1 Tuesday, 19 June 2012
2 (10.00 am)
3 (Delay in proceedings)
4 (10.07 am)
5 DR JOSEPH GASTON (continued)
6 Questions from MS ANYADIKE-DANES (continued)
7 THE CHAIRMAN: Good morning. Dr Gaston, thank you.
8 MS ANYADIKE-DANES: Good morning, Dr Gaston.
9 I wonder if I might ask you something right at the
10 outset because I wonder if there may have been a bit of
11 confusion when I mentioned or you mentioned Dr Lyons.
12 I think you referred to a Morrell-Lyons(?). I had
13 thought of a Samuel Lyons. Actually, there's a Samuel
14 Morrell-Lyons. But I wonder if there's something you
15 wanted to explain about that.
16 A. Yes. This sort of triggered something in terms of the
17 background to this, which I think I wanted to highlight.
18 Q. Yes, of course.
19 A. One of the things that had been apparent to me during
20 the discussions following the death and into the period
21 of investigation, which would have occurred ... And
22 I said in the statement -- and I say this still
23 clearly -- I don't remember in detail the meetings, but
24 the one thing that became apparent to me in some of
25 those meetings was that I felt we needed an external

1 opinion. I felt that it probably needed to be
2 a paediatric anaesthetist with particular experience in
3 fluid electrolyte balance.
4 There were certain sensitivities around that and
5 having only been in Northern Ireland a relatively short
6 time and having had very limited experience of the
7 National Health Service, I felt that I needed to talk to
8 someone senior. And Dr Morrell-Lyons had no role within
9 the management of the Anaesthesia, Theatres and
10 Intensive Care directorate, but he had been president of
11 the Association of Anaesthetists and I ... He was
12 a senior -- to me, conceived to be a senior person and
13 I needed a confidential conversation.
14 I explained to him that I felt that this case could
15 be quite an area where there could be some differences
16 of opinion that needed to be cleared up and I felt we
17 needed someone with real experience to actually advise
18 the coroner. He agreed with me and we then went and we
19 had a meeting. I spoke to Dr Murnaghan and he arranged
20 a meeting with Mr Leckey, Dr Murnaghan and myself and
21 Dr Lyons and we raised this issue.
22 The outcome of that meeting was that I would agree
23 to find, on behalf of the coroner, someone who would
24 meet the specifications that I had suggested. I didn't
25 have any names because I just didn't know the

1 establishment in the same way, but I knew that
2 Dr Peter Crean was a member of the Society of Paediatric
3 Anaesthetists and felt he might have someone who he
4 could suggest or could find out from London.
5 So I went to Dr Crean and said, "This is what we're
6 looking -- we're looking to see if we can get
7 a paediatric anaesthetist with particular experience
8 in the management of fluid and electrolyte balance". He
9 went to either the College or the Association or the
10 Paediatric Society and he came back and said, "The name
11 that we have been advised to submit is Dr Ted Sumner".
12 That, I think, explains what Dr Sumner's role -- he then
13 became adviser to the coroner.
14 Q. Yes. I wonder if we can pull up this -- I think to some
15 extent Mr Leckey has rehearsed a little bit of that in
16 a letter that he sent to Dr Armour on 13 December 1995.
17 We can find that at 011-027-128.
18 If you see there in the first paragraph:
19 "I had a very useful meeting with Dr Murnaghan and
20 two anaesthetists from the Children's Hospital."
21 That's yourself and Dr Lyons. Then he has you both
22 saying it would be most important to obtain a paediatric
23 anaesthetist's opinion and they both pointed out that
24 Dr John Alexander has little, if any, experience in that
25 specialist field. That's the paediatric side. And they

1 made the point that, in their considered view, the death
2 had nothing to do with anaesthetics. We will come back
3 to this letter later on, but from your point of view,
4 what then goes on to be said is:
5 "They all agreed it was an immensely complex case.
6 The meeting was amicable and I agreed to obtain the
7 opinion of a consultant paediatric anaesthetist."
8 He goes on to say, although he doesn't say how he
9 came by that name, he goes on to say that
10 Dr Edward Sumner has agreed to provide him with an
11 opinion. The upshot of all this is really for Dr Armour
12 to make contact with him and she ultimately sends him
13 a letter of instruction. If you look over the page to
14 129 you see:
15 "I feel he will be in a better position than I would
16 to set out the complexities in the case."
17 That's exactly what she does. She sends him
18 a letter in much the same way as she did with
19 Professor Berry and attached documents for him. And he,
20 in due course, produced a report for the coroner and
21 attended to give evidence at the inquest. That's what
22 you're talking about?
23 A. Yes, it is.
24 Q. Thank you very much indeed.
25 There are some matters that I have been asked also

1 to pick up and some that I would like to pick up with
2 you from your evidence yesterday. I will take them in
3 the order in which you gave it because that might help
4 you. I hope that we can pull up the transcript. If
5 we can, it's the transcript of yesterday, which was
6 obviously 18 June, and if we go to page 106. I'm hoping
7 that we'll be able to do that.
8 Yes, we can. If you go down to line 23. This is
9 the whole issue that I was asking you about, whether the
10 State Pathologist's Department had asked that the bodies
11 could come to the mortuary with the lines out and so on.
12 There's an issue about whether that would be standard
13 practice. But in any event, you end up by saying:
14 "I think this case that we're talking about is
15 somewhat different from usual in that there was a great
16 effort to resuscitate him at the end."
17 What did you mean by that?
18 A. Well, I think initially -- and I'm going back a little
19 bit. My understanding is the end, whenever Dr Taylor
20 ended the anaesthetic, he realised that the patient had
21 got fixed dilated pupils. In terms of his cardiac
22 outputs, et cetera, I'm not sure where they were, but
23 he wasn't at that point -- he was possibly clinically
24 dead, but he still had activity. So there was -- and
25 I think this comes from the evidence. There was some

1 resuscitation exercises, trying to address this
2 possibility that this was, in fact, not a terminal
3 event.
4 Q. Yes. That's what I'm trying to get at really. You're
5 the medical person. What would that actually have meant
6 that they were doing there in the theatre?
7 A. I think it would be important probably that that be
8 taken up by Dr Taylor at that point.
9 Q. Well, I entirely accept that. It's just that -- it's
10 one of those things that you have remembered and said
11 that there was a great effort to resuscitate him and I'm
12 trying to find out what that was.
13 A. There was some statement -- I think it was when
14 Dr Taylor gave evidence originally -- that he went back
15 to the intensive care unit and I think when I'm saying
16 resuscitate, I'm talking about that intensive care
17 services were provided to him, is what I'm saying.
18 Q. Ah. Just so that we are clear, are you talking about
19 something that you have learned subsequently or
20 something that you knew at the time because Dr Taylor,
21 in that conversation you had with him, told you that?
22 A. It would have come out in terms -- I think probably in
23 some of the discussions or maybe even the coroner's
24 inquest that that had happened. I don't think Dr Taylor
25 said to me at the time -- I can't remember the details

1 of that conversation, but I don't think so. I mean,
2 what I was trying, I think, to explain at that point in
3 time is that it was, I think, general practice that if
4 you had -- in fact, if you had a death in theatre and
5 it's really then the standard procedure should have been
6 and was that all lines were remaining in place, all
7 endotracheal tubes remained in place, so you had
8 a static situation so that whenever you then went to
9 investigate, there was nothing that could actually --
10 and I think that was what the State Pathologist felt and
11 I think that was the appropriate thing.
12 I think in this case it may have been that because
13 it wasn't declared in theatre that the patient then went
14 to intensive care unit and I'm not sure now at what
15 point he was declared clinically dead. There may well
16 have been a sense in which there was a period of time
17 there when it wasn't considered that that was an acute
18 incident in the sense of why the lines had been pulled.
19 That might be.
20 Q. So what you're positing is that because he may not have
21 been considered to have actually died literally there
22 in the operating theatre, but was taken to paediatric
23 intensive care and was declared dead there, it might be
24 in those circumstances that they would remove the lines
25 for some reason?

1 A. It might possibly be, particularly if they would -- and
2 I can't say here because I didn't work there. But it
3 might be to actually reduce distress to the family that,
4 in that situation, they would make it as acceptable and
5 easy for the family to view. That might be an
6 explanation. I don't know.
7 THE CHAIRMAN: In other words, when his mother's holding him
8 for the last time, there aren't lines and tubes coming
9 out?
10 A. Exactly, that might be one explanation of this because
11 certainly with regard to death in theatre, there was
12 a standard procedure. I knew it from my North American
13 experience and I know Dr Murnaghan would have done it.
14 I can't remember the exact time, but he would have said
15 "don't touch anything". So that might explain why it
16 was slightly different in this case.
17 MS ANYADIKE-DANES: I understand that and, of course,
18 Professor Savage is going to give evidence and he's
19 a person who's recorded as having requested the lines to
20 be removed so obviously we can ask him. But from
21 a procedures point of view, presumably that's just the
22 very area that the hospital and the State Pathologist's
23 Department might have a discussion over because on the
24 one hand you have the consideration to be given to the
25 families when you're dealing with the death of a child,

1 particularly a very young child --
2 A. Sure.
3 Q. -- and on the other hand, you have the needs of the
4 pathologists, who are trying to have as full and
5 complete a picture as possible to help them with their
6 investigations. So is that not an area where one might
7 have considered "Maybe we should have some sort of
8 memorandum or discussion as to where the balance lies"?
9 A. I think it probably would, in fact -- but I would say
10 that I don't know that it was appreciated by everyone
11 that this was a standard procedure with regard to death
12 in theatre. I was very aware of it, particularly
13 because of my North American experience, but also
14 because of -- I knew that Dr Murnaghan was very aware of
15 this too.
16 Q. I understand. Then if I can -- maybe I didn't quite
17 understand what you meant, but if I can take you to
18 page 114. Just at the bottom, you say:
19 "I was part of the investigation into Adam's death."
20 What did you mean by that?
21 A. I was part of the ongoing discussions and I'm not sure
22 at which point -- I don't remember how many meetings
23 there were, I don't remember who or what was there, but
24 I was part of a -- I suspect, most of the meetings that
25 were held to actually discuss what might have happened

1 in this case and look for the way forward. That was
2 part of the reason why I felt we needed an external
3 assessor because it wasn't particularly clear right at
4 the beginning that this was just something very
5 clear-cut and there were differences of opinion and it
6 needed to be, I think, clarified.
7 Q. No, we'll come to that. The only thing is that the use
8 of the expression "investigation" by someone like you,
9 who actually is peculiarly qualified to know what that
10 means and its significance, that's why I'm trying to
11 understand. Discussions are one thing. Part of an
12 investigation into Adam's death could well be another
13 thing.
14 A. Right. I have to, I think, have the ... I would have
15 probably perceived and probably still would perceive
16 that the discussions that were ongoing were part of
17 a broader sense of investigation into Adam's death.
18 I think that -- I feel that that would be part ...
19 Discussions were part of the investigation, I feel.
20 Q. Right. That's a very helpful clarification because I am
21 going to ask you about investigations, obviously, but
22 I'm going to do it when we come to it in its rightful
23 place. Thank you. Just while we have it, you mentioned
24 there were a number of discussions. You yourself have
25 said that the meeting -- not really a meeting, but the

1 talk -- that you and Dr Taylor had, you believed you did
2 record that somewhere, or at least it would have been
3 your practised to do that. In terms of these other
4 discussions was anybody making a record of that? I'm
5 thinking particularly of your experience in these
6 matters. Is anybody making a record?
7 A. These meetings were chaired by Dr Murnaghan and it would
8 have been my experience that Dr Murnaghan would have
9 kept a minute or some information with regard to that.
10 Q. Thank you.
11 A. And that would have -- I can't be clear about it now.
12 Q. And because he was doing that in the role of chair, then
13 you wouldn't be doing it for your purposes?
14 A. I might have made the odd note from my own point of
15 view, but I wouldn't have made a detailed note, no.
16 Q. Then moving on to page 125. This is just at the time
17 when I'm asking you about Dr Taylor coming to see you
18 because you have recorded, as I recite at line 10, that
19 he did come to speak to you. What you then say towards
20 the bottom at line 21 is:
21 "I think I might have known a little bit, but not
22 very much."
23 This is about the circumstances of the death before
24 Dr Taylor actually comes to see you.
25 A. Yes.

