid

that was administered. That can be seen from the records. But apart from anything else, you know -- because he has told you about it -- that he had a concern about the CVP.

A. Surely.

Q. There is a compressed trace of the CVP which shows its high levels and you have seen that. At least, I think the documents indicate that you have seen it. That's not a normal parameter. At least, that's the evidence that the inquiry has received. So when you saw this and you have just described that as you thought that was an appropriate report, now you think about it, was it appropriate?

A. I can't answer now.

Q. Well, this report was being prepared to go on, I think you accepted, "To whom it may concern". Given that the coroner is involved at such an early stage, very likely to the coroner because, apart from anything else, he wants the equipment to be examined.

A. Surely.

Q. So this report is going to the coroner. Dr Taylor's statement, in some shape or form, is going to the coroner. None of this really seems to square with what you had been told or recollect being told by Dr Taylor about some of the concerns and I am simply asking you

what you think your responsibility was.

A. My responsibility would have been pulling that all together. I don't remember doing that, but I -- you know, that would be what I would normally do. I would have actually seen if there were discrepancies. Dr Gibson had been chosen because she was a pretty forthright anaesthetist and I would have -- she had a lot of detailed knowledge. So that then -- and then what became apparent in the -- whenever these came to the discussions was that there were some differences of opinion with regard to all of this. That was why I felt that we did need, at that point -- we certainly needed, before the coroner's inquest, we needed further expert opinion.

Q. Yes, you have said that. When you say "differences of opinion", do you mean there were differences of opinion or differences as to some of the basic facts as to what had happened?

A. I think there were some differences of opinion, say, with regard to the fluid loss, differences of opinion with regard to blood loss, differences of opinion in terms of the significance of the drapes, the wet drapes. Those were areas where there was some significant opinion. I don't remember individual meetings in detail. I don't remember when they occurred and I don't

remember if there was more than one, but the one thing that was apparent to me was that there were some differences of opinion among the people who had managed this case as to how it had gone.

THE CHAIRMAN: Well, let's develop that because I think we're moving on past Dr Gibson's report and the technical report and the differences of opinion, as I understand it, are what leads you and Dr Lyons to suggest to Mr Leckey that he should bring in somebody who turns out to be Dr Sumner.

A. That's right.

THE CHAIRMAN: Then, in terms of input into these internal differences, I fully understand why you can't remember how many meetings there were, who was at them and so on, but when you talk about differences of opinion, do you remember, for instance, was Dr Savage one of the people who had an input, did Dr Taylor have an input? Who had an input?

A. I remember at various times the surgeon having an input. When I say "various", I remember on one occasion definitely the surgeon had input. I know there was some, say, disagreement about blood loss, as there would be between surgeons and anaesthetists. It's a pretty standard thing.

THE CHAIRMAN: When you say "the surgeon", who are you

referring to?

A. I am referring to Mr Keane. Is that his name? The transplant surgeon who I had never met before that. There was some difference of opinion. He felt it had been more straightforward than had been suggested.

MS ANYADIKE-DANES: Who was he differing with?

A. It would have been with Dr Taylor. The things that Dr Taylor had mentioned to me during the meeting, I raised those or actually I felt that those needed to be clarified. So those were raised and there was differences of opinion with regard to the blood loss. There was [sic] differences of opinion in terms of things like irrigation. It was important these were discussed. So I would have prompted, because I knew that, and there would have been differences of opinion as to whether this was a longer surgical operation than normal.

Those would have been issues that would have been -- that, say, we would have either -- Dr Taylor would have issued or I would have raised and said: was there more of this or this particular --

Q. And who else would have been there? Would you have brought in Mr Brown, for example? He was a senior surgeon.

A. I didn't organise those meetings in any way. I knew

they were going ahead. I don't -- I can't answer whether Mr Brown was at any of the meetings. The people I remember who had been at some of the meetings would have been Professor Savage, Mr Keane, certainly on one occasion, and Dr Taylor and myself and Dr Murnaghan. Those are the people that I remember, but there may have been more.

THE CHAIRMAN: It makes sense, obviously, for Messrs Savage, Keane and Taylor to be there because they were the people who were most directly involved. Mr Brown you can't remember. But --

A. There might have been someone from the paediatric directorate. And I'm not -- I'm slightly confused as to who was the clinical director of paediatrics at that point in time. I'm not sure.

MS ANYADIKE-DANES: Conor Mulholland, I think, was acting.

A. I don't remember Dr Mulholland. I can't remember him being at meetings, but that doesn't mean he wasn't.

Q. I appreciate that.

MR FORTUNE: Can we find out from Dr Gaston how many meetings Professor Savage is said to have attended? And if Dr Murnaghan was present, whether any notes still exist or indeed whether Dr Gaston has any notes? Because at some stage, sir, you're going to have to make determinations of fact. And frankly, it is a matter

entirely for you. You may ask yourself: am I being assisted by this conspicuous lack of clear recollection?

THE CHAIRMAN: Well, I'm being assisted to the extent that Dr Keane told us last month that he waited in the City for the phone to ring and nobody rang him and he had no input. And I'm now being told by Dr Gaston that whether directly to Dr Gaston or through others, meetings he isn't entirely sure who was at and when they were held, but that Mr Keane did have an input.

A. I'm almost certain that -- I mean, I'm ... I feel he was present at some -- at at least one of the meetings. I'm pretty sure.

THE CHAIRMAN: Well, would you be pretty sure that you were at that meeting, which is why you remember?

A. Yes. That's why I -- I mean, if I hadn't been there, I wouldn't have had the ... Because I think that was the first time I ever met Mr Keane. I didn't know him at all. I'm not sure.

MS ANYADIKE-DANES: In fairness, Mr Chairman, although we will get the reference for you, I think in his evidence Mr Keane said that he -- it's either his evidence or his witness statement. He believes he was at one review, didn't attend any others because it was to do with paediatrics and that's what he wasn't going to carry on doing or do very much more of, if I can put it that way.

There is, I think, a reference to it. I can find that for you, but I think he only acknowledges attending once.

A. That would be my perception too.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Since we are at these meetings, we have --

THE CHAIRMAN: Sorry, let's just follow up Mr Fortune's point.

You're having the same difficulty as we anticipate others will have in remembering about who was there, how many meetings took place and so on. Do you remember taking any notes or do you --

A. No, as I said I don't remember taking any notes. And my -- I would have anticipated that either Dr Murnaghan or ... I don't know if his ... The manager who worked with him ... I would have anticipated that -- and it would have been normal practice for Dr Murnaghan to take notes actually. That would have been why I wouldn't have been the specific person to take notes.

MS ANYADIKE-DANES: Can I, just before we leave Mr Keane entirely, pull up 059-036-070? This is a letter from Mr Keane, 1 May, to Dr Murnaghan. He refers to a regional meeting. Do you know what that means, "a regional meeting"?

A. No.

Q. No? But it says "Our regional meeting". It states on page 1, whatever that is -- oh, it's the letter enclosing the autopsy report:

"The blood loss was 1,500 cc."

Again, in the summing-up it states that.

"The blood loss in this operation was 1,500 cc. I think it is worth correcting this in that the estimated fluid loss -- which contained blood, peritoneal fluid and urine -- was 1,500 cc. The reason this point is important is that 1,500 cc of blood loss in a child of that age [would] constitute virtually his entire blood volume and would have been massive blood loss, which is very definitely not the case."

Is that the sort of difference of view that emerged in that meeting?

A. Yes. I mean, I can't comment on these volumes. I have no recollection. But this is the sort of issue that would have been discussed at at least one meeting.

THE CHAIRMAN: Sorry, just to get it clear. You will correct me if I'm wrong because I thought that the meetings you were talking about having been held were meetings a long time prior to 1 May 1996. Adam died in November 1995 and, if I understand the sequence correctly, you have the report from the technical

people, you have Dr Gibson's report, you have spoken to Dr Taylor, but it's because differences are emerging between people who were directly involved that you suggest to Mr Leckey that he should get -- who turns out to be Dr Sumner. So the meetings you were talking about a few minutes ago and, for instance, at which you're pretty sure Mr Keane was at one and you were pretty sure you were at the same meeting, the regional meeting which is referred to here, which comes much later, that is much further down the line than --

A. That is much further down the line.

MS ANYADIKE-DANES: But is the issue or the difference the one that you were referring to us?

A. Yes, there was a discussion about blood loss.

Q. Does this mean therefore that what Mr Keane is drawing attention to is that somehow the information that has gone to the pathologist reflects the 1,500 cc as blood loss and not his point, which he was making in these early discussions, that actually it wasn't all blood, there was urine, peritoneal fluid, irrigation and so forth? Is that the point so far as you understand it?

A. Sorry, I'm beginning to get a little tired here. I apologise.

THE CHAIRMAN: We will break in a few minutes for lunch. I think the point here is that what Ms Anyadike-Danes is

asking you is whether the point which is being made by Mr Keane in this letter is, in effect, a repetition of the point which he had been making some months earlier about the extent of blood loss.

A. Yes. My memory is that there were a series of meetings. I mightn't have been at all of them and that at one point there was this issue between the surgical opinion of blood loss and the anaesthetic opinion of blood loss. That would be something that would be very common, actually. But the exact volumes and the exact things, I don't remember.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: I understand. We have been able to find dates of meetings.

A. Right.

Q. And it may be that you can help with which ones you think you attended. The first is 17 April 1996. We have that from 059-043-098. You are included there as part of the ...

A. I don't ...

Q. Actually --

A. I don't think my name's on there.

Q. No, your name's not on that, sorry.

THE CHAIRMAN: Leave that for a minute. Let me see who is at that: Mr Brangam, Mr Keane, Mr Brown, Webb, Savage

and Taylor. Okay, thank you.

MS ANYADIKE-DANES: Can we go perhaps to 059-030-061? That seems to be another meeting and you're not at that either. That's 23 May.

A. There was quite a long period when I would not have been involved in meetings at all, but I'm not sure how the dates go. I would have actually been not involved in meetings for quite a long period.

THE CHAIRMAN: Sorry, pause. There's no reason for Dr Gaston to be at that meeting. It's a pre-inquest consultation and Dr Gaston is not a witness at the inquest; isn't that right?

MS ANYADIKE-DANES: No, I'm simply trying to identify the records of meetings that we have and whether he can assist us as to whether his meetings effectively came to an end at the point when they start to prepare for the inquest.

A. I think ...

Q. 059-017-043. There you are. That is circulated to you. This is also a pre-inquest meeting. Then there's some correspondence received from the Trust solicitors that is to be discussed and the reports from doctors Sumner and Alexander. That meeting has been arranged for 5 June. Do you recall being at a meeting where those documents were present and discussing them?

A. I recall being at a meeting around that time. I don't recall the details of it at all, I'm afraid.

Q. Right. Can we go back to 059-024-051? It is a file note, 31 May:

"Dr Murnaghan met with Dr Gaston and Dr Taylor at 1 pm at Dr Murnaghan's office."

That's 31 May. Do you recall a meeting like that?

A. I recall a meeting and I'm having difficulties actually at the minute -- can you remind me when the date of the coroner's inquest was? It's difficult to remember.

Q. 18 June.

A. I do recall being asked by Mr Brangam to attend the inquest because, as clinical director, there might have been some issues that I might have been the only person that could have provided information.

Q. I am actually trying to get to before that period.

A. I think because of that there was a point at which I was asked to attend a meeting with the people who -- with Dr Murnaghan and, I think, Mr Brangam. There was a meeting at some point in advance of that. I can't remember, actually, the details.

Q. We might be able to help a little bit, although the documents on this are rather sparse, so I'm sorry if I put things to you and you say, "I certainly can't remember that".

What I was trying to see is whether this series of dates -- and it seems that we have only identified three of them -- where you might have been involved in a meeting. I think you have said that that might have been part of the run-up to the inquest in getting yourself prepared and so forth. It seemed though, when you were answering my questions and also addressing the chairman, that you were talking about meetings much earlier than that.

A. Yes, there were meetings earlier.

Q. So these would be in the early part of 1996; is that right?

A. Maybe even actually in December.

Q. In December also?

A. I'm absolutely certain. That's why, in a way, whenever I'm looking back, I know that there was far more discussion and involvement in terms of looking at this than I now can remember.

Q. Yes, I do understand that.

A. So I mean, I know there was. I can't remember, say, the structure. I don't remember who would have been at the meeting. But I think -- and it has been difficult probably to get this across -- the idea somehow that this event was left floating up in the ether with nothing happening, that actually wouldn't have been

true. It is just that I have great difficulty now of saying how that was actually done to be quite honest.

Q. I do understand that. Maybe it would help if you did it in this way: can you recall what you thought your role was in those meetings?

A. My role was, first of all, to actually look at us getting to the bottom of the story. I felt that this was -- there was more to this than just that event that had happened.

