

TRANSCRIPTION OF DEPOSITION OF DR R H TAYLOR

With regard to the cause of death I cannot understand the finding of "impaired cerebral perfusion". I cannot understand why a fluid regime employed successfully with Adam previously, led on this occasion to dilutional hyponatraemia. I do not know if in fact there was impaired blood flow from the brain and if there was, whether it was a factor in this case. I had no knowledge of the other 9 deaths until Dr Savage told me. I believe the underlying cause of the cerebral oedema was hyponatraemia (not dilutional) during renal transplant operation. In Adam's case it was not practical to carry out electrolyte tests at the commencement of surgery.

Miss Higgins: I believe I was involved in previous surgery concerning Adam. I saw the scar on Adam's neck. It was reasonable to attempt access to the same site. I believe it is possible to place lines in ligated veins. On this occasion I was unable to speak to Miss Strain prior to surgery. Adam had not a sodium deficiency - it was being managed successfully. There was no reason to believe there would have been a change in electrolytes between 11.00 pm and 6.45 am. nothing in that period happened to change that. Adam was the only child with polyuric renal failure I have anaesthetized for renal transplant. He needed a greater amount of fluid because of the nature of the operation. I believe the fluids given were neither restrictive or excessive. The new kidney did not work leading to a re-assessment of the fluids given. This made us think we have underestimated fluid and we gave a fluid bolus at 9.32. I checked CVP as soon as I had inserted the line (about 7.30 am). The monitor gave a continuous display and there was a computerised print-out also. The electrolytes at 9.30 were not in an acceptable range. We felt we had taken adequate measures to stop the sodium falling further and to increase it. The skin closure stage of the operation was reached at 11.00 am. We were considering taking another electrolyte test in conjunction with other tests at the end of the operation. I was aware of the Arieff article when it was first published. In hindsight I cannot say what I would have done differently. I do not believe turning the head to one side impaired venous drainage. The catheter in the right subclavian vein - I do not know if it had any effect on drainage. I cannot explain the mercury reading of 17 but I agree with the views expressed by Dr Alexander.

Witness asked if he believed death could have been avoided but claimed privilege.

Mr Brangham: The purpose of the blood/gas machine is to analyse blood gases. Electrolyte measurements are normally carried out in our Labs. I would not rely on the machine to accurately analyse sodium levels. That is a common practice in the RBHSC. We measured the total number of fluids given against those emitted. The bladder being opened did affect my calculations. I believed the tip of the catheter was not in close relation to the heart. I confirmed the manually by touching. There is no clear view on venous drainage from the brain. If there had been such a problem I would not have been able to be aware of it. If everything had gone to plan when the clamps were released surgery would have been completed soon afterwards. The fluids I gave were isotonic - the same potential as plasma which should have mimicked those that Adam previously received. I produce a further statement C5.