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

1 the one thing I do remember. I don't know how I then
2 took it forward. There were three other -- two other
3 deaths that came up. I didn't know about those deaths.
4 I only became aware of those deaths whenever the request
5 from the coroner came. And that comes back to what
6 I said yesterday that in the separate directorates,
7 I wouldn't have known -- and they were usually handled
8 within those directorates, including the links between
9 the anaesthetists and the surgeons and the other
10 services. That would have happened in the cardiac
11 directorate and I would suspect there were quite
12 a number of deaths in cardiac surgery that I have never
13 known about, actually, because it wasn't -- it was
14 normally managed within those services. So I wouldn't
15 have automatically have moved in to say," What's going
16 on here?"
17 Q. Well, yes, except to say that these are, nonetheless,
18 deaths happening within your overall directorate, if I
19 can put it that way.
20 A. Absolutely. And I think, in the circumstances, the only
21 way I can explain that is to go back, that there was an
22 anomaly in the way this whole thing was set up. It
23 wasn't actually -- it would probably have been better
24 that the whole things had been managed within the
25 individual service area and then anaesthetists would

1 have been part of that. But the anaesthetists were
2 never at all keen on that being part of the
3 establishment. It was some years later, before
4 I think -- I think they now are much more integrated but
5 it was some time later that that happened in all cases.
6 Q. Why did Dr Taylor come to see you then?
7 A. I think I was perceived as the person who understood
8 some of the challenges that the paediatric anaesthetists
9 faced. They had gone through -- and I alluded slightly
10 to it yesterday. They had been through a very difficult
11 period when, in fact, we were down to two fully-trained
12 paediatric anaesthetists and eventually, as I said
13 yesterday, I got Dr Rosalie Campbell and Dr Rao. We had
14 a significant period -- and I don't know what it was,
15 a figure of six months is in my mind -- when we didn't
16 do any elective surgery because the consultant
17 anaesthetists were -- they could not work. We had two
18 specialist paediatric anaesthetists. We had two
19 supporting, which meant that Dr Taylor and Dr Crean were
20 on call every fourth night, but also for very difficult
21 cases, they became the longstops, they became the people
22 who were contacted.
23 So I had been working on their behalf to correct
24 that and I think they may have perceived that I was more
25 understanding of the difficulties that they faced and so

1 I would very often have been the person that they would
2 have come to to discuss their difficulties.
3 Q. Is that what you meant when you said in your statement
4 that you would have offered to give them your support?
5 A. My support would have been the support with how he would
6 go through the process, yes.
7 Q. It almost sounded like counselling to somebody who was
8 a bit traumatised.
9 A. There was a degree of that, yes.
10 Q. Then at page 127, line 18. After I'd asked you whether,
11 at that meeting with Dr Taylor, he provided you with the
12 anaesthetic record, you said, "Not at that time". When
13 did you get it?
14 A. I actually think the first time I saw the anaesthetic
15 record was actually at the coroner's inquest. I think
16 that was the first time I saw it. But I could be wrong.
17 Q. But why would you wait as long as that? You're having
18 discussions --
19 A. I may have seen it as part of the discussions that were
20 going on in Dr Murnaghan's office. I didn't myself --
21 I think I said yesterday that I did not, after that,
22 have a one-to-one conversation with Dr Peter Taylor
23 [OVERSPEAKING] Bob Taylor.
24 Q. You did say that, but what I'm really asking is: why
25 didn't you go and get it? I can understand from what

1 you have said, given the way that matters arose, that
2 you maybe didn't have it with you when Dr Taylor came to
3 see you because you wouldn't necessarily know he was
4 going to come and see you and, if he didn't bring it,
5 you wouldn't have it. But after you had that exchange
6 with him, why didn't you go and get it and see exactly
7 what happened here?
8 A. I can't answer that. I mean, I can only say that,
9 again, it comes back to the fact that ...
10 THE CHAIRMAN: Sorry, doctor. You saw Mr Leckey within
11 a couple of weeks.
12 A. I couldn't remember -- yes. Certainly, it was before
13 ... It was significantly after. It was as
14 a consequence of these meetings.
15 THE CHAIRMAN: But according to Mr Leckey's note, you and
16 Dr Lyons told him that it was your view that Adam's
17 death was nothing to do with the anaesthetics. How
18 could you possibly have told him that if you hadn't seen
19 the anaesthetic records?
20 A. Well, maybe I have -- I apologise if I've got my memory
21 wrong. The thing that I remember, the only thing that
22 I can remember in detail about anaesthetics, is the
23 anaesthetic record -- was the fluid, the detail that
24 Dr Taylor had put into his fluid balance. That was the
25 thing. That was --

1 MS ANYADIKE-DANES: Dr Gaston, I promise you, we're going to
2 come to that. The issue here is: you are expressing
3 views as to the complexity of the matter, which you may
4 have gained just from what Dr Taylor said, although I'm
5 going to take you to that, but also to what the possible
6 involvement of it is. I'm trying to find out if
7 Dr Taylor did not bring his notes and records with him
8 to say, "Let's have a discussion, I'm a bit worried
9 about the outcome here". Why didn't you, with all your
10 training on risk management and so on and so forth, do
11 the very basic thing and say, "Let me get the notes and
12 records myself and see exactly what's going on here. At
13 least I can give an informed view and maybe be in
14 a position to provide more substantive support to
15 Dr Taylor"?
16 A. I cannot say other than the fact that at this point in
17 time, I cannot remember doing that specifically.
18 Q. Wouldn't you have wanted to do that?
19 A. I think that -- I think I probably, at that point in
20 time, felt that this was a discussion that needed to
21 involve all aspects of the care.
22 Q. Quite. But before you get into all the aspects, this is
23 an anaesthetist, you're the clinical lead for ATICS.
24 Wouldn't you have wanted to get the very basic
25 information yourself?

1 A. I'm sure I would have.
2 Q. Let me help you. 059-071-164. This is a memo from
3 Dr Murnaghan, which is circulated to Professor Savage --
4 Dr Savage as he was then -- Dr Taylor, Mr Brown and you
5 are there and Dr Webb and Mr Wilson are there for
6 action.
7 But in any event, what this says is:
8 "The coroner has spoken to me ..."
9 And he has:
10 "Requested a detailed statement from the anaesthetic
11 technical staff about the equipment used during the
12 surgery and anaesthesia. This has been arranged."
13 Then:
14 "Referred the matter to Health and Safety
15 Inspectorate and in order that you may prepare the
16 requested report, I'm sending with this letter an
17 extract copy of the recent case notes. I have to send
18 the original of volume 10 to Dr John Alexander,
19 consultant anaesthetist, who has been retained by
20 the coroner as an independent medical expert."
21 Firstly, this seems to indicate that you obtained
22 the recent notes and records; would you accept that?
23 A. Can I clarify a little bit now? Because, in fact, this
24 has brought back, to my memory, some aspects.
25 Q. That's okay.

1 A. One of the things that I did with regard to this was
2 that I asked -- Dr Murnaghan had asked that the
3 technical staff went in there. The technical staff who
4 went in there -- I think I alluded to this yesterday --
5 were from the Royal site.
6 Q. Sorry, if we can keep to the bit about the medical notes
7 and records, otherwise we will dive off in areas and not
8 move through it logically. Does this indicate to you
9 that you received Adam's recent medical notes and
10 records?
11 A. It does suggest that I did see them.
12 Q. Yes. Although it's a little bit difficult to see, it's
13 6 December that is actually dated. The coroner seems to
14 have worked out that he wants an independent medical
15 expert in anaesthesia and so he's indicated that he's
16 going to have Dr John Alexander. And in the letter that
17 I took you to of the coroner before, is not what's
18 happening actually a suggestion, "No, not Dr John
19 Alexander. What you need is somebody who's more
20 specialist in this area", and that's how you ended up
21 going to Dr Sumner?
22 A. Can I clarify?
23 Q. Of course you can, but in order to know that, you must
24 have looked, I would suggest, at the medical notes and
25 records to have appreciated that this is the kind of

1 case where the expertise of Dr John Alexander, whatever
2 that might be -- actually, this is a case that might
3 require something else.
4 A. That would be much more in keeping with the way that
5 I would normally have responded. I think the problem
6 I have at the minute -- I can't actually remember that.
7 I think what became clear was that I needed to have
8 someone else move -- get in to investigate very
9 immediately afterwards. Dr Murnaghan asked me could
10 I identify someone who we considered independent, who
11 could move in very quickly and actually investigate this
12 case.
13 I said, "I think the one person who's in
14 Northern Ireland who would have experience of paediatric
15 anaesthesia, major paediatric anaesthesia, and who
16 I considered independent at that point in time was
17 Dr Fiona Gibson". She was the person providing the
18 anaesthesia within Northern Ireland for paediatrics and
19 for cardiac surgery. She was also someone who would
20 have been involved in meetings and I felt to get an
21 independent -- and I believe it was independent because
22 she didn't work in the Children's Hospital. I felt
23 that, as an immediate action, I should ask Dr Gibson to
24 actually look at this.
25 I'm sure in retrospect -- presumably I actually went