Q. Sorry, what do you mean by that?

A. I meant that there were issues about, you know, things like the organisation of the transplant service, there were issues about the fact that we had -- there had been a shortage of anaesthetists at that time. There were issues about the laboratory, the ability to provide accurate sodium levels during the surgery. There were issues about the differences of opinion with regard to fluid. And I felt quite strongly -- and this goes back to my original sort of remit in a way. I felt that the full risk-management issue needed to be addressed and I also will say that I felt that issues that had been raised by Bob, Dr Taylor, with me -- it was important that even though there was a discrepancy, it was important that those were not lost, they needed to be discussed. So my role would have been -- first of all,

I wanted this to be proper, to be investigated in a way that I have identified where there might be things in the structure, in the process, that we could actually put right. And secondly, also, of course, look at exactly what had happened that had caused Adam's death.

Q. Did that mean you would have welcomed a formal investigation?

A. I would certainly have welcomed that, yes. I don't have any feeling of anybody not welcoming that.

Q. Did you maybe discuss, "Maybe we'll have a formal investigation"?

A. No, I don't remember discussing that. I think we did discuss -- and this goes back to that ... The number of people, myself and a number of people [inaudible] it wasn't a symposium that we were going to have --

Q. Seminar?

A. A seminar. That was the first step to try to look at that. But I mean -- I ... I go back a little bit to where I was coming from yesterday about risk management and I talked about Professor Reisen. One of the things Professor Reisen says is that an incident like this is like a Swiss cheese. You have a series of holes in a Swiss cheese, but the probe generally will not go through more than one or two. But in a certain very rare circumstance, the probe will go all the way

through. And that is when something goes wrong. It's when it went wrong with the Piper Alpha, it went wrong with the satellite and with the ... NASA.

In fact, when you have an incident, when something goes wrong, it's very rarely one catastrophic mistake; it is nearly always a series of things. And whenever those holes line up is when it goes wrong. And I felt that this was one of those circumstances where we needed to look at why -- what were the holes that lined up and how did we plug those so that that didn't happen again. And I felt that that was a way -- and I had no sense that anybody didn't want to do that.

I think there was a real challenge. This was -- it wasn't a culture that was embedded in organisations, actually probably in the UK, and it was a -- this was an opportunity to -- this was an opportunity to engender the culture that looked at it. It's what has come now with root-cause analysis, which came towards the end of my career, but was in industry for much longer. That sort of forum didn't exist at that point in time and I felt that this was an exercise that would address the issues, but would also help us to identify where, theoretically, the holes were, and I think that is maybe what this inquiry is doing now.

MS ANYADIKE-DANES: Thank you very much.

Mr Chairman, I'm conscious that I think Dr Gaston said he was getting a little tired. I was going to move on to look at Dr Sumner's report.

THE CHAIRMAN: Yes. We'll do that at 2.05. Thank you, doctor.

(1.05 pm)

(The Short Adjournment)

(2.05 pm)

MS ANYADIKE-DANES: Dr Gaston, why wasn't there a formal investigation?

A. I don't know. I do not know. I don't think -- I have no memory that there was anything to block it or any concept of not having one. I honestly do not know why it didn't happen.

Q. But why wouldn't there have been one? You thought it was a good idea. In fact, you actively wanted it. You didn't receive any opposition from anyone else. So why wouldn't there have been one?

A. I mean, I ... The only thing I remember was that we had the seminar, which was to go ahead, and I have no recollection of that happening.

Q. Yes, but a seminar is not an investigation.

A. No, but I think that would have been to my mind the start to how that would go ahead.

THE CHAIRMAN: Can I just ask you, a seminar can have

a number of --

A. I'm not sure that terminology --

THE CHAIRMAN: Whatever we call it, whether we call it a seminar or a symposium or a gathering, what did you envisage that was going to happen at that gathering?

A. Well, what I envisaged when I was there -- and that terminology came later -- was that I was very keen that we would have a full, open review of this. And I can say that I have no recollection of any opposition to that. Why it didn't happen, I don't know. I actually thought that that seminar was actually the start of that process.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: Okay.

THE CHAIRMAN: Sorry, you were expecting it to happen? I think it was to take place, wasn't it?

A. Yes, it was.

THE CHAIRMAN: And when it didn't take place, did you suggest or say to Dr Murnaghan, "Look, we do need this"?

A. I cannot -- I mean I know from Dr Murnaghan's statement and I know that there was an issue because it was very close to holiday time. Pulling things together like this is quite difficult given that a lot of these doctors were working in different places and then it came into holiday time, which made it even more

difficult. Then Dr Murnaghan had gone ill, had been off ill. It didn't happen after that. I think it's a -- one of the issues is that so much of your time was taken up with what was going on day by day that eventually it went out of my mind. It shouldn't have done, but it did.

MS ANYADIKE-DANES: Yes. Well, let me ask you about how the issues were developing from the time, really, when you are starting to get into the discussion, if I can put it that way --

A. Surely.

Q. -- on the whole matter. That, as you rightly pointed out, actually happens quite early.

A. Yes.

Q. I was in error to suggest to you that it really wasn't until the early part of 1996 because in fact it was happening in December, wasn't it?

A. That's my recollection. As I say, I don't have any formal details to support that.

Q. That's fine. There are some bits of documents that help us with it. There was a meeting of 3 December, we know, with the coroner, Dr Murnaghan, yourself, Dr Samuel Lyons. We know that meeting happened because that was where there was the suggestion that there should be another paediatric anaesthetist because

although the coroner had made steps to instruct Dr Alexander, you weren't entirely sure that he had sufficient paediatric expertise for this kind of case.

A. That's right.

Q. If that's the case, as the chairman was raising with you before, then somebody has turned their mind as to what kind of case we have and, therefore, who is an appropriate expert to assist with it.

A. Surely.

Q. And that only happens because either you have been discussing things with the clinicians involved and/or you have looked at the recent notes that will disclose what kind of case we are dealing with.

A. Yes.

Q. And in fact, the person that ultimately -- I think it's both you and Dr Lyons want is Dr Ted Sumner.

A. No, we -- what happened was that I didn't, nor did Dr Lyons, we didn't have any names. We didn't know. We got the name from Dr Crean and one from the Association of Paediatric Anaesthetists.

Q. That kind of discipline is what you wanted actually?

A. Yes.

Q. And his particular kind of discipline is somebody who has experience in electrolyte disturbances and so forth.

A. Absolutely.

Q. So if you're content that he's the appropriate person, even if somebody had asked you, "Is it to be Dr Sumner?", you don't particularly know him, but once you know what his experience is, you're happy that that's an appropriate person?

A. Yes.

Q. And that means that you have not only turned your minds to the fact that you have a paediatric anaesthetist issue, if you like; you have a particular kind of issue within that, which is fluid management.

A. Yes.

Q. So whatever you had been discussing with whomsoever at that time you all -- at least you and Dr Lyons -- had formed a view that that was the issue in Adam's case, whatever else there might be that was an issue in his case?

A. Yes.

Q. Thank you. Then I am going to try and see if you can help us with how that issue actually developed and what your views were. You have had those meetings, the equipment is investigated and so forth. I had read you out a series of dates when I thought that you might have had meetings, which is after that now, coming into the run-up for the inquest, if I can put it that way.

If I can pull up 059-032-064. That is a handwritten

note, I think, by Dr Murnaghan:

"I will have further discussions with Dr Taylor about the various potential problems that may arise at the inquest and will probably [I think it looks like 'involve'] Dr Gaston prior to these."

Then at 059-027-058 we have a letter from Dr Murnaghan to the Trust solicitors. If you look at the third paragraph:

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

What were those problems that he was going to consult with you about?

A. I don't remember now actually. I just don't remember the details of that.

Q. Right. Well, so far as you were concerned, after the equipment had been inspected and after you'd received that report and received Dr Gibson's report, which seemed to, on the face of it, exclude the anaesthetic and the anaesthetic equipment, what were then the problems that you foresaw?

A. Well, I think one of the -- sorry, excuse me, can I get my glasses?

Q. Of course. Sorry. (Pause).

A. Can you just develop that again?
THE CHAIRMAN: It's the paragraph that highlighted in yellow where Dr Murnaghan is saying to Mr Brangam:
"I will have further discussions with Dr Taylor about the various potential problems."
And you said you didn't recall what the various potential problems were and you were then asked:
"After the equipment had been inspected, after you had Dr Gibson's report, what were the problems which you foresaw?"
A. Right. I think one of the issues, and a very important issue -- we had asked an independent person in Dr Sumner and there were issues that he raised with regard to the fluid management.
MS ANYADIKE-DANES: So you'd seen his report at this stage?
A. I think so, yes. I think so.
Q. Right.
A. In fact, I'm sure I saw it, actually.
Q. Okay.
A. And these were issues which Dr Taylor needed to look at.
Q. Okay.
A. And he needed to actually think how he was going to respond to the accusation. So I think that's what we were talking about.
Q. Had you seen Dr Armour's report on autopsy at that

stage?

A. Yes, I had.

Q. Right.

A. I mean, I think that was -- I got that report fairly early on.

Q. Very good. Let's go to that quickly. So we will see the sort of things that were in your mind that you're discussing. 011-010-041. There you are. Sorry, I should say this is the end of her report. This is where she has a commentary section and this is the latter part of that; okay? She starts off with a highly complex case in the same view that you have expressed. Then if you look at the third paragraph:

"In this case, the volume of urine output was greatly increased and the urine was also dilute. This was probably due to the fact that the kidneys did not function and their ability to concentrate the urine was minimal."

Then she goes on to discuss those issues. We get to the various readings. Then she goes into:

"Also, during the operation the sodium was low along were the haematocrit. It is known that a condition called dilutional hyponatraemia can cause rapid and gross cerebral oedema. There is no doubt in this case that the sodium level was low during the operation."

Then she goes on. She culminates [sic] that with:

"It seems likely therefore that the hyponatraemia in this case was the cause of the cerebral oedema and most of the intravenous fluids given in the cases cited in this paper [she's referring to a paper she had seen] were administered as 280 mmol of glucose per litre in water."

Then she goes on to deal with the CVP and, finally, I think she concludes in that paragraph starting "another factor":

"Therefore, the most likely explanation is that the cerebral oedema followed a period of hyponatraemia and was compounded by impaired cerebral perfusion."

So what she's talking about there is that Adam had dilutional hyponatraemia, which means he received too much low-sodium fluid for him.

A. Well, on those readings he had dilutional hyponatraemia.

Q. Yes.

A. I can't speculate as to the reason.

Q. So you saw that. Then if we go to Dr Sumner's report, 011-011-063. And his penultimate paragraph:

"To summarise, I believe that on the balance of probabilities Adam's gross cerebral oedema was caused by the acute onset of hyponatraemia from the excess administration of fluids containing only very small

amounts of sodium. This state then was exacerbated by the blood loss and possibly by the overnight dialysis."

In any event, both of them are pointing to Adam receiving too much low-sodium fluid.

A. Yes.

Q. You accept that?

A. Yes.

Q. So that's what you knew about as you're going into these meetings to discuss, or there are going to be meetings to discuss the potential problems. Just a minute ago, you said that Dr Taylor would have to address that point.

A. Yes.

Q. But that's not an issue that you have to address, save, "How are we going to deal with the fact that we have had an incident that's arisen in that way?" Dr Taylor has to account for himself --

A. He has to address it. I couldn't address it.

Q. Yes. So what then were the discussions that you were going to have with Dr Taylor or that were going to be had with Dr Taylor about the various potential problems?

A. That obviously was one because I know it's there. I can't remember -- I mean, I think the things that Mr Brangam was talking through with Dr Taylor -- and I was there listening in -- were the issues he was going

to have to deal with and I can't remember what those were. I do remember, obviously, Dr Armour's report and Dr Sumner's report were two things that he had to deal with. And he had to be able either to agree with them and point out why he agreed or, if he disagreed, why he felt that his fluid management was appropriate. And I think that was something that he had to -- he had to address. I could not address that.

Q. Did you agree with Dr Sumner and the pathologist in the post-mortem report that there had been too much low-sodium fluid administered?

A. I can say that that was the report, that was what it said. As to whether I agreed or not, I can't answer. The thing that I believed that Bob needed to address, or Dr Taylor, was what his fluid management had been, what he did, what were the issues, and how did he look at that in light of what had been the information that was provided by Dr Sumner.

Q. But it's not just Dr Taylor. You're the clinical lead. Dr Murnaghan is also a lead of a directorate. The child was treated by a hospital within the Trust. So it's not just Dr Taylor for himself.

A. No, I'm not saying that I didn't need to look at this in the future and, of course, we did with regard to how one would look at the management of hyponatraemia,

dilutional hyponatraemia particularly.

Q. Let's look at the --

THE CHAIRMAN: Sorry. Did Dr Ian Carson, who you have told us also was an anaesthetist, as the medical director, was he involved in some of these decisions?

A. I have no memory. I can't remember whether he was or not.

MS ANYADIKE-DANES: By the time you get to the stage where you've got, so far as the anaesthetic equipment is concerned -- that seems to have been discounted although there's an unfortunate thing in relation to the fact that they hadn't seen the right monitor, but that seems to have been discounted.

