Edward Sumner MA BM BCh FRCA

[redacted]

Telephone/Fax [redacted]

E-mail [redacted]

January 12th 2005

Dr John Burton

[redacted]

Dear Dr Burton

I vividly remember meeting you at the inquest of Conor Mitchell.

I was dismayed to receive your letter about the inquest of Adam Strain as I had hoped to conclude my involvement in these cases in Northern Ireland.

I have re-read my report and stand by the contents and the conclusions concerning the mode of death, though I note that I queried that the venous drainage from the head might have made a contribution, as did the pathologist. That there were hyponatraemia and coning is without doubt and that Adam was effectively brain dead by the end of the surgery.

I only attended the first day of the inquest and did not hear Dr Taylor's account. I also did not see Professor Berry's report about the infarcted transplanted kidney. I noted that the pathology report said this kidney was infarcted, but I assumed that this could have happened at any time after the transplant as I had not seen Prof Berry's comments.

In my experience it is not uncommon for the transplanted kidney to fail in the very early postoperative period. It is unthinkable they would have closed the wound if the kidney were not pink and functioning. Sometimes the closure distorts the vascular anastomoses or puts pressure on the venous drainage. In children the transplanted kidney is often relatively large. I could not find any note of the urine volumes passed at any stage. I did note that there was polyuria, but it is not clear when this was. In particular, there is no note I could find of how much urine was being passed at the end of the procedure.

At the end of the procedure when it was found that Adam would not breathe and had fixed dilated pupils, I imagine that the anxieties moved away from the function of the kidney. It is my understanding that Adam was passing urine and that his renal failure was not of the anuric type, but the quality of the urine was so poor he required dialysis for filtration of waste products. If this were the case then urine output could not be used to assess renal function – it would be necessary to look at the urinary electrolytes and see what was happening to the blood urea and creatinine.

To summarise, I still believe that Adam died from dilutional hyponatraemia which occurred during a kidney transplant. The fact that this transplant failed is not therefore relevant, in my opinion. It is unthinkable that they would have closed up the incision if the kidney function was in doubt at that stage.

I hope these remarks are helpful.

Do come back to me if you want more opinion.

Yours sincerely

NOT SIGNED ::
[E-mailed attachment]
JR

Edward Sumner
Consultant paediatric anaesthetist