1 over the notes with Dr Gibson in advance of that,
2 I can't remember that, I apologise. Then Dr Gibson came
3 in, and she came back with a report, she felt that the
4 fluid management had been good, the anaesthetic delivery
5 had been excellent. I think there's a copy of --
6 Q. We have and we're going to get to that. Is what you're
7 saying: because you received that report, you were able
8 to reach the view that this had nothing to do with
9 anaesthesia when you met with the coroner?
10 A. I can only presume that was the reason why I said that.
11 Q. So if we park that for a moment, leaving aside the fact
12 that she'd looked at the report, you have looked at the
13 medical notes and records?
14 A. I must have done.
15 Q. Exactly. Are you saying, having looked at those medical
16 notes and records, you could be advising the coroner
17 that this case really had nothing to do with
18 anaesthesia?
19 A. I felt that, yes, it -- let's say I felt that at this
20 point in time it wasn't apparent that it was to do with
21 anaesthetics and I felt we needed an external -- as did
22 Dr Lyons because I had spoken to him as someone who had
23 a wider experience than I had. I had spoken to him and
24 we felt that it needed someone with --
25 Q. I understand that. Sorry, I don't mean to cut across

1 you. What I'm trying to get at is -- maybe we're using
2 terminology slightly differently. When you said this
3 had nothing to do with anaesthesia, did you mean this
4 had nothing to do with the anaesthetic or this had
5 nothing to do with the conduct of the anaesthetist?
6 A. I think I was ... That's going back a long time,
7 actually.
8 Q. But it's quite an important distinction.
9 A. It is an important distinction. I don't think I can
10 give you a straight answer -- not a straight answer,
11 I can't give you an answer to this. What was in my mind
12 as to whether it was an anaesthetic or whether it was
13 the anaesthetist, I honestly don't know. But the reason
14 I felt that we needed an expert is that that needed to
15 be cleared up. We needed to be sure of what.
16 Q. Well, yes, we will look at Adam's anaesthetic record.
17 But if you looked at that record, which if you were
18 going to look at his recent medical notes and records,
19 would at least involve looking at the anaesthetic
20 record --
21 A. Sure.
22 Q. -- could you have looked at that record and come to the
23 view that whatever happened to Adam couldn't somehow
24 involve the conduct of the anaesthetist?
25 A. No, absolutely not.

1 Q. Thank you. Then at page 128, when you -- one of the
2 things that you suggested, I think to Dr Taylor, is that
3 -- this starts at line 12:
4 "He was so upset that he needed one of the really
5 senior people to be able to talk it through with him as
6 well as having talked it through with me."
7 A. Yes.
8 Q. When I asked you a little while ago why was it you
9 thought that Dr Taylor had come to see you and you
10 explained your reason, that you were a little bit of an
11 advocate for them in their difficulties and so forth,
12 and a sympathetic ear as well as being a very senior
13 person and the clinical lead. But you now have
14 a suggestion that he go and speak to one of the really
15 senior people --
16 A. Mm-hm.
17 Q. -- in anaesthesia; why is that?
18 A. I think because I had come in quite recently. I mean,
19 I'd become clinical director in, I think,
20 about April 1993. I felt that he needed to talk to
21 someone else. Not just to me. I was then in a position
22 where I was the clinical lead and I had to be aware of
23 that. I felt at that point in time that Dr Taylor --
24 and this goes back a little bit to the counselling thing
25 we were talking about. And we had ... There is within

1 anaesthesia -- and I think, at that time, what we called
2 "three wise men", and that obviously is something,
3 I think, post-Bristol, et cetera. I think that changed.
4 And Dr -- the two names that I mentioned there were ...
5 Dr Morrell Lyons and Dr Dennis Coppell, I think were two
6 of those people, and I felt that --
7 Q. And what were they to do if he went to see them?
8 A. Well, that would have been another sense in which
9 someone else other than me, who was an anaesthetist, had
10 a -- a senior anaesthetist had an opportunity to talk to
11 Dr Taylor.
12 Q. Yes, but what were they going to talk to him about?
13 A. I think there was -- his feeling about the anaesthetic,
14 his feeling about what had happened, his feeling about
15 how he was going to actually take it forward, and how he
16 would cope with it. That was really what I was thinking
17 about.
18 Q. In the sense, the coping with it, although it was my
19 terminology -- I think you agree with it -- there was an
20 element of counselling going on between you and he. So
21 on that side of it, you're providing that support and he
22 had that confidence because he came to you in the first
23 place; you didn't seek him out. In relation to the
24 other aspects of it, the actual anaesthetic aspects of
25 it, you seem to have formed a view, from what you told

1 us yesterday -- although I will make sure about that
2 when I take you to it -- that you were broadly seeing
3 where he was coming from in terms of his difficulties.
4 A. Yes.
5 Q. So what were these two wise men going to add to that?
6 A. They were adding a certain seniority and a -- I think it
7 was important that Dr Taylor had an opportunity to speak
8 to some other people of a senior level in ... Partly as
9 a follow-up to the counselling type situation that I had
10 talked about.
11 Q. Were you concerned that there was a risk that he was in
12 error in some way and that it would be useful for him to
13 speak to some very experienced anaesthetist if that was
14 the case?
15 A. I was concerned about his welfare.
16 Q. Yes. That's a different --
17 A. It was. And I also was concerned at the possibility
18 there was a mistake. I didn't actually say -- I didn't
19 highlight that to him and Dr Taylor was concerned about
20 that himself.
21 Q. He was concerned he might have made a mistake?
22 A. Yes. He said, "Looking at this anaesthetic, I can't see
23 what I was done wrong, but if there is --
24 Q. But if we leave Dr Taylor to one side -- because he is
25 going to give his own evidence about that -- this is

1 you.

2 A. Yes.

3 Q. You were concerned that there was a possibility that he

4 could be at risk, he might have made an error?

5 A. I think once you have a death in an operating theatre,

6 there are a number of things that can contribute to it.

7 And one would be anaesthesia. It is just a fact that

8 it is. All too often it's the one that's identified as

9 being the cause initially and I've experienced that

10 myself in the past. All too often it's that. What

11 I didn't do at that meeting -- and I can clarify that

12 because I do -- I did not ask Dr Taylor to bring notes

13 to that meeting. When I saw the notes, I cannot

14 remember, I'll be quite honest, but it wasn't at that

15 meeting, I do know that.

16 Q. That's fine. Let's just stick to this point: the extent

17 to which you thought he might be in error, and,

18 therefore, if that was a possibility, he actually needed

19 some senior anaesthetic people to talk to. Is that the

20 sort of thing that was going through your mind?

21 A. That's right. This was -- I had very, very little

22 knowledge of this.

23 Q. I understand.

24 A. And I suddenly was faced with a very complex situation

25 with a distressed anaesthetist. I had to think, not

1 necessarily -- in retrospect, I might have said, "Maybe
2 this and this", but I was faced with that at that point
3 in time and I had to look at what was the best way
4 forward. And one of the things I felt was -- and it was
5 important that Dr Taylor made that decision himself.
6 I did not want to push him to go and talk to someone
7 else, but I offered him the opportunity to speak to
8 someone else because certainly, in terms of the
9 follow-up to this, it would -- I didn't feel that was
10 the exact time and maybe I should have then said, "Come
11 back to me and we will talk over this in detail later".
12 I have no recollection that I did that.
13 Q. I'm going to ask you about that. Do you know if
14 Dr Taylor took you up on your suggestion?
15 A. I do not know.
16 Q. Sorry?
17 A. I don't know. The obvious person to have -- for
18 Dr Taylor to have gone to was the senior anaesthetist at
19 that time, who was -- in paediatrics, who was Dr Kielty,
20 but Dr Kielty was ill and off. He was the obvious
21 person because he was the senior paediatric
22 anaesthetist. He was the person that he probably would
23 have gone to first, but he was ill.
24 Q. Yes.
25 A. So I think I was probably the next person that he came

1 to. I felt that it needed -- he needed to talk this
2 further, but I couldn't pressurise him to do that.
3 I offered him the opportunity.
4 Q. Yes, you have said that and it may be that we've gone as
5 far as we can with it. But I am still trying to find
6 out whether ... You are a senior anaesthetist yourself.
7 You are senior in the directorate because you're his
8 clinical lead. Whatever are the anomalies in the
9 situation, you are his clinical lead.
10 A. Sure.
11 Q. You're the person, for whatever reason, he chose to come
12 and speak to. I'm still not entirely sure why you
13 didn't follow that up. I have understood what you said,
14 that you didn't think that that was the time to be
15 getting into the details of it, but after he had left,
16 you could have got his medical notes and records. You
17 could have seen from a more informed basis what was
18 going on. You could have brought in the two others so
19 that you then formed the three wise men and the three of
20 you could have spoken to him and seen exactly what was
21 going on once you had informed yourself. I'm trying to
22 understand why you didn't do something like that.
23 A. I'm sorry, I can't go back and -- I can't tell you the
24 answer to that because I just don't know.
25 Q. Isn't that how the three wise men system, if I can

1 elevate it to a system, works?

2 A. I think it was, but it wasn't anything I'd had to

3 activate before in the UK.

4 Q. Did you, in some sense, think it was better if this was

5 going to get a little bit difficult that somehow you, as

6 clinical lead, weren't the person having the direct

7 personal, if I can put it that way, exchanges with

8 Dr Taylor?

9 A. I felt that I did not have the experience in paediatric

10 anaesthesia that was required to actually fully

11 investigate that case. And that goes back to the

12 structure of the way it was set up. I think that --

13 I would have not had the experience of paediatric

14 anaesthesia that would have allowed me to take this

15 forward in detail. And I think at that point in time,

16 the nearest I came to someone who would have had that

17 would have been Dr Fiona Gibson.

18 Q. I understand that. But in fact, you've acknowledged

19 that in some shape or form you were part of an

20 investigation, maybe not a very formal one, but you were

21 part of an investigation.

22 A. That's right.

23 Q. So you felt yourself sufficiently able to be part of

24 that investigation with Dr Murnaghan. So the question

25 I'm asking you is: did you see a difference between

1 doing that and lending support and assistance to
2 Dr Taylor that he might require and maybe, if it's going
3 to be an issue that potentially there's a problem with
4 what he did, it might be better that you're not the
5 person closest to dealing with him, if I can put it that
6 way?
7 A. I think that that probably was my thinking, yes.
8 Q. Thank you. Can we now go back to when he's meeting with
9 you and you go through and you say you help a little bit
10 and, with a little bit of prompting, go through what you
11 thought were the key difficulties.
12 A. Using my background in adult --
13 Q. I understand that entirely. I'm just trying to get your
14 sense of it. Page 131 is, I think, where you start. It
15 doesn't actually start, but it's where we can distill
16 it. Line 3. I summarise what you are saying by asking
17 you whether that meant that Adam was polyuric and you
18 said: yes, it did. I'm going to ask you about that
19 because you have described the whole procedure, from an
20 anaesthetic and every other point of view, as being
21 highly complex.
22 I am going to ask you why you think Adam's polyuria,
23 from an anaesthetist's point of view, made it a complex
24 procedure.
25 A. Because there was -- first of all, it wasn't

1 particularly common actually, and I know there was --
2 I've read some of the advice that's come from one of the
3 experts with regard to this, paediatric anaesthetists,
4 and said that in his case it would have been relatively
5 common for him. He acknowledged that in
6 Northern Ireland the incidence was less. I think the
7 other point was that -- and from my own experience
8 in the past, even though I did not anaesthetise
9 paediatric anaesthesia, there were paediatric
10 transplants that were done by the team of which I was
11 a member.
12 Q. Yes.
13 A. And I do not remember ever a situation where that had
14 been considered. The ones that I knew -- and this would
15 have been in Saudi Arabia the ones that I knew. To my
16 memory, it would have been very rare for it to be
17 a polyuric --
18 Q. Let me ask you this: at the time when he was discussing
19 it with you, did you appreciate what the implications
20 were for urine output of a patient being polyuric?
21 A. Oh, absolutely.
22 Q. So you knew that Adam would have a fixed urine output?
23 A. Dr Taylor actually said to me that he had anaesthetised
24 this child before and he actually -- and I can't
25 remember, but he quoted to me what his urine output was.