A. I think that's fair.

Q. You have a surgeon who's saying: actually, the blood loss wasn't as high as your anaesthetist seems to suggest it was. You have the anaesthetist who has numbers of issues as to why the thing should have been as complicated as it was and may explain why things went the way they did without necessarily conceding any fault on his part. You have the report on autopsy, which seems, fairly squarely, to put the cause of the cerebral oedema down to dilutional hyponatraemia, caused by too much low-sodium fluid as well as an exacerbating factor to do with cerebral perfusion.

The independent expert who you particularly wanted to have brought in because you foresaw the need for that expertise, very clearly has said, "This is about dilutional hyponatraemia, too much low-sodium fluids". So you have all of that. Is this not a time to bring in the medical director?

A. As I said, there was a normal line of communication, which was through -- me through Dr Murnaghan. And it would have been my impression that if Dr Murnaghan -- the perception would have been that if Dr Murnaghan would have ongoing discussions with Dr Carson -- I don't know if he did or not -- but to inform him of where the case was and what were the issues. I'd be surprised if he didn't, but that would have been the normal --

Q. I accept that.

A. I would have expected that would have been the mechanism of it.

Q. But you very fairly said to the chairman in answer to the question that whatever was the normal reporting lines, if I can put it that way, there was absolutely nothing to stop any clinical lead going to the medical director with an issue?

A. No.

Q. And in fact you said that you had very good relationships with him.

A. That's right.
Q. So this is something that, whatever might be the way the structure operates, it is within your directorate.
A. Surely.
Q. Why did you, at this stage, serious as it is, given you have an independent opinion now, not bring in the medical director on your own volition?
A. Um ... I don't actually know why I didn't bring in the medical director. I think the other thing that was quite important in regard to this -- and it is something that actually, I think, was mentioned yesterday by Mr Keane, which was that there were a lot of colleagues who would have known the case. There were colleagues within the Children's Hospital, there were anaesthetic colleagues. At no point did anyone say to me ever before during or after, "We have concerns about Dr Taylor's management". Ever. There never has been.

There is not a single complaint ever come to me in my time as clinical director before, after or subsequent of any single nurse, technician, doctor, anaesthetist, surgeon putting in a complaint about Dr Taylor's ability to deliver his anaesthetics. Never. And I think that's very, very important. And sometimes that is -- this case wasn't hidden, people knew about it. But nobody ever once within our operation, within Northern Ireland,

questioned Dr Taylor's ability to deliver anaesthetic services.

And I think his record since actually substantiates -- I am not saying that he didn't have difficulties in this case, but there never was a single complaint by any of the anaesthetic surgeons [sic] brought to me. I don't know if there's any went to Dr Murnaghan, I don't know if there was any went to Dr Carson. So that didn't happen.

The mechanism for alerting Dr Carson would normally have been through Dr Murnaghan. Did I speak to Dr Carson? I can't say. I don't remember.

THE CHAIRMAN: Let me explore this with you, Dr Gaston, because this is important generally for Dr Taylor and for others. Your evidence to me then is that before Adam's operation and since Adam's operation, during the time that you worked in the Royal, you had no cause to worry about Dr Bob Taylor's competence?

A. Not only did I have no cause, I was constantly being reminded by the quality of his work.

THE CHAIRMAN: Okay. Let me take you on to the next step. I really do not want you to go into names, but were there other doctors or other occasions from time to time when somebody came to you, "I am a bit worried about Dr X or Dr Y"?

A. That was not uncommon and in the situation when Dr Murnaghan was there, I would frequently have talked that through with him and/or Dr Carson. And when Dr Murnaghan took up his next position, I would have talked to Dr Carson. I think the thing that is missing is that somehow or other, the Trust didn't have a mechanism for -- they didn't have a written mechanism, to the best of my knowledge, for identifying underperformance in -- we did. There were mechanisms whereby -- it might be a technician who worked with an anaesthetist who would speak to someone. It might be a surgeon who would speak to someone. It might be a junior anaesthetist who would speak to someone. And that just didn't -- that applied across. In other words, if we had concerns, as an anaesthetist, with a surgeon, we would -- I would have gone to the director of surgery and said, "Look, it's been reported to me. It's not in my -- I don't have the experience to deal with the surgical thing, I'm reporting it to you, it's up to you to decide how you're going to handle it and do that in consultation either with Dr Murnaghan and Dr Carson".

THE CHAIRMAN: I understand that, and look, that's very helpful for me to know. As I understand what you're saying, it means that there's any number of channels

through which word can get to you or your fellow --

A. And it did.

THE CHAIRMAN: -- directors that there's a problem with various people working in the hospital, if that is the case.

A. I'd like to clarify. I think there were two points you explored very nicely yesterday through my past experience. I had to deal when I was chair -- we talked about my role of chair of anaesthetics. I had, on one occasion, to investigate a complaint involving my senior colleague, who at the time had a very senior role within anaesthesia in North America. And I had to do that and I did do it. It was a complaint about his attitude to patients. It was an complaint and there was certainly some concept within the hospital that he would have had a pretty brusque manner with patients.

What we did with that is I spoke to him, I spoke to the head of his department, I spoke to the patient separately and then we came together. We had a conference in which there was an agreement on how to manage it.

I'd like to look at another case, which was in -- we talked about the audit in the King Fahad on the basis of the quality assurance. And I talked about the Audit Committee meetings and the fact that we had incidents --

you can call them critical incidents, but actually they were to do with identification of where practice didn't appear to be right.

We had a meeting in which we had a very frank exchange about one of our colleagues. He was present. We had the record, that record showed that the standard of care was not met. And the other thing that we had is we had a -- I had with the chief a profile of every anaesthetist in the department. That was available. In other words how many standard of cares -- when you had a query, how many were accepted as standard of care met, how many were standard of care met with variants and how many were standard of care not met.

We had, and I can't remember exactly -- the only thing I do know is if standard of care was not met, you were not expected to have any and they were in limited number. That was available to every hospital in North America. If they wrote to the hospital, they could get my profile or any other profile. He had a profile that showed to me he had had several episodes. I was acting chairman, I felt for the safety of the rest of the patients I had to suspend him immediately, which I did. And then whenever the chairman of anaesthetics came back, his contract was terminated immediately.

So I had had to deal with these. And in all of

those cases, I had other information coming to me that --

THE CHAIRMAN: Okay. Let's move forward then because I understand the general background that you've described from your own experience and I also understand the evidence that you have given about how good an anaesthetist Dr Taylor is.

A. Absolutely.

THE CHAIRMAN: Let's then look forward to what happened with Adam in 1995. Clearly, something went very badly wrong.

A. Yes. We now know that because --

THE CHAIRMAN: It's not just that you now know it, you knew it, for instance, from Dr Sumner's report.

A. Sorry, yes.

THE CHAIRMAN: And you said before lunch that there were internal differences of opinion.

A. Surely.

THE CHAIRMAN: And we've heard something of that over the last few weeks of evidence and, to put it probably too crudely, we've heard Dr Savage and Mr Keane both in ways pointing the finger at Dr Taylor; right?

A. Yes.

THE CHAIRMAN: The internal differences of opinion that you heard in 1995/1996 were, I assume, along the same lines.

A. I think, broadly.

THE CHAIRMAN: Okay. And then you have Dr Sumner's report, which is along the same lines. And then, whether you intervene at that point before the inquest or whether you wait until after the inquest, you then have an inquest finding which is on the same lines.

A. Surely.

THE CHAIRMAN: This is a slightly different problem to ones you were describing before.

A. I agree.

THE CHAIRMAN: On your evidence, this is a good doctor --

A. Yes.

THE CHAIRMAN: -- who has made a pretty terrible mistake or two --

A. He certainly had.

THE CHAIRMAN: -- and has led to a child's death. So what happens?

A. Well, I felt that that was best investigated in a broad-based investigation, or a broad-based -- input from the surgeons, input from the pathologist, input from the -- both of the surgical specialties, both the transplant and also input from the clinical director.

THE CHAIRMAN: You see, the biggest concern I have listening to all this evidence is Dr Taylor has eventually come to the inquiry and admitted that he made a lot of mistakes. That's an admission that he did not make in 1995 or at

any time before this year, so far as I can make out.
A. Sure.
THE CHAIRMAN: On the documentation you have just been taken to, you were talking to him before the inquest to discuss the various problems which faced him at the inquest.
A. Yes.
THE CHAIRMAN: And at that point, as we see from his inquest evidence, he appears not to have accepted the criticisms of him. But what then do you do, Dr Gaston, if you have a doctor, even a very good Dr Like Dr Taylor, who appears to have made mistakes and isn't even facing up to them because he can't or doesn't recognise them because there's maybe a gap in his knowledge? Either of those two scenarios is very worrying, isn't it?
A. At that point in time -- I mean, I can't answer now. I don't know whether there was -- I think that I was waiting for the sort of discussions that were going to come and I felt they had to come quickly in terms of the whole breadth of the input from the various organisations.
THE CHAIRMAN: But let's look at it in a slightly narrower basis: once you had the inquest verdict, which I understand was accepted by the other doctors, but was it also accepted by you?

A. Yes, I think that having had -- I mean, it was clear that an expert like Dr Sumner had made that. That was an accepted statement. Yes, I accepted that.

THE CHAIRMAN: And frankly, once the coroner returns that verdict, you can't really go behind it. You are stuck with it; isn't that right?

A. It would have been inappropriate, yes.

THE CHAIRMAN: So even at that point, does somebody not have to sit down with Dr Taylor and say,"Look, this is now confirmed, you have had your say at the inquest, you have had your say internally, you got it wrong. How are we going to move forward?". But you don't need the surgeons there for that. You don't need the nephrologists there for that.

A. I certainly don't have any recollection that I had that discussion.

THE CHAIRMAN: What I'm really asking is: why not? You were the head of anaesthetics. You would also have been supported by Dr Carson, who is the medical director and an anaesthetist.

A. Yes.

THE CHAIRMAN: So why not have that discussion at that point with Dr Taylor?

A. I don't know. I mean, I don't know. I may well have spoken to Dr Carson as well. I can't remember.

THE CHAIRMAN: Well, what I'm going to ask you is this: in a sense, were you reluctant to have it because generally he was a very good doctor and therefore, even though he'd made some awful mistakes, which had certainly contributed to some extent to Adam's death, however that is finally resolved, you were reluctant to take him on in a sense because he's a good doctor?

A. No, I wasn't reluctant to take him on. That may have been a factor in the decision, not in terms of reluctance to take him on, but in terms of how he took forward in terms of -- he had to continue to work. There was nothing that said to me, apart from this, that he should stop giving anaesthetics. If he did, we probably would have had the collapse of anaesthesia and ICU in Northern Ireland. That was probably what was going to happen. So I had to actually look at the time and I think we had to look at the time -- was this an incident that was going to actually in any way impair Dr Taylor's ability to deliver anaesthetics? Yet, looking at it back as I do now, it didn't.

THE CHAIRMAN: Yes, but --

A. But part of that was, I think, the way it was managed. In other words: yes, it would have been better to have had an investigation, better to have a discussion, but it was important that Dr Taylor's confidence and his

ability as an anaesthetist was not damaged by the process. And I still believe -- and I believe that today and I think history backs that up.

THE CHAIRMAN: Okay. I understand the point, doctor, that since then there have been no adverse incidents involving Dr Taylor.

A. And there hadn't been prior to that either.

THE CHAIRMAN: I really don't understand how you could have decided in 1995 or 1996 that his ability wasn't impaired when you had an inquest verdict and an expert report, which said that he had made so many mistakes and he was denying that he had made any mistakes. Denying in the face of Dr Sumner's evidence, never mind the other views held internally. How could you be reassured about his ability in light of the fact that in essence he was standing alone?

A. Standing alone in?

THE CHAIRMAN: On the issue of the cause of Adam's death.

A. I think one of the things when you find yourself in a situation like that -- and I hadn't ever been there, but I had had situations where ... I think you need a time to accommodate to what you have just found out.

THE CHAIRMAN: Okay.

A. And I think that takes some time. Usually it's -- and I didn't know this because I ... I didn't know that

Dr Taylor had found this difficult to accept for so long. I think that that is something that, in a way, one needs to accommodate to. It's probably difficult explaining this because from a clinical point of view, but when you have something like this happen, it is utterly devastating. If you are a highly conscientious, very highly motivated person, as a doctor, this is an extremely undermining -- and of the people who I knew, and I had one in Canada who had that problem. It didn't destroy his career, but it made it very -- he never had the same confidence again. In terms of what was the service that would be provided to the people, the children of Northern Ireland, to have in any way destroyed Dr Taylor's confidence, I think it was important that he had -- he had to look at this himself. The facts were there. He had to come to that accommodation himself. And I feel ... Yes, we needed -- we needed to look at this as a whole issue. And from what I've seen, the inquiry has looked at this.

We needed to look at: was it appropriate to have been doing those cases? Was it fair to Dr Taylor to have been asked to do that case? Had he had the experience? There weren't many people in Northern Ireland, there were no anaesthetists other than Dr Crean and Dr Taylor who had any experience, and from

what I hear, I have read, Dr Taylor hadn't done that. There weren't actually, I think, probably -- I think Mr Keane said he hadn't that much experience.

So the question that probably needed to be asked: was it unfair that Dr Taylor was put into the position in the first place? Was the fact that we were so short of anaesthetists, was the sense that the show must go on -- did that precipitate Dr Taylor into a situation? I had then to look -- and I think it was important that everybody looked at why were we doing these cases in the Children's Hospital? I had never been part of any discussion that said that. If one of the anaesthetists had come and said, "Look, we're unhappy about this, we're unhappy about doing these cases, we are not sure that we actually have the experience to deal with it", I would have reacted, but I think -- I definitely would have reacted. I would have said, "We need to discuss about this".

THE CHAIRMAN: Sorry, these are all the range of issues that you would have liked to have discussed at your gathering?

A. Absolutely.

THE CHAIRMAN: The end result is that none of them was discussed, Dr Taylor continued to work, the paediatric renal transplants continued to take place and, in

a sense, Adam is forgotten about.

A. Adam ...

THE CHAIRMAN: Okay, if you're going to suggest to me that Adam wasn't forgotten about, in what way was anything learned from Adam's death?

A. Well, I mean, I think ... I was very aware of dilutional hyponatraemia. I actually was very aware of that condition because it had been a situation in Atlantic Canada in the early 80s that two children having tonsillectomies which were complicated had died with what was dilutional hyponatraemia. They had been given 5 per cent dextrose with no salt. There was also another death on that, that was the same GP anaesthetist in the same hospital with no supervision other than his father, who happened to be the surgeon. There was a young woman who died having a procedure. There were three deaths in that hospital. All three died having had 5 per cent dextrose and low sodium. And the Arieff paper, as far as I remember, identifies two risk groups: one was small children and the other was young women. So here were three healthy children that died and it was due to dilutional -- that ended up with the equivalent of Panorama picking up that and it was discussed across ...

So I was very aware, and I also just did my Canadian

fellowship when it was current. I was then asked to look, on behalf of a colleague, at a case of another young woman aged about 32 who had had an abdominal hysterectomy. She had just been given 5 per cent dextrose with no saline. And she had died in the immediate post-operative period. So I was very aware of this. I was aware that this wasn't something that happened -- didn't happen just in transplant surgery.

So I felt that this had been a one-off, but there were lessons that needed to be learned. And we needed to look at those lessons. Yes, it had -- it was dilutional hyponatraemia. I think there were issues round how difficult it had been for Bob to actually decide on the correct level of sodium during the surgery. One theory was the fact -- and this was certainly my perception on the main site -- that the blood gas analysis machine was not a reliable place to get sodium from, apart from the fact that if you used heparin with sodium in it -- which was what was available most of the time -- that would screw the results up. So I can understand why there was some perception that this wasn't an accurate way to do it. And of course, there were issues with regard to the laboratory, the term "near-patient testing" wasn't really appropriate at that time, but in terms of

satellite laboratories, they could only function when you had the right staff in place and they weren't in place out-of-hours and --

So these were things that I felt needed to be addressed because these are things that could have impacted --

THE CHAIRMAN: But the frustrating thing is you have gone through a list, which -- we have sat for a number of weeks and spent years preparing for these hearings, but that list that you have given, you knew that list in 1996 and you said you thought there were lessons to be learned, but is there any evidence that lessons were learned?

A. I can't say there wasn't any evidence that they were learned because, in the meantime, I think if one was to revisit, I think many of the issues that were issues then have been addressed, whether due to the fact that standards have changed in the interim or whether as a result of that, I can't answer. But I think many of the issues probably have been corrected over that period of time, whether as a result of this ...

THE CHAIRMAN: You see --

A. Sorry.

THE CHAIRMAN: The frustration here is that there's parents here in this chamber today whose daughter came in the

following October for treatment. Claire Roberts came in the following October. And what I'm looking to see is if there's any evidence that, by October, lessons had been learned which, if those lessons had been learned, Claire's life mightn't have been lost.

A. I'm not sure which patient that is.

THE CHAIRMAN: Claire came in in October 1996 -- a few months after Adam's inquest, about 11 months after he died -- and she also died and dilutional hyponatraemia was a major factor in her death.

A. Is she the one that was admitted directly to the Royal Hospital or did she go somewhere else and come in?

THE CHAIRMAN: Sorry, the point about Claire is that you're sitting here saying all of the lessons which you identified at that time which should have been talked about and lessons learned and changes implemented and, with all due respect to, what you're saying to me is those lessons have been learned at some time since then, but you're not sure if they were learned from Adam's death. Whereas the point is you think they could have been learned from Adam's death and that is why you wanted the gathering, to learn the lessons, to implement changes to make things better.

A. Certainly within the Royal, I did feel that changes needed to be made. I think that ... It was difficult

for me, and I don't want to -- it was difficult for me to take this forward. I certainly would have voiced my opinion that these needed to be issues. When they didn't occur, well, maybe -- in fact, I should have done, I should have actually stimulated that process. I couldn't do the process myself.

THE CHAIRMAN: Let me make it clear to you that I'm not singling you out, but does that mean that there is really a collective responsibility here for not learning the lessons?

A. I think that it was a collective responsibility. It was probably a responsibility for the whole organisation to actually look at ...

THE CHAIRMAN: Different individuals had different opportunities to force it along and to make some greater input, but it just didn't happen?

A. I think that's a fair comment.

MS ANYADIKE-DANES: Thank you.

The chairman has taken you really to the kernel of the issue in terms of the lessons learned and the dissemination. We are also interested in the path, the travel, and why it was that people had concerns that actually didn't materialise into anything that was likely to come out of, from the point of view of the public, out of the hospital. And we pick up some of the

attitudes -- and I did note that you said that there was a real concern that Dr Taylor's confidence shouldn't have been dented. There was a real --

A. That was my concern.

Q. I understand that. And that there was a real need for experienced consultant paediatric anaesthetists and so forth. And there's undoubtedly going to be an issue as to where the balance lay. If we pull up 059-020-047. It is the second page of a letter from the Trust solicitors to Dr Murnaghan, dated 30 May 1996. In fact, just so that we don't get into difficulties, can we pull up the first page of it, 059-020-046 alongside.

There you see this is the Trust solicitors referring to a recent meeting with Dr Murnaghan, Mr Savage and Dr Taylor regarding the inquest. So we know that the inquest is coming, they've had their meeting, and if you look at the second page, they know exactly what the issue is. The essential issue, of course, relates to the fluids, which were given to the child:

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

That sounds like rather defensive mode, wouldn't you agree? Just reading it, it sounds like defensive mode.

A. Yes, it sounds like that.

Q. Thank you. Then if we go forward to 059-014-038. There are three pages of this letter so we can't get it all in one go. 059-014-038. There has been a meeting, which we saw was being set up from some of the dates that I put to you before and the documents:

"I refer to the discussion of fifth instant with Dr Taylor and Dr Gaston."

So this is a letter from the Trust solicitors to Dr Murnaghan, referring to that meeting at which you were present and it's in relation to the forthcoming inquest:

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

Does that mean that you were agreeing with Dr Taylor's position?

A. No, it doesn't mean that actually. It neither means that I was or I wasn't. What I did -- what I would have done, as I had done right at the very beginning, I would

have ensured -- I would actually ensured that Dr Taylor actually was able to express the views that he had held up to that point. It was then, I think, that a decision by the coroner, having got the points of view that were made -- it was the coroner's decision to actually say what the balance of the evidence suggested.

Q. Well, wasn't it the Trust's responsibility to the patients that it had to embark upon some sort of investigation so that the Trust could satisfy itself that patients were not being put at risk?

A. I'm not sure that I follow that line of -- there was no evidence that ... Other than this one case, I don't think there was evidence at that point in time that the patients were being put at risk.

Q. What you have at that point in time is you have the independent experienced expert that you wanted to bring in. I'm not saying the name necessarily, but the discipline that you wanted to bring in, and he has, from the beginning of that year, submitted a report, which indicates that the problem is cerebral oedema caused by dilutional hyponatraemia, too much low-sodium fluid and that he has identified errors made by the anaesthetist.

A. Yes.

Q. So that's what you have. You wanted that independent opinion. It could have gone the other way. It could

have said he was fine and it was something else, but it hasn't. That's where it's gone.

A. And that's why we wanted an independent person.

Q. Did you, when you received that, accept Dr Sumner's conclusion?

A. Yes, I accepted his conclusion, but I felt that Dr Taylor had made -- he had been in the case, he had done it, he knew exactly where he was. I felt he needed an opportunity to put the reasons why he had made the decision. He was the anaesthetist who was there. He was the anaesthetist who knew the patient. He was the anaesthetist that followed it through. And he needed -- he had the opportunity to put his points of view and I think that was important when it went to the autopsy that he did that.

Q. Yes. But the issue here is that you may have a consultant paediatric anaesthetist who doesn't properly appreciate the polyuric condition and the implications of that. That's what you might be dealing with. Certainly, when he gave his evidence later on -- admittedly, to the PSNI under caution -- it became quite clear -- and he has himself conceded that point in evidence here -- that he did not properly understand. He made irrational decisions or gave irrational explanations as to what he was doing. So he did not

properly understand what was going on. So you have somebody who may not appreciate that condition, who may come across that condition again in a patient before the coroner has had an opportunity to do whatever the coroner is going to do in the finding of his verdict. Is it not for you as part of the Trust to satisfy yourself that any patient with that condition that he is likely to come across will be safe?

A. Yes.

Q. Yes. Thank you. And if it was for you to do that, what did you do to satisfy yourself that that would be the case?

A. I do not remember, actually, now at all.

Q. Well, are you aware of seeking to do anything to satisfy yourself that that would be the case?

A. I'm not aware of either. There may well have been a mechanism that said that while this case was going on and if, in fact, a renal transplant came up, that either Dr Savage, as he then was, or one of the anaesthetists would have said, "Look, let's discuss that". And certainly with regard to elective transplants --

Q. You mean discuss whether he should be anaesthetist in another --

A. [OVERSPEAKING] should go ahead -- even with any of the anaesthetists to have gone ahead. I would have felt

that that was something which might well have been communicated. If there had been a renal transplant in the period in between, I would have thought, given the circumstances, that there was some -- a significant area of doubt with regard to this, that that would have been highlighted -- it wasn't something that would have been written down, as I said, but I would have been very surprised if, in fact, someone had not or someone had not been ensuring that there was actually consideration given during that period of time to whether that transplant should have gone ahead.

Q. You see, the difficulty is you have these --

MR FORTUNE: Is it suggested that Professor Savage should have taken responsibility, bearing in mind Dr Gaston's position?

A. No, I'm not suggesting that at all.

MR FORTUNE: That was the implication.

A. No, what I'm suggesting was that in light of this case, it would have been surprising if somebody had not said ...

MS ANYADIKE-DANES: Who could that person have been other than the clinical lead or the medical director?

THE CHAIRMAN: I think you should be careful because I think, with all due respect to Dr Gaston, I'm not sure if even Dr Gaston isn't just guessing this evidence.

A. I think that's fair.
THE CHAIRMAN: Am I wrong, doctor?
A. No, I think that could have happened, but I think that's conjecture. I think that's probably fair.
THE CHAIRMAN: Let's not go too far. We have some established facts, we have some uncertainty about others, but there's a limit to how far we go away from what you can actually recall and what we can document, so ...
MS ANYADIKE-DANES: Perhaps I can put the question to you in this way, although I entirely accept what the chairman has said.

Given your position, given your experience in handling these sort of quality assurance, risk management issues, what do you think should have happened in that intervening period?
A. I think that, as a Trust, we should have actually looked at suspending doing the renal transplants until this had all been clarified.
Q. And what would be the mechanism for doing that? What would be the forum where that sort of decision --
THE CHAIRMAN: Sorry again to interrupt. Is that something that you have thought of at the time or is that something which you're looking back on now from 2012, which you're thinking would have been an appropriate

response?
A. I think I probably didn't think it at that point in time, but I think I thought it in the interim. Not just now.
MS ANYADIKE-DANES: Do you know when you formed that view that that would be a good thing to do?
A. I don't know actually.
Q. Before or after the inquest?
A. No, it was well after that. It would be something that when I look back on this case, you know, from my own point of view, at the time and also as we've looked at it now, I have looked at the things that I could have done differently. I've looked at the things that, as an organisation, we could have done differently and I think, in light of what was in place at that point in time, yes, I think -- what became apparent in later years as governance changed, I think that this would have been handled differently.
THE CHAIRMAN: That's undoubtedly true, doctor, but one of the things I have to be careful about is not judging the Royal or the individuals within the Royal for what they did in 1995/1996 from the perspective of 2012 or 2008 or 2005; okay?
A. I agree entirely.
THE CHAIRMAN: So let's be careful again about where we're

moving to with your evidence. You did not think at that time in 1995/1996 that it would have been an appropriate step --

A. Not that I remember.

MS ANYADIKE-DANES: The obvious question is: why didn't you think that?