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

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

1 there is an urine output that can expand to cope with
2 increasing volumes of fluid being administered?
3 A. Certainly at the time Bob's -- Dr Taylor said that he
4 had anaesthetised -- I think this is true -- he had
5 anaesthetised this child several times before. He had
6 experience of managing the --
7 Q. Sorry, I beg your pardon, this is a different question
8 that I'm putting to you. The issue that I am drawing to
9 your attention is, from the way you have described it,
10 that Dr Taylor was describing a situation where Adam's
11 urine output could increase to accommodate volumes of
12 fluid being administered. When I asked you whether you
13 appreciated the significance of the polyuric condition,
14 you said that you did and then I put to you -- and
15 somebody will check it on the transcript. Maybe I'm not
16 getting the terminology precisely right. But when I put
17 to you, "Did that mean that you appreciated that he
18 would have a fixed urine output?", that's the whole
19 point about a polyuric condition.
20 A. Again I go back to my memory. My memory at the time
21 was --
22 Q. Sorry, I'm asking you about your knowledge. Did you
23 know that that's what a polyuric condition meant, that
24 the patient would have a fixed urine output?
25 A. At this point in time, I can't say if I did or not.

1 Q. You don't know whether you knew that?
2 A. I don't now, no. I have been out of medicine for five
3 years and I apologise.
4 Q. No, no. I understand.
5 A. I've been out of clinical medicine since 2004. What I
6 knew then may have been somewhat different to what I
7 know now and I apologise for that.
8 Q. No, no, please don't. I understand that entirely. Let
9 me just -- one more point on this and perhaps recast it
10 slightly differently.
11 When he described that problem that he experienced
12 of Adam really having -- I wouldn't like to say an
13 endless capacity, but in any event being like a bucket
14 with a hole in it, even if he may not have used that
15 precise terminology, but something like that analogy,
16 when he described that to you and the difficulties that
17 that presented to him in trying to calculate his fluid
18 management, did that strike you as incorrect at the
19 time?
20 A. I don't think I would have been -- at that time, I would
21 have had the knowledge to be able to make an opinion,
22 but I don't know --
23 Q. If you had thought it was incorrect, what would you have
24 done about it?
25 A. I would have said, "Bob, we need to actually investigate

1 this further. We need to check that that was right".
2 Q. Did you not think that maybe you should check that
3 anyway because that would be a fairly fundamental
4 element of his condition if that was the case?
5 A. I think that was part of what I had asked Dr Gibson, to
6 give some assessment because she wouldn't have had the
7 knowledge that a paediatric anaesthetist specialising in
8 renal transplantation would have had, but she certainly
9 had very detailed knowledge of the management of both
10 the fluids and urine output of children who would have
11 had congenital abnormalities, which might well have
12 included abnormalities of their kidney, their renal
13 function.
14 Q. And do you think that you asked Dr Gibson to look at
15 that element of it as well?
16 A. I asked her, I think, to look at the whole case, the
17 whole aspects [sic] of the case, and I think now that
18 actually I probably talked the case -- including the
19 notes -- through, but I just ... I can't confirm that,
20 I can't remember.
21 Q. Let's just have a look. It may be that she has dealt
22 with it separately and we just don't happen to have
23 that. If we go to 059-069-162. That's her report and
24 we've got redactions because those are the other two
25 cases. They are not of our concern.

1 So this is a report. Ultimately, this report was
2 provided to the coroner. In fact, if we go just to the
3 preceding page, 161, there it goes:
4 "Dear George, please find enclosed a report of my
5 visit to RBHSC as per your request. I hope it is
6 suitable for your purposes."
7 That is dated 4 December and then, when we come to
8 the page which I first took you to, 162, it's headed "To
9 whom it may concern", so that suggests it's a report
10 that's going to be made available for somebody as
11 opposed to just your consideration. That would be
12 right, wouldn't it?
13 A. That would be.
14 Q. Let's see what she says about it:
15 "I visited the operating theatre suite at the
16 Children's Hospital on 2 December 1995 at the request of
17 doctors Murnaghan and Gaston to discuss with Dr Taylor
18 three patients whose post-mortem examinations had been
19 brought to the attention of the coroner."
20 If we pause there, there's no suggestion, is there,
21 that Dr Taylor had been involved in the other two
22 patients?
23 A. No.
24 Q. In fact, I think she says that somewhere down in the
25 report part of it.

1 A. There weren't common anaesthetists. I think there
2 weren't common operating theatres either from what I
3 remember.
4 Q. In fact, it says that in the penultimate paragraph. It
5 says:
6 "Each case was performed by a different surgeon and
7 each anaesthetic conducted by a different anaesthetist,
8 all of consultant standing."
9 But nonetheless, is that first statement that she's
10 made correct, that you and Dr Murnaghan had asked her to
11 discuss with Dr Taylor the three cases which, of course,
12 would have included Adam's?
13 A. I don't remember, but since she has said that, I presume
14 we did.
15 Q. Yes. And then she deals in the next paragraph with
16 Mr Wilson and Mr McLaughlin. She talked about the
17 technical checks, what they demonstrate. If we come
18 down to case 3, she sets out her views on Adam:
19 "A four-year-old child with polyuric renal failure
20 was brought to theatre for renal transplant. A very
21 thought out and well monitored anaesthetic was delivered
22 with great care to fluid management in a child whose
23 normal urine output was 100 ml per hour."
24 Do you have any idea how she formed that view?
25 A. I don't, no. It is possible that she had got ...

1 I don't know if she got it from the notes or she got it
2 from Dr Taylor, I don't know. I can't answer that,
3 sorry.
4 Q. But if you saw his notes, you could have formed the same
5 view as to what his normal urine output was.
6 A. I might well have done at that time, but I don't
7 remember.
8 Q. If you saw that, and on the other hand you record your
9 conversation with Dr Taylor, who describes him as like
10 a bucket with a hole that he was pouring fluid in, that
11 might be something you might be a bit concerned about.
12 A. I think I should be clear, actually. I think at what
13 point I heard about the bucket element -- I'm not sure
14 it was that first meeting, you know. It may be that at
15 that first meeting, what he said was, "This is what his
16 urine output has normally been when I have anaesthetised
17 him".
18 Q. Like a bucket with a hole normally?
19 A. I'm not sure that that was -- in fact, he may have said
20 to me at that stage, "This is what it normally is", and
21 I think it might have been that he said 100 ml and that
22 the phrase came out later. I honestly can't be clear
23 about that and I just can't.
24 Q. So he could have said 100 ml when he was meeting with
25 you?

1 A. He could have done. He could have done.
2 Q. And of course, if he had said that, that wouldn't have
3 caused you any concern at all, the fact that --
4 A. No, because at that point in time, he would have known
5 what had been Adam's standard urine output, yes.
6 Q. Yes. We will come to that because you'll know that
7 actually one of the difficulties in this is -- and one
8 of the errors that Dr Taylor has now conceded is that he
9 didn't calculate Adam's fluid management on the basis of
10 100 ml an hour.
11 A. I'm not aware of what the developments were because I've
12 been in England since. I don't know how -- I don't
13 know --
14 Q. You would have known that because you would have been
15 part of the discussions investigating how --
16 A. Sorry, I'm referring to the fact that Dr Taylor has said
17 that he didn't do that. I wasn't aware of that at that
18 point in time. That is something which has come
19 recently.
20 Q. I understand. Then she goes on to say:
21 "This child was well-known to the anaesthetist as
22 he had anaesthetised the youngster very many times in
23 his short life. Full records of all monitored
24 parameters are available on this case and show that no
25 untoward episode took place and that a very stable

1 anaesthetic was given. At the end of the operation, the
2 child was found to have fixed and dilated pupils and
3 a CT scan showed it to have gross cerebral oedema."
4 Then she goes on to summarise:
5 "In relation to all three cases, all of significant
6 complexity ... substantial increased risk of morbidity
7 and mortality ..."
8 And then the part that I told you before:
9 "Although they were all in the same room ... used
10 the same suite ... nonetheless different clinicians
11 involved ... all extensively monitored. The protocols
12 for monitoring anaesthetic set-up and drug
13 administration in this area are among the best on the
14 Royal Hospital site and I can see no reason to link
15 these very sad cases into any pattern."
16 Was that your concern that there might be actually
17 be a pattern here because there'd been three paediatric
18 deaths?
19 A. It was the coroner's concern. I came into this without
20 knowledge of the other two cases. I think one of the
21 things I knew from my past was that if there was
22 a trend, if you want -- in other words, if you had three
23 deaths together, you needed to look to be sure that
24 there wasn't a common element, whether it be a piece of
25 equipment, whether it be the anaesthetist. It wouldn't

1 have been the surgeon because it was in different
2 things. One needed to look at that. I didn't know
3 about the other two cases and I asked Fiona to look and
4 Dr Gibson did, at the behest of the coroner that she
5 consider all three cases to rule out, first of all, was
6 there a common element. And from what I had seen in the
7 initial -- it didn't seem to me there was, but it was
8 important that we at least look at that.
9 THE CHAIRMAN: So having done that, Dr Gibson in effect
10 saying there's no common pattern, you then revert to
11 trying to understand what went wrong in Adam's case?
12 A. Yes. In a sense, that was one of the important elements
13 of what she was doing.
14 MS ANYADIKE-DANES: Sorry, can I just ask you about that
15 last paragraph?
16 "The protocols for monitoring anaesthetic set-up and
17 drug administration in this area are amongst the best on
18 the Royal Hospital site."
19 What did you understand the protocols to be?
20 A. At that point in time, I don't know because I didn't
21 work there. They wouldn't have been the same. I think
22 what you would have found is that in paediatrics, as in
23 cardiac, they had more detailed protocols than would
24 have been true in the other clinical services, and
25 I think that's more or less in keeping with what

1 Dr Gibson says.

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

3 A. Sorry?

4 Q. Did you ask to look at them, the protocols that she's

5 talking about? Because if they are, then as part of

6 your general interest in quality and standards, that's

7 something that you could adopt.

8 A. We were adopting policies and procedures that were,

9 I think, in line more with the anaesthetics that we were

10 giving on the Royal site. And that would have developed

11 more, probably, after Adam's death. To what degree that

12 influenced, I don't know. But the policies and

13 procedures that were there were largely ones that I had

14 inherited.