A. I don't know.

Q. If we go over the page -- in fact, we can get these two pages, page 2 and 3 of this letter, next to each other. So this, as I said, is this letter from the Trust solicitors, going to Dr Murnaghan. All the reports are in and dealing with the implications of them, if I can put it that way, in the run-up to the inquest. So you've had one reference made to yourself in the first page which I took you to and you feature on both these pages.

If we go through it, you see there are a number of issues or veiled criticisms which the solicitor takes from Dr Sumner's report. You can see them there, but that's not really what I want to take you to. It's the final paragraph on page 2:

"Dr Gaston has indicated that during the course of the procedure, Dr Taylor did not have an opportunity of accurately measuring urinary output due to the fact that the bladder had been opened early on in surgery. This

point will have to be made in very trenchant terms to Dr Sumner and he will be asked what other opportunities the anaesthetist had to measure urinary output."

The first point is: when did you first appreciate that that might have been a difficulty for Dr Taylor?

A. I don't remember.

Q. You don't remember?

A. No.

Q. On what basis did you form the view that he might not have had an opportunity of accurately measuring the urinary output?

A. I don't remember when, but I think that was something which Dr Taylor raised actually.

Q. Sorry, I appreciated you said you didn't remember when, so what I was asking you was: on what basis did you form that view?

A. It would have been on the information that Dr Taylor would have provided to Mr Brangam.

Q. That he didn't have that opportunity?

A. Yes.

Q. Well, you're an anaesthetist. In an operation, is it not possible for an anaesthetist simply to ask for a catheter to be inserted if he doesn't feel he's going to do it himself?

A. It wouldn't have been routine in most situations for an

anaesthetist to put in a catheter. That would have been very, very rare. He could ask, yes. I'm not sure if, say, the surgeon may not want to do it. He may have wanted the bladder to be extended as part of easing his re-implantation or the implantation process. I can't answer that in terms, but yes, he couldn't put it in, but he certainly could have asked the surgeon to do that.

Q. And in fairness, we have had some evidence in relation to that, but the point that you have answered is: one, he could; two, you don't really remember the basis any more upon which you formed this view.

A. Surely. Sorry.

Q. Then if we go to the next page:

"I will put one additional point raised by Dr Gaston. I think it's related to the potential for this child, for whatever cause, to absorb fluid into the brain. I would like to see some literature which might help us in propounding such a theory -- and I emphasise only as a theory and as something that simply cannot be excluded from the present position -- and in particular that, in some individuals, the physiology that such an occurrence can happen. Obviously, if we suggest such a potential, then that of itself would be a factor which might, to some extent, explain the oedematous state of

the brain."

Where did you form the view that there might have been a difficulty with Adam's brain in absorbing fluid?

A. I have no idea now. I mean, I might have known something at that point in time, but I don't know now. I don't know where it came from.

Q. One way of looking at this is what's really happening in this stage, preparing for the inquest, is that Dr Taylor is being supported and not just in the sense of he's a colleague. Obviously, it's very distressing for him so we want to give him support as a colleague, but he's being supported in the sense of people trying to find potential explanations, defences and deflect, perhaps, from the clear position that Dr Sumner has concluded in his report?

A. No, I don't think that is right. I think there was a perception that Dr Taylor had to answer certain questions and that there would be issues that he needed to look at in addressing. And I think those were suggestions that would have been made. I have no idea where that comes from now. I don't know.

Q. We will see and take it up with Dr Taylor to the extent to which, in any of his statements, he addressed the issue that a problem for him was that he wasn't able to put in a urinary catheter and we will see whether there

is any evidence of somebody suggesting that Adam might have had a difficulty in absorbing fluid into the brain at that stage.

A. That comment doesn't mean anything to me now at all.

Q. Okay.

THE CHAIRMAN: I think, Ms Anyadike-Danes, from yesterday's questioning, this morning's questions and this afternoon's, I have now got a clearer and clearer idea of what it is that Dr Gaston can help us with. I'm not sure that it's going to progress the inquiry to go through -- I understand why you had intended to go down this line, but we've slightly jumped ahead and I am not sure it's going to necessarily be helpful to go through these letters and documents paragraph by paragraph.

MS ANYADIKE-DANES: I understand that, except to see if it could be revealed the view that the Trust was taking and to what extent the Trust was taking a position that might have been helpful or not to the coroner. As it happened, the coroner formed his view from Dr Sumner's report.

THE CHAIRMAN: But the first page of that letter was asking for what Dr Taylor said in response to what Dr Savage was likely to say. So I get the general picture, which is Dr Taylor's going to be under some pressure at this inquest, he's going to have a lot of questions to

answer, some of them are coming from Dr Savage, some of them are coming from Dr Sumner. Dr Taylor will have to give evidence at the inquest and these are the points that he will have to address.

MR FORTUNE: Sir, did you mean Dr Savage or Dr Sumner?

THE CHAIRMAN: I think, on the first page, a few moments ago or -- maybe it's not this letter but an earlier one -- there was a point being made about what Dr Savage would say at the inquest.

MR FORTUNE: That I accept, yes.

MS ANYADIKE-DANES: There is a further letter --

THE CHAIRMAN: Maybe it was a letter we looked at a few moments ago, not the first page of this one.

MR FORTUNE: Thank you.

MS ANYADIKE-DANES: Yes, it is the letter that we dealt with earlier. There is a letter from Professor Savage, which we can deal with with him, but just to say that Dr Gaston was copied in on it. It's 059-003-005. Then if you see in handwriting at the top, point 3, "Copy this to Dr Gaston before next meeting".

So this letter was going to be copied. Are you aware of having discussed this letter at a meeting?

A. I cannot remember that letter now. I'm sorry, I just don't remember it at all.

Q. Well, maybe that's something that we'll take up with

Professor Savage and Dr Taylor. Then, if I take you to one point that I would like your assistance with.

I think that you have said that you did accept what Dr Sumner had concluded. It's just that you felt that Dr Taylor ought to have an opportunity to be able to express the things that he felt that he was having difficulty with.

A. I believe that was right, yes.

Q. Then if we go to your first witness statement for the inquiry, which is 013/1, page 2. You will see that the main question is:

"Describe your input into the assessment of and/or comments on the likely cause of Adam's death."

And you say that:

"[You] did express your views at a number of meetings to discuss the management of the case."

And you say who you think attended them. And you then -- I think it's the final sentence in that paragraph:

"I expressed my view that Adam's high-output renal failure was extremely rare and his surgery had been complicated. But while the patient did suffer from hyponatraemia, it was simplistic to assume that Adam had too much fluid, particularly low or non-salt containing fluid."

But he did have too much fluid, too much low-sodium fluid.

A. I think what I was saying there is it was too simplistic, given the information that Dr Taylor had provided to the autopsy or to the coroner's inquest, how he had detailed his fluid management and how he had given the details of how he'd done it, why he had calculated what he did. I felt that there actually still were issues that needed to be clarified.

Q. Of course. But in terms of cause of death, why he had the difficulties that he said he did is one thing. But in terms of cause of death, Dr Sumner was very clear on the cause of death. The cause of death was essentially too much low-sodium fluid.

A. I think -- well, I can't remember the actual wording of that.

Q. Of his report?

A. I do remember -- yes, I can't remember the exact report of the coroner. I must apologise.

Q. It was one I took you to just a minute ago.

THE CHAIRMAN: I don't think we need to go back to it. Does that answer in paragraph 1 not refer to an earlier stage?

A. That was an earlier -- I'm not sure. I'm not sure what it refers to.

MS ANYADIKE-DANES: I think the bald question is: describe your input into the assessment of and/or comments on the likely cause of Adam's death.

THE CHAIRMAN: Yes. Okay.

A. I'm not sure when that statement was made.

MS ANYADIKE-DANES: But in any event, in terms of the cause of Adam's death, did you agree with Dr Sumner on the cause of it?

A. I agreed that this was dilutional hyponatraemia. I think there was some issue over the discussion with regard to the fluid given to do that. I think the diagnosis or the autopsy -- sorry, the coroner's inquest conclusion I accepted, yes.

Q. If we then move forward to around the time of the inquest, you didn't give evidence at the inquest.

A. No.

Q. Did you attend the inquest?

A. I was present, yes. I say I was present. I certainly was present -- I can remember part of it. I have no memory of, say, Dr Sumner. I don't have any memory of most of it. The one thing -- I remember for the first time seeing the family. For me, that was quite important because all of this was something that we were dealing with in a -- I was dealing with it as a process. And then you saw the family of what this had --

devastating this had had [sic]. I understood that because my daughter had had, at the age of 7, an abnormality of her renal tract. She'd had to have reconstruction very similar to what Adam had. Never as bad, but we had three or four years when she had gone through -- so I actually ...

THE CHAIRMAN: You had a fair degree of understanding? Thank you, doctor.

MS ANYADIKE-DANES: Thank you. Would you like a moment?

A. So I had two abiding memories. One was that and the other was the detail that Dr Taylor had put into his notes. I had said yesterday that I had seen many records. By 1995, I had reviewed a very large number of charts in a very large number of places and I had never seen at that point in time -- and I think this is something which Dr Gibson comments on. I had never seen one so meticulously presented in terms of the fluid that was administered and the fluid that had been given. It was of a high standard, a very, very high standard. I won't say never, but it was one of the very highest standards of presentation. It did actually, I think, contribute to the coroner making his decision. I think it would have been a great deal more difficult for him to have made that decision if he hadn't had the sheer quality of Dr Taylor's record.

Q. But you --
A. That's the one thing I remember about it.
Q. Let's deal with that since you have mentioned it. You know that that record keeping has been the subject of some criticism itself.
A. I've read that from some of the comments, yes.
Q. Does that just mean because those who criticise it are having a higher standard than you think was fair? Or what is the reason why the criticisms are capable of being made?
MR UBEROI: [Inaudible: no microphone] just to establish what the basis for that comment is? In terms of this anaesthetic record, Dr Haynes wasn't asked to criticise it. To the extent that he passed comment on it, he commended it for its detail in a similar fashion to this witness. Since then -- and I mean no criticism of my learned friend for this -- one issue with regard to dopamine has emerged and Dr Taylor's conceded that the administration of dopamine, which is not in fact an anaesthetic drug, but nonetheless was administered in the hurly-burly wasn't in fact recorded here. So I think from that we can conclude from the evidence that it's not a perfect record, but I don't think we can go on to discount the view of Dr Haynes and say that it has been the subject of severe criticism.

MS ANYADIKE-DANES: I'm not sure I used the word "severe".
MR UBEROI: "Some criticism", I do apologise.
MR SIMPSON: [Inaudible: no microphone] I object as well.
THE CHAIRMAN: I'm not sure that we need to go to it. In fact, I thought I made the point a few minutes ago that I think Dr Gaston has been very helpful to us yesterday and today and I'm not sure whether we're not reaching the end of the useful evidence that he can give. If he has a view that the records are better than some other people do, I'm not sure that it's necessary to take Dr Gaston through that again.
A. I'm happy enough to take that, to explain, sir, if you want. I'm happy to explain why --
THE CHAIRMAN: I'm not sure it's going to help me, doctor.
MS ANYADIKE-DANES: I accept that. I'm content to move on. The only reason I would have taken the issue at all, Mr Chairman, is because there is a seminar given when these records are being presented, if you like, as best practice. That's the only reason. Because if one is talking about lessons learned and if that's being presented as the way you could provide your record keeping or documentation, then it becomes an issue from that point of view. But I am content, Mr Chairman, that you have the point --
THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: -- and I won't seek to develop that any further. And I suppose, Mr Chairman, the other thing is if one wants to see where the instances of the evidence that we have received so far in relation to the record keeping, we have identified them with their references in the governance opening. So it is there.

MR UBEROI: I'm afraid that's one of my issues in that, for example, that is referring to the CVP not being recorded when, in fact, the chart was present because it had been printed out by Dr Taylor or Mr Shaw and Dr Haynes would have known from reviewing this that the CVP wasn't recorded, so I don't accept all the examples listed in the governance opening. And as far as I can determine, the only issue that has been determined squarely as being deficient is the recording of dopamine.

MS ANYADIKE-DANES: I'm not going to get into a debate about the whole thing although I have to say that if anybody had a concern about the accuracy of it, the whole purpose of releasing it a week in advance is so that that could happen. In relation to the CVP printout, the point that is made that the guidance tells you that if there are artefacts in the printout, then one of the things you have to do is identify where those artefacts are. And one thing that is absolutely clear is that

there were artefacts. That's when it dropped to zero when the CVP was being re-zeroed.

THE CHAIRMAN: This is very easily dealt with. You have set out a number of points in your governance opening. Mr Uberoi, you're going to make a closing submission in writing at the end?

MR UBEROI: I am, sir.