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

16 that --

17 A. No, I didn't. But I would have seen them, I think,

18 because I had done the -- I had been involved in the

19 King's Fund preparatory team investigations and one of

20 the things that I did form out of that was that there

21 was very good practice in terms of record keeping in the

22 Children's Hospital. They had better standards of

23 protocols, et cetera, than I felt were true across the

24 site.

25 Q. I understand.

1 A. And we were in the process, as part of the King's Fund,
2 to try to do that. Did I look as to whether I picked
3 those up and brought them to the main site? I don't
4 think I did --
5 Q. Did you see them at any point?
6 A. I think I probably would have done.
7 Q. So they did exist?
8 A. Yes, I think so. I'm pretty sure there would have been,
9 yes.
10 MS ANYADIKE-DANES: Mr Chairman, I wonder if this might be
11 a good moment?
12 THE CHAIRMAN: Okay. We'll take a break for a few minutes.
13 (11.05 am)
14 (A short break)
15 (11.25 am)
16 MS ANYADIKE-DANES: Dr Gaston, you referred, when we dealt
17 with the polyuria issue, to the fact that you have read
18 somewhere that others had differing views, if I can put
19 it that way, about the incidence of polyuria -- not its
20 implications but the incidence.
21 A. I think there was a statement, if I remember correctly.
22 Q. Let me quickly take you to that. It arises in the
23 evidence of Dr Coulthard, who's the inquiry's expert.
24 The transcript of 8 May of this year, page 64 is where
25 it starts at line 18.

1 This is actually a quote from something that
2 Professor Savage said, recalling a report of
3 Dr Coulthard:
4 "I think you'll remember Coulthard has said that
5 some 60 per cent of children requiring a transplant have
6 dysplastic kidneys and they are likely to be polyuric."
7 Then there was an issue as to whether the incidence
8 of dysplastic kidneys in Northern Ireland is as high as
9 it might be in the rest of the UK.
10 But in any event, when it comes to the complexity of
11 Adam's case, if one goes to page 99, line 19, he's being
12 asked about that directly. He says:
13 "There's a spectrum. There's no child who's going
14 to have a transplant that isn't in some way going to
15 have some complexity or component."
16 Then he talks about some children having
17 complexities that are vast:
18 "I would consider Adam to be kind of average."
19 And over the page because he's invited to expand on
20 that. He says:
21 "There would be children that would be much more
22 complex than him because their blood vessels were
23 congenitally abnormal or something like that. So within
24 that, and there's always a degree of complexity, he's
25 kind of run-of-the-mill."

1 And he apologises for using that sort of term:
2 "But he's kind of -- he's kind of a degree of
3 average complexity for a child of that age coming for
4 a transplant."
5 So for those who carry out paediatric renal
6 transplants on children of that age, Adam presented no
7 great complexity. He was sort of average; would you
8 accept that?
9 A. Yes, absolutely.
10 Q. Thank you. Then in relation to the protocols, when you
11 said -- to be fair, you didn't go and look for the
12 protocols when you received Dr Gibson's report, but you
13 have in mind that they did exist and you had seen them
14 at some point.
15 A. Yes. I have the picture in my mind of the paediatric
16 hospital having one of the best, in terms of protocol
17 and in terms of their documentation, simply because
18 having been in the -- done the King's Fund pre-visit
19 schedule, that was an area that was of high quality.
20 Q. So you were looking at that as part of your mock surveys
21 for --
22 A. Yes, I would have seen the picture across the trust in
23 different services.
24 Q. Thank you. Let's go to reference 305-014-001. We were
25 trying to find those protocols. This is a letter from

1 DSL dated 21 July 2011. And so the inquiry entered into
2 some exchange with the DLS about them and the upshot is:
3 "I confirm that it is the Trust's belief that the
4 protocols referred to by Dr Gibson did not exist in
5 written form. I would also confirm that Dr Gibson's
6 statement request --
7 I'm sorry, that's another matter. We don't need to
8 get into that.
9 The important bit was that so far as the Trust was
10 concerned, and they had asked or conducted their own
11 inquiries for us, the protocols did not exist in written
12 form.
13 So your observation on that?
14 A. At this point in time, I'm sorry, I cannot answer that.
15 Q. That's okay. Can we go back to your transcript at
16 page 131? In addition to the polyuric element that was
17 one of those things that arose in your discussion with
18 Dr Taylor, you said that there was another key issue,
19 which was the central venous pressure.
20 A. Yes.
21 Q. And this is to be found at line 6. When I asked
22 what was the issue, you said:
23 "He was concerned that it wasn't an accurate
24 reading."
25 Did he explain to you why he had that concern?

1 A. I don't remember, actually. I've seen some transcripts
2 where he has said information -- but in terms of my own
3 recollection of that, I can't remember why. I think
4 there were difficulties about inserting it, but I'm not
5 sure.
6 Q. In a way, you weren't just passively listening to what
7 he had to say; you were trying to tease out from your
8 experience and knowledge what some of the difficulties
9 might be. Were you able to gain any appreciation for
10 the significance of that error for him or the inability
11 to perhaps get an accurate reading?
12 A. Again, I'm coming from a clinical -- having been a long
13 way away from it.
14 Q. Yes.
15 A. So central venous pressure would have been something
16 that you would have wanted to know accurately. You
17 could make some calculations if you didn't think it was
18 in the right place, as to what it might be -- you might
19 expect it to be.
20 Q. Yes.
21 A. But at this point in time I can't actually enlighten on
22 that, but I would have known at that point in time there
23 were some ways in which you could assess possibly what
24 a realistic figure was.
25 Q. In any event, this was a concern for him.

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

1 I think very reasonably.
2 Q. If we go over the page to 132, just so that we tease out
3 exactly what he meant by "using quite a lot of
4 irrigation fluid". Did he explain why that was an issue
5 for him, why that had made things difficult?
6 A. I presume that that would have gone -- would have
7 been ... I mean, in any operation whenever there's
8 irrigation fluid, it gets taken into the suction bottle
9 and so it will add an increased volume to that suction
10 bottle, which makes it sometimes difficult to assess
11 what is related to the actual loss of fluid from tissue
12 and what is related to the irrigation fluid. And
13 I think that was the point he was making.
14 Q. So he has that discussion with you and he's very upset
15 during it. What happens immediately after that from
16 your point of view?
17 A. I don't remember exactly after that, actually. I don't
18 remember what the sequence of events were. I would have
19 certainly had interacted with Dr Murnaghan. Whether
20 I had interacted before that, I can't remember. At what
21 point I would have had an interaction with Dr Murnaghan,
22 I don't know. I didn't, to the best of my knowledge,
23 have any further detailed conversations with Dr Taylor.
24 I don't remember having them. I may have.
25 Q. What happened is quite a serious thing and it's

1 certainly not a particularly common thing.

2 A. No.

3 Q. Firstly, a child has died. That's not particularly

4 common. Did you know that another child had died

5 in relation to a renal transplant procedure?

6 A. In the hospital?

7 Q. Yes.

8 A. No.

9 Q. You didn't know that?

10 A. No.

11 Q. But in any event, this is the third child who has

12 died -- not related symptoms, but the third child who

13 has died. Did you know that at the time you were

14 speaking --

15 A. Third child from a renal transplant?

16 Q. No, the third child who has died.

17 A. No, no I didn't know that. The first I knew about that

18 was when I was asked to contact someone to set up --

19 Q. I understand.

20 A. I go back that ... I wasn't -- and I know this is very

21 hard to understand. I was not -- and it goes back to

22 the way things were set up. I was not privy in a sense

23 to the day-to-day workings of the paediatric set-up and

24 the cardiac set-up and I would actually probably have

25 known more about paediatrics than I did about cardiac

1 because paediatrics at that stage, as I said, were
2 actually -- I became, in a sense, more close to them
3 because they were going through a difficult period.
4 Q. I appreciate that. So what has happened, though,
5 leaving aside that at that stage you don't know that
6 this is the third, but you do know that a child has died
7 in surgery, which is not a common occurrence.
8 A. Yes.
9 Q. And you have had the anaesthetist before you, who's been
10 very upset. He's explained certain things that are
11 concerns to him. You have in the back of your mind the
12 possibility that maybe something went awry that he might
13 be involved in and maybe he really ought to go and speak
14 to somebody more senior and experienced. So that's your
15 mindset if you like. When he leaves, leaving aside what
16 you can remember you actually did, what from the point
17 of view of the organisation would have been the
18 appropriate thing to do at that stage?
19 A. Well, I would normally have taken forward enquiries,
20 I would have spoken, say, to Dr -- and I don't know,
21 I can't recollect. I would have spoken to somebody like
22 Dr Peter Crean. I would have obviously discussed with
23 Dr Murnaghan and I would have -- and I think I followed
24 up with some discussion with Dr Gibson. I can't
25 remember, but that would have been the way. I would

1 have looked at the people who were part of that.
2 I probably wouldn't -- in fact I'm sure I wouldn't
3 because of the fact that I wasn't ... I wouldn't have
4 discussed this further within the paediatric directorate
5 in terms of the other personnel.
6 I saw that -- that actually happened as part of the
7 discussions that would have happened in Dr Murnaghan's
8 office. So I would have had some -- and I did have
9 some -- I would have been prepared for that discussion
10 for those meetings and I would have obviously had
11 discussions with a number of people who prepare for
12 that. I don't remember the sequence or the details of
13 that, I'm sorry.
14 Q. I very much appreciate that point. So I think what
15 I have from you is that you would have had some
16 discussion with Dr Murnaghan?
17 A. Yes.
18 Q. And you would have possibly had some discussions with
19 another anaesthetist, maybe Peter Crean, who was having
20 the day-to-day management of matters.
21 A. Sure.
22 Q. Would you have thought, given at that stage even
23 Dr Taylor considered that Adam's death was unexplained,
24 would you have thought to involve the medical director?
25 A. That normally -- I can't imagine that that -- the normal

1 mechanism in a death like this would have been, to the
2 best of my memory, Dr Murnaghan reporting to Dr Carson.
3 Q. So you wouldn't do that?
4 A. I wouldn't normally have done. If I felt that the
5 mechanisms that were normally in place had fallen down,
6 I would have gone and spoken to Dr Carson, but
7 I wouldn't otherwise have done so, no.
8 Q. Can I ask why you wouldn't? Because you are -- he's
9 your medical director. Why wouldn't you raise an issue
10 that has clinical concerns, if I can put it that way,
11 with your medical director?
12 A. I cannot say that I didn't have a conversation with
13 Dr Carson.
14 Q. No, but you said that that wouldn't necessarily be the
15 normal way.
16 A. The normal way would have been --
17 Q. I'm asking you why it wouldn't have been the normal way.
18 Why wouldn't it be normal for you to raise an issue of
19 that sort of thing, raising clinical concerns with your
20 medical director?
21 A. I think the thing that -- actually the structure, the
22 way it was at that point in time was that Dr Carson,
23 like me, was actually undertaking a significant amount
24 of clinical work. And the one person who ended up as
25 the link in this would be Dr Murnaghan because he

1 didn't -- he was available unless he was off ill.
2 He was the person who was available and would have
3 actually ended up as being the person that one would
4 have talked to first because he was available.
5 Did I speak to Dr Carson later? I'd be surprised if
6 I didn't, but I don't remember.
7 Q. We'll get to that. What it looks like then, and it's in
8 some ways perhaps helpful that you're the witness
9 helping us with this, given your background, is that
10 when one lays out the organisational structure that
11 emerges from the documents and one sees the lines and
12 what one assumes would be the reporting lines, that all
13 looks fairly straightforward. But what in fact happened
14 wasn't that at all.
15 A. I think actually, again, coming back to my experience
16 with the King's Fund, that didn't happen in a lot of
17 organisations.
18 THE CHAIRMAN: Sorry, doctor. I have a fairly clear picture
19 between yesterday afternoon and today that when an event
20 like this happens, to take this event, when Adam dies in
21 unexpected circumstances, to put it neutrally, there is
22 a report made to Dr Murnaghan --
23 A. Yes.
24 THE CHAIRMAN: -- who's in charge of medical administration.
25 He, in effect, takes charge.

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

1 a position to respond immediately, which the rest of us
2 who were doing clinical work wouldn't, was Dr Murnaghan.
3 So the sensible thing, in a way, was the way it was set
4 up.
5 THE CHAIRMAN: And you are free to go to speak to Ian Carson
6 or you're free to speak to anyone else if you want?
7 A. Absolutely. Ian Carson was an anaesthetist as well and
8 a very close friend, so I would certainly not feel in
9 any way inhibited about speaking to him.
10 MS ANYADIKE-DANES: Can we just deal with after you had had
11 your discussion with Dr Taylor, at some point, although
12 I don't think you said that you could remember exactly,
13 at some point you go and seek or suggest that Dr Gibson
14 is brought in?
15 A. Yes. That was, I think, quite soon after the incident,
16 I think.
17 Q. Have you already had any discussions with Dr Murnaghan
18 at that stage?
19 A. I can't remember. I don't remember.
20 Q. Well --
21 A. I would have had some discussion as to why he felt that
22 we should do that and the fact that the coroner had
23 identified these three cases, so in that sense there
24 would have been -- and it would have been prior to
25 meeting Dr Gibson, yes.

1 Q. Is it you who recommends Dr Gibson?
2 A. Yes.
3 Q. Can I pull up one of Dr Taylor's witness statements.
4 008/3, page 43? It says there in answer to question
5 119:
6 "I would have reported to Dr Gaston and Dr Murnaghan
7 in relation to the inquest following Adam's death."
8 And then:
9 "State whether you were required to: (i) formally
10 report Adam's death and the circumstances thereof;
11 and/or (ii) explain what happened to Adam to a senior
12 manager or clinician within the Trust. If so, state to
13 whom and when you reported it."
14 He says:
15 "I reported to Dr Gaston and Dr Murnaghan
16 in relation to the inquest following Adam's death."
17 Then in relation to the nature of the
18 report/explanation he says:
19 "The deposition to the coroner."
20 I want to pull something up and perhaps you can help
21 me as to whether you actually saw this: 011-002-003.
22 This is written from Dr Taylor to Dr Murnaghan on
23 30 November -- it's dated 30 November. This provided
24 the basis for his deposition to the coroner; did you see
25 this?

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

1 Dr Gibson. Was I involved in that discussion? I can't
2 remember.
3 Q. So if I can take you then to what might have -- I'm so
4 sorry, can we go over the page? It looks like you did
5 get it, "cc Dr Gaston".
6 A. I obviously did get it. I'm not sure of the time frame.
7 As I say, I do not remember this document, but ...
8 Q. If it's cc'd, are you likely to have got it?
9 A. Oh yes.
10 Q. Then --
11 THE CHAIRMAN: It would make sense for Dr Taylor to send it
12 to you?
13 A. Absolutely.
14 THE CHAIRMAN: Yes.
15 MS ANYADIKE-DANES: This is what's going to form the basis
16 of his statement to the coroner. Let's see whether he
17 addresses the things that he raised with you as
18 concerns. Let's go back to the first page.
19 THE CHAIRMAN: Can we put the two pages up, please?
20 MS ANYADIKE-DANES: Thank you very much, chairman.
21 So the first paragraph, he's describing the general
22 anaesthetic:
23 "He was in polyuric renal failure [the date of
24 admission] ...made aware of his perioperative problems
25 of fluid administration. Usually received night feeds.

1 Couldn't be given two hours prior to surgery.
2 Encountered no difficulties following his arrival in
3 theatre, accompanied by his mother."
4 It gives his weight:
5 "General anaesthesia induced uneventfully."
6 Then:
7 "IV access, arterial access and a central venous
8 catheter all placed without undue difficulty. Lumbar
9 epidural. Administered IV fluids as usual, calculated
10 to correct his fluid deficit, to supply his maintenance
11 and replace operative losses."
12 Then it says what he gave him and how much.
13 It totals over 4 hours, so you don't get an
14 appreciation of the rate, which of course you would get
15 if you looked at the anaesthetic record, but in any
16 event, over 4 hours. Then:
17 "There was a substantial ongoing blood loss from the
18 surgery. Packed red blood cells were given."
19 It gives his haemoglobin. The nurse is asked to
20 weigh the blood soaked swabs. Then it says how much
21 blood he indicates was lost in the swabs, how much
22 in the suction bottle and an unknown amount in the
23 towels and drapes. And it gives what the total loss he
24 estimated to be was and how he replaced that and:
25 "The infusion of fluids was titrated against CVP and

1 BP to ensure that the blood volume was more than
2 adequate and at maximum perfusion for the donor kidney."
3 Then it refers to the low-dose dopamine infusion:
4 "Pulse rate, CVP and arterial blood pressure gave me
5 no cause for concern throughout the case and a blood gas
6 at 9.30 confirmed good oxygenation."
7 Of course, if one had looked at his records, one
8 would know that he also had, with that blood gas report,
9 he had a serum sodium level of 123.
10 "In view of the CVP, heart rate and BP, I did not
11 consider the fluids to be either excessive or
12 restrictive. Indeed, I regarded the fluids to be
13 appropriate and discussed this with the other doctors
14 present in the theatre. At the end of the case,
15 I reversed the neuromuscular block. I anticipated the
16 child waking. No sign of this. I examined the pupils
17 and found them to be fixed and dilated. Extremely
18 concerned that he had suffered brainstem injury.
19 Transferred him to paediatric intensive care."
20 Then he was on hyperventilation and mannitol:
21 "IV fluids restricted. Spoke with Dr Savage, spoke
22 to Adam's mother, offered her my sympathy for the loss
23 of her child. Could not supply her with a clear
24 explanation. Accompanied Adam to the CT scan room later
25 in the day. Informed by the neuroradiologist that

1 he had gross cerebral oedema and herniation of his
2 brain. Extremely perplexed and concerned that this
3 happened to Adam and cannot offer a physiological
4 explanation for such severe pulmonary and cerebral
5 oedema in the presence of normal monitoring signs.
6 Did that, as a description of what happened, accord
7 with what Dr Taylor had told you when he came to see
8 you?
9 A. No, it doesn't entirely. As I remember it, it doesn't.
10 As I remember what Dr Taylor spoke to me -- it doesn't
11 entirely, no.
12 Q. When you received that, what was your reaction?
13 A. I don't remember. I don't remember my reaction to it.
14 I'm only realising now as you put this up that actually
15 I have seen this at some point. I did see this.
16 I couldn't remember. But I have seen it.
17 Q. What do you think your reaction should have been, given
18 that it doesn't accord with what Dr Taylor told you?
19 A. My reaction would have been, as I think I did, which was
20 to broaden the input of information, which was why I --
21 if and I'm not sure that this was -- this may well have
22 been prior to Dr Gibson, I don't remember. Dr Gibson
23 was brought in because, again, this wasn't my area of
24 expertise. And secondly, we had then asked Dr Sumner to
25 become involved.

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

1 A. I did not feel that I was in a position -- I would not
2 have felt I was in a position to actually take that
3 further. I had one set of things that Bob talked
4 through with me. I had this. I think at that point in
5 time I would have felt that this needed to be discussed
6 at a further meeting, which would have been part of the
7 investigation.
8 Q. Well, did you raise with anybody that, "This actually
9 isn't quite how Bob Taylor put it to me when he was
10 explaining matters to me"?
11 A. I don't know.
12 Q. Well, do you think you should have done that?
13 A. I might well have been. I don't know. I can't answer
14 that at this moment in time.
15 Q. Do you think you should have?
16 A. I should have, yes.
17 Q. Yes.
18 A. Did I? I don't know.
19 Q. I understand that. If you had appreciated that this was
20 going to go forward as a statement to the coroner, what
21 do you think your response should have been?
22 A. Well, first of all, I don't know that that hadn't gone
23 to the coroner first. I don't know that.
24 Q. Then if you had thought it had gone to the coroner, what
25 do you think your response should have been?

1 A. My response would have been to -- there were clearly
2 some issues that were in conflict from what I had. I do
3 not feel that at that point in time I had the expertise
4 on that particular area to come down and say what were
5 the issues that needed --
6 Q. These are just factual differences. Just factual
7 differences.
8 A. There were factual differences, but in terms of someone
9 who has come distressed, at that point in time, my
10 conversation with Dr Taylor would have been in
11 a somewhat more informal way than this because he was
12 a distressed person and we were talking through in broad
13 outlines what were the challenges that you saw in this
14 case --
15 Q. Yes, but --
16 A. -- and then he has put this letter in.
17 Q. Absolutely. But he says nothing --
18 MR UBEROI: Can I rise at this stage? Because my
19 recollection of the witness's evidence yesterday was
20 that, firstly, he couldn't remember the meeting with
21 Dr Taylor, but secondly to the extent that he was trying
22 to assist by speculating as to what would have been
23 said, Dr Taylor was effectively racking his brains going
24 through what happened in the surgery and was unable to
25 explain what had gone wrong, which is in fact exactly

1 what he's doing in this letter.
2 THE CHAIRMAN: Well, Dr Gaston also said yesterday that some
3 of the conversation which he had with Dr Taylor, he
4 thinks was him prompting Dr Taylor. I think he used the
5 word "prompted" yesterday in relation to that
6 conversation.
7 The difficulty, Mr Uberoi, is this. We will come to
8 it I'm sure very, very soon, because we have a child
9 who's died unexpectedly. We have Dr Taylor being upset
10 and distressed about that, and of course that doesn't
11 mean it's his fault. You can be distressed and upset
12 because some event has happened even if you're not to
13 blame for it.
14 MR UBEROI: Of course.
15 THE CHAIRMAN: But Dr Gaston has said this morning that in
16 this scenario, one of the things that immediately
17 springs to mind because it's happened to him himself
18 is: were there mistakes with the anaesthetic? Right?
19 So it must be one of the issues to look at is: did
20 Dr Taylor do something wrong? And you also said before
21 the break this morning, doctor, that when you were asked
22 by Ms Anyadike-Danes -- it's on today's transcript at
23 the bottom of page 22 and into page 23:
24 "Could you have looked at the records and come to
25 the view that whatever happened to Adam couldn't somehow