A. I would like to say something. That was that from what I could see, the two governance statements, one came from someone with a nursing background, one came from someone with a chief executive background. I would have worked with, on the King's Fund, and I would have worked with one of the experts. The person who actually reviewed the charts was me. If I was on a team, it wasn't the chief executive officer who did it.

The other thing I think it's important that we say with regard to this is that this was not just a straightforward renal transplant. I know that we have had discussions around that. Dr Taylor was really involved in this case. There was a huge amount of -- there was a lot of challenges for him. It was a complex case by his standards and by the standards in that hospital. He kept what was the most important thing that he had at that point in time, which was the fluid -- became the fluid balance. At the end of the

operation, if you had been in a normal renal transplant, you would have gone and sat down, taken the patient to the recovery room or you would have taken him back to the renal transplant unit, the renal unit. You would have had time to sit down and if there were things that were missing, you could put them in.

Dr Taylor at the end of that case had a very difficult situation to deal with. I am not surprised that there were certain details missing. I am not at all surprised. And I think he then would have had the situation of that patient going out to the intensive care unit, he would have been involved in actually working with that patient. So I think -- and it comes from my own background, from what I remember of that, I think some of the issues that have been raised, I think didn't take into perspective what was a very difficult clinical situation.

Q. I understand that. It's clear that the chairman has taken your evidence in relation to certain matters, we don't need to pursue those. There is simply one area that I would like to review with you, and that relates to the production of the recommendations that went before the coroner and the press statement that was released and then if you can help us a little bit further with the whole issue of the seminar, which is

actually only referred to in passing in one document that we've seen. So that's the limited area that I would like to have you assist us with.

If we go first to your witness statement, 013/1, page 1. Under previous statements:

"On 19 June in consultation with --

A. I know the statement you're referring to.

Q. "... I wrote a draft report on the prevention and management of hyponatraemia arising out of paediatric surgery."

A. Yes.

Q. And then what I wanted to ask you is: what was that report that you wrote?

A. We wrote -- that was the report, and I think there's a copy of that report in a statement somewhere. That was -- I was asked to draft a report or ... Sorry, I'm slightly lost with that.

Q. I'm simply trying to understand what you have written here.

A. Oh right, in the prevention and treatment? Yes.

Q. Yes.

A. I was asked, as I gather from the coroner, to come up with some guidelines as to how one would manage dilutional hyponatraemia.

Q. Who told you that?

A. It would have come from Dr Murnaghan who would have asked me to have done that. That was to be a draft document. I had really quite detailed knowledge, as I said, of dilutional hyponatraemia back from the 1980s. But I needed a perspective from Northern Ireland and particularly from the paediatric anaesthetists. So it was -- I actually engaged with the paediatric anaesthetists to draft that document.

Q. Yes. What is the report that you produced? Maybe I will show you something and you can tell me if this is it. Let me just pull something up and you can tell me whether this is it. 060-018-035. Is that it, is that your writing? That's handwritten.

A. That's the handwritten notes initially that I made for myself as we were going through.

Q. To produce it?

A. It was then -- it was all discussed among the group, actually.

Q. Can we perhaps go to 036; is that it?

A. Yes, that's correct.

Q. Is this your draft report on the prevention and management of hyponatraemia in children having surgery?

A. I think I want to be clear here. When I was asked to draft that, I did that in light of the case, not necessarily addressed, but addressing a complex case.

I didn't address -- we didn't ... We did not set out to produce a document that completely -- that addressed the whole issue of a hyponatraemia and dilutional hyponatraemia. We never set out to do that. It wasn't my understanding that that was what was wanted. I think if I had understood that, my attitude would have been: I don't think we're the people to write a report that is going to be covering every area of hyponatraemia or sodium management. If that had been the case, I would have said, "Look, I think this is something that -- and I would have suggested the Department of Health should have been asked, they should have got -- I would have thought a team of experts who would put this together ... I was looking at this having my previous experience. I had seen no evidence of people using --

Q. Sorry --

A. -- 0.18 per cent sodium chloride, 4.3 per cent dextrose. I had seen no evidence of anybody using that in Northern Ireland at that point. I would have had a good idea because all our junior staff would have rotated through the province and you can be absolutely sure that if they had picked up a bad habit, we'd have been aware of. I was never, ever aware that this was an issue outside these complex cases.

Q. Okay. Sorry. If I just -- the reason I asked you that is because you say in your witness statement, and it's your language, that:

"I wrote a draft report on the prevention and management of hyponatraemia in children having surgery."

That's your language.

THE CHAIRMAN: He also referred to it on the next page as a draft document on a policy for managing hyponatraemia.

MS ANYADIKE-DANES: Yes.

A. I think my statement that I made at that time is misleading, actually. I apologise for that.

Q. Okay.

THE CHAIRMAN: It's a note, isn't it? It's a note rather than a report?

A. It was, yes. It wasn't a formalised report. It was put in draft form. At that point in time I didn't know what was going to happen to it.

MS ANYADIKE-DANES: That was going to be my next question.

What did you understand the purpose of it was to be? Dr Murnaghan has asked you to provide it. What did you understand was going to happen with it?

A. My understanding was that that was, I think, going to go back to the coroner. That was sort of my understanding. It may have been completely wrong, but that was my understanding of it.

Q. That this was something that was going to go to the coroner?
A. That was my understanding, yes.
Q. To indicate how these matters were going to be addressed in future?
A. Yes. And I was thinking very much, as we all were -- we did not believe that, at this point in time, there was any evidence that this was a problem other than in complex surgery.
Q. Okay. And you say that you did this in consultation with consultant paediatric anaesthetists?
A. Yes.
Q. And I think we know that that involved Dr Taylor, Dr McKaigue and Dr Crean.
A. Yes, they would have been the paediatric anaesthetists at that time.
Q. And Dr Murnaghan, of course, also saw it and had some involvement.
A. He saw it. He wouldn't have been involved in the drafting of it. That was our area where we would have done, but he knew about it, yes. And it was given to him.
THE CHAIRMAN: He says that the note was forwarded to Dr Murnaghan. That's in his witness statement at page 2:

"The report was forwarded to Dr Murnaghan and Mr Brangam."

A. That was my -- that would have been my understanding.

MS ANYADIKE-DANES: I think Dr Murnaghan does say that he had some involvement with its production, but anyway --

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

Q. Let's go to it anyway. It starts off with reference to the Arieff paper.

A. Mm-hm.

Q. And I think you said that you were aware of the Arieff paper.

A. I was -- as part of the whole looking at the whole concept of this case.

Q. You were aware of it?

A. I had already read it. And Dr Crean had identified that paper to me some time -- quite some time into it. So I had read it, absolutely.

Q. And you would understand that that paper is by no means confined to major surgery or even surgery at all?

A. Absolutely. There is a well-known case of an actor in the West End, and I think you may know of that case.

Q. Yes. And then you talk about:

"A number of renal transplants complicated by hyponatraemia leading to death in ten ... reported

in May 1996."

That information came from Professor Savage, didn't it?

A. I don't know where that came from. It was Dr Crean who gave me that information.

Q. Dr Crean gave you that?

A. Yes. Where it came from, I'm not sure. I think that we did possibly look at some literature to follow it up, actually. But yes, it was Dr Crean who told me, but now that you have actually said to me, I think it was now in -- my memory is that actually Dr Savage had told Dr Crean that and that's how we knew about it.

Q. But you didn't actually see the details of those cases?

A. I'm not sure that's true, but no, I'm not sure.

Q. You might have?

A. Yes. I think there were some of those that might have been available to be seen.

Q. Okay. In any event, that's the context and then you make these three points.

A. Surely.

Q. "Major surgery in patients with a potential for electrolyte imbalance should have a full blood picture, which includes haematocrit value and electrolyte measurement performed two-hourly or more frequently if indicated by the patient's clinical condition."

Did that constitute in any way a change from what was happening?

A. I think this was reinforcing.

Q. Yes, but if you had major surgery in a patient with the potential for electrolyte imbalance, you would want a full blood picture.

A. Absolutely.

Q. Right, so you didn't need to write that in there for people to know that that's what they would want?

A. No. But I mean, I think -- yes.

Q. You didn't. And a full blood picture would include a haematocrit value.

A. Yes, it would.

Q. And if you had a patient with an electrolyte imbalance going in to major surgery, you'd certainly want an electrolyte measurement.

A. You would want the electrolyte measurement prior to surgery of any kind.

Q. And in fact --

A. Not any kind, but of major surgery you would want that, yes.

Q. And in fact, that was part of Professor Savage's renal protocol.

A. Yes, it would be.

Q. And so if you knew already that you had a patient with

the potential for electrolyte imbalance, you would certainly be wanting to keep a weather eye on their electrolyte measurements.

A. Well, that would depend actually as to whether you expected there to be major fluid shifts during the operation. You might -- once you had got someone to a level of sodium which you would normally -- you wouldn't have brought somebody to elective surgery or to emergency surgery who came in with a low sodium. I can't go into the details now from a clinical point of view, but you would have actually corrected that. If you thought -- and that would have been extremely rare for any of the cases that we are dealing with -- that that patient's sodium would have actually varied during the case -- and that would be very rare -- then if you did know that, then you would have actually wanted to get regular sodium.

Q. Exactly. And if you look at how you finish it off:

"Or more frequently, if indicated by the patient's clinical condition."

Of course, if the patient's clinical condition indicates that you need to know what their electrolyte balance is, then you're going to measure it?

A. Yes, but I think --

Q. Yes.

A. -- this was reinforcing something that may well have been there --

Q. Already?

A. There, but it was bringing this to people's attentions.

Q. So then:

"If a serum sodium value of less than 128 mmol/litre indicates that hyponatraemia is present."

But that was so anyway because the normal value is 135 to 145. The normal value is 135 to 145. So if you have a serum sodium value of less than 128, you didn't need to write this down for an anaesthetist to appreciate that that was indicating hyponatraemia.

A. Well, if one took that point of view, then what was the point of Arieff writing his paper if, in fact, people understood that. What we were doing actually was taking the key issues of the Arieff paper and other information and actually making sure that people had thought about it and that they realised what the implications were. So I think that was where we were coming from in this report.

Q. I understand that. Then the third point you make is:

"The operating theatre must have access to timely reports of a full blood picture and electrolytes to allow rapid intervention by the anaesthetist when indicated."

You would want to have that in any event.

A. I think you would, but in circumstances that -- and I think this was something that was dealt with. That was an issue on this particular case for a number of areas. And we felt that that was something that needed to be in place. In other words, if you did have that, you couldn't have a situation where you were sending a blood sample off and the porter took 45 minutes to take it to the laboratory and another 45 minutes after they'd done it coming back.

And that was something that wasn't just happening in the Royal Hospital; this was something that in these big older buildings was a real issue.

Q. I understand. But that third point, that would be an issue that the Trust would have to address --

A. Yes.

Q. -- to make sure that that was available.

A. Sure.

Q. So is the point of producing this so that, in a way, the coroner could have confidence that things were likely to change, the sorts of things that had come out of, if I can put it that way, the consideration of Adam's case?

A. That would have been correct.

Q. Is that the purpose?

A. That is the purpose.
Q. If that was so, how was that draft communicated to people so it could be actioned?
A. Communicated?
THE CHAIRMAN: Within the Royal.
A. I forwarded it to Dr Murnaghan and it would have been my perception that that would have been distributed beyond that. I still don't know -- I mean, I don't know if that was the case or not.
THE CHAIRMAN: Sorry, does that mean that this is one of the things that would have been developed at the gathering or the seminar that you envisaged --
A. I think there were some issues that I think one would have been looking at and one would have been the access to accurate, rapid measurements of electrolytes. That would have been an issue, which -- it was an issue which was cropping up during the case. I think it was an issue that needed to be addressed.
MS ANYADIKE-DANES: I think if we go to Dr Taylor's -- maybe we don't have to go to Dr Taylor's deposition to the coroner. There's a signed version of this that goes to the coroner. 011-014-107A.
I wonder if we can pull the two up alongside each other. The previous one was ...
THE CHAIRMAN: 060-018-036.

MS ANYADIKE-DANES: Thank you.

This is what goes to the coroner.

A. I have no recollection of ever seeing that, the one on my left to Dr Taylor --

Q. The signed one?

A. I have no recollection of ever being involved in that at all. I have no recollection of that. I can recall quite clearly the draft, but I have no recollection of that signed statement.

Q. It is slightly different and certainly, if one looks at the second paragraph about:

"In future, all patients undergoing major paediatric surgery who have a potential for electrolyte imbalance will be carefully monitored according to their clinical needs and, where necessary, intensive monitoring of their electrolyte values will be undertaken."

So that's not so dissimilar:

"Furthermore, the now known complications of hyponatraemia in some of these cases will continue to be assessed in each patient and all anaesthetic staff will be made aware of these particular phenomena and advised to act appropriately."

This is something signed, something put before the coroner. So the anaesthetic staff come within your directorate?