1 involve the conduct of the anaesthetist?"
2 And your answer to that was:
3 "Absolutely not."
4 A. I think once you have a death in this situation, I don't
5 think you can come to the conclusion early on exactly
6 who was responsible. And I think that -- when I say --
7 but one thing you can be -- it will be in the
8 equation -- is the possibility that the anaesthetic or
9 the anaesthetist contributed in some way. That has to
10 be something that is in the discussion.
11 THE CHAIRMAN: We need to clarify this because I understood
12 the answer you gave earlier on to go somewhat further
13 than that. You were asked by Ms Anyadike-Danes:
14 "Could you have looked at the records and come to
15 the view that whatever happened to Adam could not
16 somehow involve the conduct of the anaesthetist?"
17 And you said:
18 "Absolutely not."
19 And I understood that to mean that when you look at
20 the records and when you see how much fluid is given,
21 you must conclude that what happened to Adam somehow
22 involved Dr Taylor. There's been a bit of toing and
23 froing about when you first saw the records.
24 A. Sure.
25 THE CHAIRMAN: But as I picked up your answer earlier, once

1 you look at the records, there is a real concern about
2 whether Dr Taylor has made mistakes; is that not right?
3 A. I'd like to clarify that because I think what -- there
4 are two points. The first is that once a child dies in
5 theatre, anaesthesia has to be in the frame.
6 THE CHAIRMAN: Right. And that's --
7 A. That's just a general comment. The second one is ...
8 THE CHAIRMAN: If your second point comes back to you,
9 great, but my second point was going to be --
10 A. It's going back to what you said actually.
11 THE CHAIRMAN: My second point is if you then think that it
12 may involve the anaesthetist, then at some point fairly
13 early on in the investigation, you look at the
14 anaesthetic record.
15 A. Yes.
16 THE CHAIRMAN: And if you look at the anaesthetic record in
17 Adam's case, your concerns that this may have something
18 to do with the anaesthetist must increase.
19 A. That is, I think, the one thing that was clear
20 throughout this case, until certainly Dr Sumner's
21 evidence, and that was that there was a debate about
22 what was the appropriate fluid balance. And that was
23 something which would have come up at the -- some of the
24 meetings. So there was some debate of which I wasn't in
25 a position to be -- not at that point, but at some point

1 there was. I felt I would have -- I would have felt
2 that this was something that was an area that was open
3 to some debate because -- and I go back to the fact that
4 he has -- that he had said to me and [inaudible] here
5 was the fact that there were contributory factors that
6 made it difficult for him to assess the fluid balance.
7 THE CHAIRMAN: Okay.
8 A. And I think that is actually -- that was partly in
9 prompting with him and talking through the case.
10 I think that then developed at a later stage whenever --
11 at the later stage in the investigation, during
12 discussions, that was an issue that came up.
13 THE CHAIRMAN: Okay. If you just pause for a moment.
14 Mr Uberoi?
15 MR UBEROI: I entirely understand why that general issue is
16 being pursued and the specific question of when the
17 record was seen is being pursued. The point I was
18 making was more focused on the characterisation of the
19 content to the best of the witness's recollection of the
20 oral conversation, set against the content of this
21 letter. Because my note about the content of the oral
22 conversation is -- I think it was about the challenges
23 that he met:
24 "High output renal failure, the fact that
25 [Adam Strain] was polyuric, issues around the CVP,

1 [et cetera]."
2 And then moving on to basically conclude that
3 Dr Taylor, going through these checklists, couldn't
4 actually fathom what had gone wrong. So the point of my
5 interjection was to point out that that is in fact what
6 he's doing in this letter.
7 MS ANYADIKE-DANES: Well, Mr Chairman, it'll be --
8 THE CHAIRMAN: Up to a point.
9 MS ANYADIKE-DANES: It'll be a matter for you to determine.
10 What I was seeking to develop, and I must say I hadn't
11 appreciated that the witness would have the feeling that
12 this letter could actually have gone and then he might
13 have had the rest of the discussions but pulled together
14 those half a dozen matters, or --
15 A. I --
16 Q. If I may just conclude -- that caused Dr Taylor concern.
17 My only question is at some point in time when he did
18 have a number of matters from Dr Taylor that caused
19 Dr Taylor concern, and in fact when I asked him about
20 that, because I was anticipating that Dr Gaston may not
21 recollect these things accurately, and it's at page 130,
22 I say:
23 "Question: Do you recollect what they were? I'm
24 not asking you to recollect the terms he used or even
25 all of them, but do you recollect what they were?

1 "Answer: I do recollect them because I think
2 I would have made these points."
3 I appreciate that maybe they didn't all come in the
4 first conversation, although you did say that you only
5 had one conversation with Dr Taylor.
6 A. I think I had only one one-to-one conversation with
7 Dr Taylor. I think that's true.
8 Q. Right. So if these matters are being raised and you're
9 hearing them from Dr Taylor, it's all happening in that
10 one conversation. And my only point is at whichever
11 time you see the letter that was just up -- maybe we can
12 pull it back up again in the two pages side by side. At
13 whatever point you see that, you would appreciate that
14 the terms of that letter do not entirely -- and I think
15 you yourself fairly said so -- accord with the points
16 that were being canvassed with you or you were teasing
17 out as having caused Dr Taylor difficulties.
18 A. Yes.
19 Q. If you read that, you wouldn't, for example, have any
20 appreciation that the CVP might have caused anybody any
21 difficulty because that's not expressed there in any
22 way.
23 A. No, but it was expressed at --
24 Q. I entirely appreciate that. Nor would you have
25 appreciated that, for example, there was a potential

1 problem with the extent of irrigation fluid because that
2 just doesn't feature there at all.
3 A. I think he does mention that there were difficulties in
4 here in terms of assessing blood loss and part of it was
5 the fact that the drapes were soaked, that there were --
6 and there were issues as to why the drapes were soaked.
7 Part of your assessment of blood loss would have been
8 looking and -- and fluid loss, would have been what were
9 in the drapes ... So part of his assessment that there
10 were higher levels of irrigation fluid -- and I think
11 this came out a little bit more at a later date -- was
12 actually not just the bottles, but there would have been
13 thing like drapes being -- which I now see here and I'm
14 coming -- I apologise. My memory of this -- it's
15 obviously a very long time ago and I may not be
16 absolutely certain of what event occurred at what time.
17 Q. No, that's entirely to be understood, except for what he
18 seems to be talking about on the second page is all to
19 do with blood and his calculation of blood and how
20 heavily soaked he thought the towels and so forth were.
21 But leaving that point aside, of the matters that
22 you described to us, and if one takes the CVP, which was
23 a very important one, and you have explained why the CVP
24 would be such an important matter, that is not raised at
25 all. In fact, if you read where he talks about it, it's

1 over on the second page, he says:

2 "The pulse rate, CVP and arterial blood pressure

3 gave me no cause for concern throughout the case."

4 A. I can't answer why that statement was in there. But

5 it's certainly my understanding that there had been

6 an issue with the CVP.

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

8 THE CHAIRMAN: The very last line is:

9 "In the presence of normal monitoring signs."

10 MS ANYADIKE-DANES: Exactly, Mr Chairman.

11 THE CHAIRMAN: And if there's one thing that's absolutely

12 clear, it's that there were not normal monitoring signs

13 in Dr Taylor's or Dr O'Connor's evidence.

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

15 sorry.

16 THE CHAIRMAN: It's not just that it's not in that letter.

17 The very last line of that letter says that what were

18 present were normal monitoring signs. You were being

19 told something quite different, weren't you?

20 A. Not about the monitoring signs, but I certainly had the

21 perception from Dr Taylor, from what I remember of that

22 conversation, that it had been challenging. And some of

23 the areas that were challenging were around the CV

24 [sic], were around the fluid loss, were around the fact

25 that the surgery took longer. To what extent my

1 prompting as we went through that conversation would
2 have been, I don't know.
3 THE CHAIRMAN: The CVP -- well, even if you prompted the
4 CVP, it's a point which Dr Taylor made, and it's also
5 a point that Dr O'Connor found when she arrived in
6 towards the end of the operation. She saw the CVP
7 readings were askew and she was given an explanation for
8 that by Dr Taylor, which she accepted. There's endless
9 further debates about that, but the one thing which is
10 clear, relatively clear from the evidence, is that there
11 was not a normal monitoring sign from the CVP. But that
12 letter, written by Dr Taylor to Dr Murnaghan, says that
13 there was in terms.
14 A. I'm sorry, I can't comment on the conflict of what
15 I remember of the conversation with Dr -- and what's on
16 there, I'm sorry.
17 MS ANYADIKE-DANES: That I understand. My question to you
18 is: what should you have done about it when you
19 appreciated that discrepancy, particularly when you gave
20 evidence that you might actually have been seeing that
21 letter once it had already gone to the coroner?
22 A. Basically, I think I would have wanted these things to
23 come out in a discussion, at a further discussion,
24 because there were issues there which would have
25 involved the surgical opinion with regard to that.