A. The anaesthetic staff come within my directorate.
Q. Exactly.
A. But I go back to the fact that --
Q. I appreciate --
A. -- paediatric anaesthetists would have been auditing within the paediatric directorate.
Q. I appreciate that. But the anaesthetic staff come within your directorate.
A. Surely.
Q. So what was going to happen to make sure that:

"All anaesthetic staff will be made aware of these particular phenomena and advised to act appropriately."

So far as you are aware?

THE CHAIRMAN: Sorry, Dr Gaston has no recollection of ever seeing this document.
A. I never remember seeing that document at all. I have no recollection of that.
MS ANYADIKE-DANES: I beg your pardon. Let me put it another way. Were you aware of the fact, even though you didn't see the document, that all anaesthetic staff were going to be made aware of the dangers and complications of hyponatraemia?
A. I wasn't aware, but clearly from my own point of view, and it is mentioned in one -- I did highlight the fact that the issues which had been raised at the autopsy

with regard to fluid management and electrolyte management, that I felt this was an area where -- and I addressed that, that this was an area where we needed to absolutely bring our standards up because our -- particularly our fluid balance documentation was not up to standard. And it was very important that we actually had good records with regard to electrolytes and also in terms of managing our fluid balance.

Q. And then it goes on to say:

"The Trust will continue to use its best endeavours to ensure that operating theatres are afforded access to full laboratory facilities to achieve timely receipt of reports on full blood picture and electrolyte values, thereby assisting rapid anaesthetic intervention when indicated."

Even if you didn't see this statement, did you know that that assurance was being given?

A. No, I don't. And I suspect this is actually addressed to the Children's Hospital. I certainly am not assured -- I have no idea if this was actually an assured position. I don't know.

Q. Were you present at the last day of the inquest when Dr Taylor gave his evidence?

A. I was present at one of the days and I can't remember -- certainly, I was there when Dr Taylor gave his evidence,

whatever day that was. I was there for at least part of that day.

Q. This document was provided to the coroner. It's attached as part of his deposition.

A. Sorry, I have absolutely no memory of that at all.

Q. Do you recall any discussion as to how the lessons that could be -- I mean at the inquest --

A. No, I don't. The main things I remember -- I've already stated the things that I remember so clearly for that.

Q. From the inquest?

A. Yes, and I have addressed one of them. The other was the fact -- the fluid balance management, which I keep going back ... The documentation of Dr Taylor's in terms of his fluid balance management and the way he argued his case was of a very high standard and that's something that I knew there were very few of us would be able to do.

Q. You have said that. Then a final point is that this document that you produced, the draft document which you thought was, in fact, the document that would go before the coroner, did you think that that kind of guidance, if I can put it that way, which you said you were sort of reinforcing, would go further than the coroner and would actually be used to guide the anaesthetists within the Trust?

A. I would have thought that this -- I would have felt that there would have been a -- this would have passed out around, but -- sorry.

THE CHAIRMAN: I think you said that you thought you knew that Dr Murnaghan had that and you thought it would lead to it being actioned internally and would at least lead to -- that it would lead to change or at least to discussion about change.

A. Yes, sorry.

MS ANYADIKE-DANES: Was there any reason why that message, if you like, in relation to electrolyte imbalance and the dangers of hyponatraemia couldn't be disseminated further afield than just the Trust?

A. There wasn't any reason, but it would not normally be a situation that the Trust would do. And certainly if one had been producing a document that was, as I said -- if you were producing a document that was a comprehensive review of hyponatraemia, I think it would have been a different document to what we've produced. It would have been a much more comprehensive one. I don't think that we, as the anaesthetists in the Royal Hospital -- certainly in my case, I had no knowledge of the hospitals outside the Royal because I hadn't been there. I think that, you know, had one realised what this was really for, if that was what the

coroner's idea was, then I think it would have been a different document and it would have been circulated as a formal approach and I think the obvious place to take that was actually the Department of Health. I don't think that was necessarily something that was within the Trust's remit.

Q. But you see, the coroner had the view that somehow the Royal would disseminate the lessons learned from Adam's case further afield than just within its own anaesthetists.

A. Sorry, I can't comment as to what the coroner thought. I can only deal with what I knew, the information I had.

Q. Do you think that it would have been a good thing to have done?

A. I think it would have been ... At that point in time, I say it again, I don't think there was evidence that hyponatraemia -- apart from these two cases -- was a widespread issue. Of the two cases, one is Adam and the other one went into the intensive care unit which I had no knowledge of.

I don't think there was an issue out there. Something -- and I don't know where it is in the back of my mind and I don't want to be ... Somewhere, somebody may have made suggestions with regard to fluid management that, in fact, in certain situations, you

didn't need to use Ringer's lactate or Hartmann's, which was a balanced salt solution; you could manage in shorter cases with number 18 or 0.18 per cent. I just wonder if that -- and if that happened some time between 1997 and when these other cases came to light -- because I had no evidence of that at that point in time and I had no evidence later. Would it have been a good idea to have presented this as a subject? It would have been a good idea, particularly in retrospect, but then this is back to retrospect, and I think that this report, it could have been a much bigger document. It would have been a much more complex document, but it would have addressed it, the situations where hyponatraemia can occur and here's the management of it and here's what trusts should have in place to assist you.

Q. Then finally, you have a situation where matters seem to be unresolved with Dr Taylor in the sense that -- well, let me ask you. Did you know whether or not he accepted the coroner's verdict?

A. I don't know. I mean, I actually don't know what I knew at that point in time and I wasn't aware that Dr Taylor had held these views for so long. I wasn't aware of that.

Q. Well, at the conclusion of that, so that you now know what the coroner considered was the issue, the cause of

Adam's death, given Dr Taylor's fairly strong views as to not only that, but to all the issues surrounding it, did you not go back and say, "Where are we now with him as to what he thinks now and what's going to happen?"

A. I don't remember actually, I just do not have a memory as to -- I have really very little memory at all of anything after the coroner's court and the next thing -- which I didn't remember, when I filled this in, but I have done since -- was whenever there was ... The document came out and as part of the settlement, I actually don't remember much in between, and as I say, I didn't actually remember that. Whenever it was part of my statement, I said I didn't know. I now realise that I would have seen that because I recognised it once it actually was pulled up.

Q. Well, did you not think it was appropriate to find out what Dr Taylor did now think about the issues to do with dilutional hyponatraemia?

A. I've said I don't know whether I talked to Dr Taylor about that or not. I just do not remember.

Q. Would it have been appropriate to find out what he was teaching?

A. That would have been something that was not within my remit. I didn't have -- I had no role within the university department and the teaching.

Q. But was he not on the ATICS education subcommittee?
A. I don't know if he was or not. We did have an ATICS education subcommittee.
Q. I think he was. I think it says on his CV that he was.
A. Sorry, I don't remember who was on that committee.
Q. But that's your education subcommittee?
A. It was our education committee.
Q. So would it not have behoved you then to find out, if he is there, what is he teaching?
A. We had Dr Terry McMurray, who was the person responsible for the teaching -- the postgraduate teaching within the trust. And it was the responsibility of the university through their link people in the Trust -- in other words, the joint appointments -- to have actually picked that information up.
Q. Sorry, let's go to where it says, just because you were unsure. 306-019-011. If you look, you see:

"Member, education subcommittee, ATICS directorate, 1992 to 1994."

And then 1995 to 1997. He's also, incidentally, during that time --

THE CHAIRMAN: Sorry, just slow down a moment. What section are you under?
MS ANYADIKE-DANES: It's under "Management experience, Royal Group of Hospitals Trust".

Then there's "member", which is the second line down from that, "Education subcommittee, ATICS directorate", and the period there, which covers this period: it's 1992 to 1994 and then picks up 1995 to 1997.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: If you look at the next membership, he was also a member of the audit subcommittee of ATICS directorate, 1992 to 1997.

A. Actually, I didn't remember and I don't remember that we had an audit subcommittee. I don't remember that we had that, actually.

Q. Right.

A. Obviously, Dr Taylor has said -- and there were certain committees that were needed to be looked at. Most of them -- like we didn't ... I now know we had an audit committee. We didn't have a quality assurance committee --

Q. Sorry, I'm conscious of the time. The particular point I want to raise with you is the education subcommittee. You said you didn't recollect that you had an audit subcommittee. I will address that in Dr Taylor's evidence. But the education subcommittee: so he was on the education subcommittee of your directorate.

A. Surely.

Q. Over this period of time when, so far as you can recall,

you can't remember if you satisfied yourself as to what he now understood in relation to his fluid management of Adam Strain, that's why I ask you: don't you think you should have satisfied yourself as to what he was teaching and what his position was now in relation --

A. I go back again to the fact that whenever one investigated a situation, you relied to some degree on the feedback you got. One of the feedbacks that would have gone to me, a little bit more specifically to the university, was if they felt what Dr Taylor was teaching was inappropriate, they would have had feedback from that from the junior anaesthetists. There would have been feedback from the medical students; there would have been feedback from some of the joint appointments. To the best of my knowledge, I never got any reports of that. I can't speak for the university.

Q. Yes, but you were in a position to know what Dr Taylor's understanding was about the fluid management with polyuria. And to the extent that that ever arose as to how you deal with polyuric patients, you were in a particular position to know that at least up until the inquest, if you can't recall whether he accepted the inquest verdict, at least up until that point in time Dr Taylor had a view as to what polyuria meant, which doesn't seem to accord with what Dr Sumner understood it

to mean.

A. Sure.

Q. Because Dr Taylor's view was that somebody with polyuria couldn't actually develop dilutional hyponatraemia, but that was not Dr Sumner's view or conclusion.

A. I would basically go back again and say that what Dr Taylor might have believed -- might have thought with regard to this case doesn't necessarily mean that that was impacting on his teaching of the management of fluid balance and electrolytes. And I think had he been teaching something that was felt to be wrong, that would have been identified and it would probably -- it might well have come through the ATICS education to Dr McMurray, who sat on the management structure that I said yesterday. That would have come back. There was absolutely no feedback on that and, to the best of my knowledge, the university never felt that he was teaching inappropriately.

MR UBEROI: It's a matter entirely for my learned friend as to whether she wishes to establish it with this witness or not, but I'm anxious that at some point a bit more flesh is put on the bones of what exactly that meant, to sit on the education sub-committee.

MS ANYADIKE-DANES: Yes, we are going to do that.

MR UBEROI: A matter entirely for you. This witness or

Dr Taylor can obviously try and assist as well.

MS ANYADIKE-DANES: I am going to do that. I was actually going to try and develop it with Professor Savage. I think I indicated I was going to do that with Professor Savage, who seems to have had a greater role in the teaching side.

MR UBEROI: I'm grateful.

THE CHAIRMAN: I think we need to take a break now for the stenographer and, when we come back, we will see if you could work out during the break if you can work out if there are any further questions required for Dr Gaston. I'm anxious to let him get away this afternoon. Then we can work out what we're going to do with the witness schedule for the rest of this week.

(4.00 pm)

(A short break)

(4.20 pm)

THE CHAIRMAN: I think, doctor, there might be just a few more questions, but we'll have you finished in a few minutes.

A. Thank you.

MS ANYADIKE-DANES: One of the questions relates to Dr Webb. A number of those communications that I showed you, probably this morning, actually, about trying to arrange meetings and so forth -- and you could see them cc'd in

a list. You would see Dr David Webb, who, of course, was a paediatric neurologist.

A. I don't know him at all.

Q. Yes, that wasn't --

A. Sorry, I jumped ahead.

Q. That's all right. What I was going to ask you is: in any of the meetings that you attended, was he ever present?

A. I can't answer because I don't know who he is at all. I have absolutely -- I wouldn't know what he looked like, the name means nothing to me.

Q. Maybe we'll conclude the matter if I put it in this way. Were you ever party to discussions to the effect that it might be helpful to involve a neurologist?

A. No. Sorry, I don't remember.

Q. Then could I ask you this. If we go to your witness statement 013/2, page 4, it's part of the question that I was asking towards the latter part before we took the break about the draft document that you wrote on the policy for managing hyponatraemia. You can see that up at the top at 3. Then you were asked a series of questions in relation to that. Your answer to those questions is:

"I was asked to prepare a draft document by Dr Murnaghan, I believe at the request of the coroner.

I did this in close coordination with the consultant paediatric anaesthetist and the only involvement I had was to forward this to Dr Murnaghan. I do not know what happened after that. I had full knowledge of the Arieff et al paper when I wrote this document."

So that's your answer to that. Then if you go over the page to 013/2, page 5, right at the bottom there, if you see:

"Queries arising from your PSNI statement."

And just in fairness to you, just to pull it up, it's very, very short, 093-023-064. Maybe we can put that alongside. It's the second page of that I think you want, 065. Yes.

THE CHAIRMAN: You want to get rid of page 64, do you?

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: So I think what you're telling the PSNI is that you consider that the learning from the case was primarily in paediatrics and it was very limited in general anaesthetics due to the unique nature of Adam's case. Maybe I have put up the wrong page. Perhaps that was 064, I beg your pardon.

THE CHAIRMAN: It's the top line. It runs over the page.

MS ANYADIKE-DANES: I was trying to see if I could get both those things juxtaposed for you. If you'll take it from

me -- and you can certainly see it -- that the beginning of that is:

"At the time it was my opinion that learning from this case [that's Adam's case] was primarily in paediatrics. However, it was very limited in general anaesthetics due to the unique nature of Adam's case."

Then you're being asked queries arising out of that:

"Please explain what view you took. You state that this was your opinion at the time. Please state if your opinion has changed and, if so, please state when and give your reasons for the change of opinion."

Then if one goes over the page to 6, it says:

"Please state why, if the learning for this case was primarily in paediatrics, that you drafted the document [which is the one that we've seen, the draft document] with consultant anaesthetists for consultant anaesthetists."

Your answer to that is:

"I do not now have any further detail to add to my original statement."

So I think the query that people have is that if your feeling and if what you were telling the PSNI at that time was that the learning from it is all in paediatrics, then why, when it comes to the document that you draft, are you drafting it all in relation to

anaesthetics, paediatrics obviously being a much broader issue than the anaesthetics?

A. I felt that -- and I think in discussion I felt that at that point in time the issue of hyponatraemia, and particularly dilutional hyponatraemia, was primarily confined to complex paediatric surgery. It didn't mean that it didn't occur anywhere else and I have already said I was certainly aware of at least two young healthy ladies who had had it.

Q. I understand.

A. But I felt that from -- that would have been about in 1983. I felt that from the middle 80s right through to that period that that issue had been addressed, that in fact it was standard practice for people to use for replacement fluid a balanced salt solution, which we referred to in North America as Ringer's lactate and I think Hartmann's solution is the equivalent here.

I can think of one person who I remember who would have used 0.18 per cent or No.18 Solution. I can think of one person, so this was not a widespread practice. So I didn't feel that this was something that was at that point in time applying outside the lessons to do with the major surgery that was envisaged here. So at that point I didn't.

What I didn't know and I now know, but I still have

doubts, is: was there an issue at that point in time, which we didn't know at that point in time, with regard to the use of No.18 Solution throughout Northern Ireland? I had no evidence because, as I said, junior doctors would have very quickly picked up -- either would have disagreed with it or would have picked up a bad habit. I saw no evidence of it. The standard practice was to use Hartmann's solution as a replacement fluid and that was based on the understanding that you needed to use a balanced solution.

Q. Sorry, let me be clear on this because I'm conscious of the time and also that this is an issue that some people want to have absolute clarity about.

A. Sure.

Q. At a point in time, which in fact we can locate, which is 19, I think it is, June of 1996, at that stage you are thinking that this, or at least what you draft knowing that it's likely to go to a coroner, is all to do with major surgery and managing the fluid balance regime in relation to that, therefore primarily being addressed towards anaesthetists.

A. Yes.

Q. And you say, though, that you knew at that stage, you knew about the Arieff article?

A. That's correct.

Q. The Arieff article, of course, is not confined to major surgery or -- sorry, excuse me -- indeed surgery at all.
A. That's correct.
Q. But it's there to alert people to the dangers of how dilutional hyponatraemia can develop and how risky it is?
A. Yes.
Q. Are you saying that you felt by the time you got to 1996, that paper, I believe, having been written in 1992, that you felt that was old hat, that people understood at that stage about the fact that dilutional hyponatraemia was a risk in the non-major paediatric setting --
A. Yes.
Q. -- major surgery setting?
A. And it was a risk in terms of the management of fluid balance particularly in small children who would have had acute gastroenteritis, vomiting, diarrhoea. That was an area which I was fully aware of because --
Q. No, you may have been, but did you feel that that wasn't something that needed to be more widely disseminated because that was already known?
A. Yes, and I think that would have been the case with all the anaesthetists, actually, who discussed this. We did not feel that this was an issue that was a general issue

of a problem, I think we felt that that was something which was now well taught, it was clear, and that people would have been aware of the management of fluid balance and particularly sodium in regard to things like vomiting and diarrhoea in small children and in terms of replacement fluid for things like, say, an appendectomy or a tonsillectomy or whatever. You needed to be very careful about using a balanced salt solution.

Q. I understand that. The difficulty is, as the chairman has alerted you to it, that within a few months of this case there is a child who comes to the Royal and, in fact, that child is treated with Solution No. 18 and dilutional hyponatraemia ultimately is established as being part of the cause of that child's death. And then after that, there is another child in 2000, then there's another child in 2001, and yet another child in 2003 where fluid management is an issue.

A. Surely.

Q. So the point that I'm putting to you is: are you saying that you understood about these matters and you believed that others did, which is why you didn't think you needed to disseminate the Arieff issue more broadly?

A. Yes, I believed that and I think that was the consensus among us as anaesthetists who did that, yes.

Q. I understand. Then when you get to your PSNI statement,

which is dated 25 April 2006, and when you talk more broadly about the lessons in relation to -- in fact it starts just as I had it there, the bottom of 64.

"It was my opinion that at the time ..."

Which sounds like at the time in 1995/1996?

A. Yes, that's correct.

Q. "... my opinion was that the learning from this case was primarily in paediatrics."

It's that slight disconnect that people are asking me to explore with you because it doesn't sound as if that was your view with hindsight now standing in 2006; it sounds like you had the view in 1995/1996 that the learning coming out of that was primarily in paediatrics. And, if that's the case, then obviously people would like to know why the statement is drafted in that way and why more efforts weren't made to disseminate that message or those lessons more widely afield than just the pool of anaesthetists at the Royal.

A. Well, I don't really believe that was -- I didn't believe at that point in time that that was our remit to circulate it; I wasn't aware of that. I have said that if I had felt that this was a report that was going to look at the concepts that we have discussed, in other words the other situations where dilutional hyponatraemia can occur, then I would have felt that the

remit would have included a broader spectrum of people to discuss that subject.

THE CHAIRMAN: Yes. I think --

A. And the recommendations that would have come out would have been looking at a number of other issues -- areas. But at that point in time, we did not have any evidence that dilutional hyponatraemia was a risk that was actually out there. We knew there had been in the past, but we thought that that had been well taught and it was clear that actually people should have known about that.

THE CHAIRMAN: Sorry, doctor, if you look at the screen in front of you, the line from your police statement, which is highlighted, says:

"At the time [that's 1995/96] it was my opinion that the learning from this case was primarily in paediatrics."

A. Yes. That was --

THE CHAIRMAN: Is that right? Because I think the contrast is you're being asked, had you not also said that you thought it was primarily in anaesthesia?

A. Well, I think what that refers to is paediatric anaesthesia. I don't think it's -- I'm not talking about general paediatrics at that point in time, I'm talking about that --

THE CHAIRMAN: So we read that to mean --

A. Paediatric anaesthesia.
THE CHAIRMAN: Then the other point is that you didn't -- you talked about your trainee anaesthetists going out for various posts around --
A. The way they would have rotated round the province as part of their training.
THE CHAIRMAN: Was it your understanding then that Solution No. 18 was not being used?
A. Not for replacement therapy, yeah.
THE CHAIRMAN: Right. And had you gathered that from any of your trainees, would that have been something that you had -- well, sorry, if you had learned from your trainees coming back that in Omagh or Craigavon or wherever, Solution No. 18 was being used as replacement therapy, you would have told your own trainees back in the Royal --
A. I would have actually highlighted -- sorry, given that I knew the problem, I would have highlighted that and made sure that that was something that was discussed, whether it be the area anaesthetic or whatever.
THE CHAIRMAN: Yes. I understand, I think, how you would put it right internally in the Royal. But if you heard that Altnagelvin was doing it, for instance, if you heard that Altnagelvin was using Solution No. 18 as a replacement fluid, how would you go about bringing an

end to that, or at least discussing it, to encourage Altnagelvin to bring --

A. There was a structure and I'm slightly -- this is where I'm having difficulty. There was an area -- there was an advisory body at the Department of Health for every specialty.

THE CHAIRMAN: Right.

A. And it was chaired for much of my period by Dr Lyons. That would have -- we would have had members of our trust on that. I wasn't on it, I would have attended it on a number of times. To me, that --

THE CHAIRMAN: Would you have got people from your trust to raise that under departmental --

A. Absolutely.

THE CHAIRMAN: -- which would in turn have had people from Altnagelvin on it?

A. Absolutely.

THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: I was just asked to point out that if -- from the explanation that you just gave to the Chairman, if you read on from that sentence that starts "at the time it was my opinion", you go on to say:

"However, it was very limited in general anaesthetics due to the unique nature of Adam's case."

So that's the full sentence:

"At the time it was my opinion that the learning from this case was primarily in paediatrics. However, it was very limited in general anaesthetics due to the unique nature of Adam's case."

A. That would have been my opinion then. I mean, I would obviously -- obviously, I was in contact with a very large number of anaesthetists on the Royal site. If I had felt that there were issues here, if, in fact, this was something that might be an issue in the trust, then we would have had to address it, but there was no evidence that this was an issue at all in the trust.

Q. I understand. You'll be aware that an issue was raised as to education and so on. I'm just going to ask you one question to see if this is your area, and, if it's not, obviously we will pursue it with somebody else.

You were taken to Dr Taylor's curriculum vitae, where it showed that he was on the ATICS subcommittee for education. Did you yourself have a role within either the ATICS directorate or between the trust and Queen's University -- did you have a role in relation to the delivery of educational training to medical students?

A. The only role I would have had -- and it's in my C [sic]. I was a member of the consultants who would have taught students in theatre.

Q. Yes.
A. And there would have been a number of tutorials, one of which would have been fluid balance.
Q. But did you --
A. But I didn't do that section.
Q. I understand.
A. But there was.
Q. I just want to make it clear because I'm anxious not to detain you if this is not really your area. Was it within your remit, if I can put it this way, to have an oversight as to how that ATICS education subcommittee was operating?
A. It was operated by Dr McMurray; he sat on the management committee. In other words, the ATICS directorate management. But he sat as a representative of that. If he had areas that he --
Q. No, sorry, I'll get to that in a --
A. I didn't have a specific -- no.
Q. You didn't --
A. No.
Q. So you weren't in that committee, you didn't have any oversight of it?
A. I had no oversight other than it fed in as part of the structure.
THE CHAIRMAN: Sorry, I think you were going to say if

he had any issues with it -- were you going on to say that he would raise them with you?

A. He would raise them at the ATICS directorate management and he would have brought some issues to us, yes.

THE CHAIRMAN: So he would bring back from the ATICS subcommittee any issues that he needed to bring to the ATICS directorate?

A. That's right. He would have had some issues with teaching, which he would have raised with the university.

MS ANYADIKE-DANES: I see. But you yourself didn't sit --

A. No.

Q. -- on any cross-organisational body if I can put it that way?

A. Not of that type.

MS ANYADIKE-DANES: Thank you very much indeed. I think that's it.

THE CHAIRMAN: Thank you very much. Are there any more questions? Mr Simpson, Mr McGleenan? No?

Thank you very much indeed, doctor, you have been very patient over the last two days. You're now free to leave. Thank you very much.

(The witness withdrew)

Timetable discussion

THE CHAIRMAN: We now get into the usual apology about the

schedule. Tomorrow we are scheduled to have Dr O'Connor, Mr Brown and Dr Crean and we're going to stick to that. I understand that Dr Taylor, who we didn't reach today, can accommodate us by coming on Thursday; is that right?

MR UBEROI: Yes, sir. Tomorrow it's clinical business.

THE CHAIRMAN: Yes, well, I can hardly complain. That, in turn, leads, I think, Mr Fortune, to Professor Savage volunteering himself to attend on Friday, which we weren't due to sit on, but --

MR FORTUNE: It's not quite true to say he volunteered himself. He had his arm twisted.

THE CHAIRMAN: I see.

MR FORTUNE: And unless there are screams from those who have childcare, could we sit at 9.30 on Friday morning?

THE CHAIRMAN: Yes.

MR FORTUNE: And I hope that my learned friend will be able to conclude her questioning of Professor Savage within the day.

THE CHAIRMAN: He will finish within the day. Okay, I'm sorry for any disruption. We had tried to avoid sitting on Fridays for this session. It's not just because we lost a few hours yesterday, but we did lose a few hours yesterday and we'll have to make up for it and try to contain it to this week. Tomorrow morning at

10 o'clock. Is it Dr Crean that needs to go first?

MR SIMPSON: He was sent away today and told to come back tomorrow, but he would need to be told now that he's first on.

THE CHAIRMAN: The message that got to me was that he needed to be first on and we can accommodate that.

MR FORTUNE: Can I rise on behalf of my learned friend Ms Woods because she has flown in for Mr Brown and I am not sure what her movements are for Thursday, but she would be expecting Mr Brown to be completed tomorrow.

THE CHAIRMAN: I will have discussions with my team now, Mr Fortune. You've made this point to me before and I'm now making it publicly. We just can't keep running over all the time.

MR FORTUNE: Quite.

THE CHAIRMAN: Thank you very much. Tomorrow morning at 10 o'clock.

(4.45 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X