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

1 I would have had opinions, but the person who would be
2 leading the investigations is Dr Murnaghan. So in
3 a sense, all of this information would have come out in
4 those debates or in these discussions. So that's when
5 I would have felt that actually, a lot of these
6 conflicts of evidence would have come out.
7 Q. Okay. Well, the first thing that gets done, so far as
8 you seem to recall, is that -- not necessarily the first
9 thing that gets done, but a thing that gets done -- is
10 that Dr Gibson is brought in to go and have a look at
11 the anaesthetic equipment, consider the anaesthetic and
12 Mr Wilson and Mr McLaughlin are also brought in; is that
13 right?
14 A. That's right.
15 Q. You have said in your witness statement that you would
16 have been aware of PEL9336. That is 210-003-1132.
17 MR SIMPSON: [Inaudible: no microphone] and it's this: when
18 the letter was first addressed, only the first page was
19 put up. And we spent a couple of minutes back and
20 forward with Dr Gaston: do you remember receiving this,
21 I don't know, if you did get it, when did you get it.
22 It's most unfair to the witness when over the next page
23 is the CC to Dr Gaston, which my learned friend must
24 have known about. This type of ambush questioning, in
25 my respectful submission, is neither fair nor helpful to

1 the witness. If the letter had been put in its full
2 extent, then there would be none of this nonsense, I
3 respectfully say, about, "When did you get it? Did you
4 get it? I don't remember", and that is not fair to
5 a witness who's having clear difficulties remembering
6 contemporaneous events.
7 MS ANYADIKE-DANES: Firstly, Mr Chairman, I apologise. It
8 certainly wasn't intended to be an ambush. In fact, I
9 wasn't going to come to that letter at that time. I
10 only came to it because of something that Dr Gaston said
11 and I didn't actually have my own hard copy to
12 appreciate that that was that letter. There were
13 a number of letters that were written at that time and
14 I'm not aware of all of them or where their ccs went to.
15 So I apologise. There was no intention whatsoever to
16 confuse or mislead and certainly not to ambush
17 Dr Gaston.
18 MR SIMPSON: I absolve my learned friend of any deliberate
19 intent, but if that kind of situation arises
20 [OVERSPEAKING].
21 MS ANYADIKE-DANES: We will try and do better. I will try
22 and do better.
23 A. I think it is. And I can't stress this enough: for me,
24 having been out of anaesthesia since 2004, completely
25 out of medicine in every aspect from 2008, trying to

1 remember these things accurately, and I have difficulty.
2 THE CHAIRMAN: Doctor, I accept that, but I should also say,
3 even if you were still involved, I'm not sure how easy
4 it is for you to remember the events of 1995 and 1996.
5 A. Quite.
6 THE CHAIRMAN: It is a long time ago.
7 A. Yes.
8 THE CHAIRMAN: There's a general caution I have about the
9 evidence, which is that people are doing their best to
10 remember what happened 15 and 16 years ago, 17 years
11 ago, and that some of these documents will jog your
12 memory and some of them will not at all.
13 A. Yes. This one did jog my memory.
14 THE CHAIRMAN: We'll do the best we can.
15 MS ANYADIKE-DANES: This is not the right reference, it's
16 210-003-1132. That's dated 27 July 1994. It's
17 "Reporting of adverse incidents and reactions and
18 defective products" and so on. But anyway, when you
19 were asked in your witness statement request whether you
20 were aware of this document, you said at witness
21 statement 013/2, page 5:
22 "I would have been aware of PEL9336 since the
23 information was wildly publicised at the time."
24 Would you accept that?
25 A. Yes. Can I clarify that slightly?

1 Q. Yes.

2 A. In that I wouldn't necessarily have been aware that it
3 was called PEL9336, but I was aware. And as I said
4 yesterday, those critical incident recordings had been
5 a key element in us identifying several areas where
6 we were at risk.

7 Q. Thank you. So then if we just look at this:
8 "General managers and chief executives are
9 responsible for ensuring prompt reporting of adverse
10 incidents and reactions and defective products relating
11 to medical --"
12 That's the only bit that we are interested in. If
13 we go down to "Action":
14 "Adverse incidents, reactions and defective products
15 are reported promptly."
16 Over the page to 1133:
17 "For medical devices, a liaison offer officer is
18 appointed at facility level to take the responsibility
19 for reporting."
20 Then if one goes down, one sees annex C:
21 "Reports relating to all medical devices, equipment,
22 hospital laboratory equipment and medical supplies."
23 That's a particular annex that deals with that. If
24 we go over the page to 1134, we see, I think it's the
25 second sentence of the first paragraph:

1 "Every Health and Personal Social Services employee
2 has a duty to see that all safety-related incidents and
3 potentially harmful products are reported, even if on
4 suspicion only. Adverse incidents occurring in local
5 units may often have implications for the rest of the
6 HPSS."
7 Annex C, which occurs at 1139, there we are:
8 "Reportable cases. Adverse incidents in medical
9 devices may arise due to shortcomings in the device
10 itself, user practice, device service, maintenance,
11 modifications or adjustments, management procedures,
12 instructions for use or environmental conditions. You
13 should report if a device is involved in one of the
14 following."
15 Not surprisingly, (a) is "death".
16 So did that, so far as you're concerned, mean that
17 given that there was no firm view as to what had
18 happened to Adam and why, at the conclusion of his
19 surgery, his pupils were found to be fixed and dilated,
20 but on the range of things that may have been
21 implicated, the anaesthetic equipment would be in there?
22 Would that be a fair way of putting it?
23 A. Yes.
24 Q. And does that mean that you would then have to be
25 reporting it?

1 A. No. Because I wasn't responsible for that area.
2 Q. I'm sorry. I beg your pardon.
3 A. Apologies. I wasn't responsible.
4 Q. No, no, it's my incorrect framing of the question. Not
5 you, it would have to be reported?
6 A. Yes, it would be, and I think that is raised by
7 Mr Jim Wilson in regard to -- and I didn't know the
8 piece of equipment, but it was a Siemens ventilator
9 which had a problem with the pins, not something that
10 I remember now. And he picked this up and actually said
11 in his report he was surprised that this had not been
12 actioned.
13 Q. Yes. Well, let's go to your witness statement, 013/1,
14 page 3. That is:
15 "I arranged for a report on the equipment used
16 during the operations in the theatres in RBHSC."
17 And the report was prepared by Mr McLaughlin and
18 Mr Wilson and Dr Gibson. We'll come to those references
19 for the report in a sec.
20 So that was you arranging for that to happen.
21 A. As to whether -- and I think this is actually unclear in
22 a number of the statements and I'm unclear, whether
23 I asked Mr Wilson and Mr McLaughlin to do that or
24 whether ... Certainly there were discussions between
25 Dr Murnaghan and I. I don't remember whether it was he

1 who would have gone ahead and asked the technicians and
2 said, "Dr Gaston, by the way, I've asked Mr Wilson and
3 Mr McLaughlin to do this in regard to the anaesthetic
4 equipment", or whether he said, "Would you mind speaking
5 to them?". I can't remember, actually, and my
6 appreciation is that there was may be some confusion.
7 Because the time frame is so far back, it is hard to
8 tell whether it was him asking first or me and
9 I personally don't know.
10 Q. Well, we can go to what Dr Murnaghan says about it. His
11 witness statement 015/2, page 3. That might clarify it.
12 It's the answer to (ii)(2)(c):
13 "Did you arrange for Dr Fiona Gibson to accompany
14 the medical technical officers and, if so, why? This
15 was done on the recommendation of Dr Gaston to ensure
16 that there was a consultant anaesthetic input to the
17 reporting requested by the coroner."
18 At that stage, the coroner had really only asked for
19 a report on the equipment. That's correct, isn't it?
20 A. That's what it says there. I can't comment.
21 Q. So your suggestion is: well, let's have Dr Gibson go
22 along with them.
23 THE CHAIRMAN: Sorry. First of all, do you accept that that
24 was your suggestion? Dr Murnaghan is saying that the
25 reason why Dr Gibson was involved was because you

1 suggested that she should be involved; is that right?
2 Do you agree with Dr Murnaghan on that or can't you
3 remember?
4 A. This would have been a discussion between Dr Murnaghan
5 and I as to what we did with regard to it.
6 The suggestion that I remember is that Dr Murnaghan had
7 suggested that we have an anaesthetist who would go.
8 I suggested that the most appropriate person within the
9 organisation and not working in the Children's Hospital
10 was Dr Gibson, and it was -- I think it was appropriate
11 that she would be there at the same time as the
12 technical people. That would be, I think, what
13 happened.
14 THE CHAIRMAN: So it's a combination of the two
15 [OVERSPEAKING]?
16 A. I think so. And as to what did what ... I'm not sure.
17 THE CHAIRMAN: It doesn't really matter because the two of
18 you agreed.
19 A. Absolutely.
20 THE CHAIRMAN: So [OVERSPEAKING].
21 A. I would have suggested Dr Gibson's name. That would
22 have come from me.
23 THE CHAIRMAN: Thank you.
24 MS ANYADIKE-DANES: And then if we go back to your witness
25 statement, WS013/1, page 3. Sorry, I thought this was

1 going to pull up the reference for the report that you
2 actually get. It's an 011 number. I beg your pardon.
3 It's an 059 number. 059-068-157.
4 This is the report that's actually produced by
5 Mr McLaughlin and Mr Wilson; is that correct?
6 A. That's right.
7 Q. Are they both of equal standing or is one in charge of
8 the other, if I can put it that way? Can you remember?
9 A. Again, this is slightly complicated.
10 Q. Right.
11 A. Dr Wilson or Mr Wilson was the most senior MTO or
12 technician in the hospital. But he was within the ATICS
13 directorate and Mr McLaughlin was the technician within
14 the cardiac directorate. And in terms of years of
15 experience, Mr Wilson would have been the most senior
16 one in terms of years, but they did not work in the same
17 directorate, and this goes back to the structure again.
18 One of the reasons that we would -- and I think this was
19 at my suggestion, was that I would have said to
20 Dr Murnaghan, "I think it's important that it's not just
21 from our directorate that this person comes, that
22 we have one from our directorate and we have one who
23 understands paediatric equipment", because that would
24 have been within the cardiac directorate.
25 So they were not in the same line management, they

1 were not in the same management structure at all.
2 I felt that that was actually adding value to the
3 information we got.
4 Q. You said in your witness statement, the second witness
5 statement at page 5, that you thought that they were
6 independent because they didn't work for the Children's
7 Hospital?
8 A. That's correct.
9 Q. But they're all employed by the same employer?
10 A. Yes, but these organisations were still, in a sense,
11 operating as separate -- there wasn't the
12 cross-integration that I think ... Maybe if you look
13 at the structure ... And that was particularly true
14 between the paediatric hospital and the Royal. The
15 paediatric hospital, I think, had been -- it was before
16 I came and I had never worked there at any time.
17 I think that the paediatric hospital would have been
18 largely a stand-alone unit and managed itself. It had
19 been integrated into the Royal Trust. Whenever services
20 are integrated, there is a sense in which they maintain
21 a certain degree of their own identity and that's one of
22 the challenges of bringing them together and this was
23 very early stages.
24 Q. Does that mean that the Children's Hospital was under
25 the paediatric directorate?

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

1 the paediatric hospital, but they wanted to maintain
2 their identity.
3 THE CHAIRMAN: Okay.
4 A. That didn't apply to surgery, to the best of my
5 knowledge. So surgery -- I think the surgeons in the
6 paediatric hospital were part of the paediatric
7 directorate. They were not part of the surgical
8 directorate.
9 MS ANYADIKE-DANES: You may not know the answer to this and,
10 in any event, we do have the benefit of
11 Professor Savage. But the Paediatric Renal Transplant
12 Service, which is the thing that is in issue here with
13 Adam, was that therefore -- given that that involves
14 surgery, anaesthesia by definition, and children, did
15 that come within the paediatric directorate or did that
16 in some way involve other directorates?
17 A. Within the Trust?
18 Q. Yes.
19 A. First of all, until this incident, I knew nothing about
20 the paediatric -- the transplant service. I didn't know
21 anything about it at all. This was completely new to
22 me. The only other areas where there would have been
23 some cross-involvement might have been, say, with
24 pathology. It certainly wouldn't have been with surgery
25 because my perception -- and I'm sure I'm right -- was

1 that the surgeons within the paediatric hospital, of
2 whom one would have been Mr Stephen Brown, he would have
3 been part -- in fact he had been, at some point,
4 clinical director of paediatrics. Whereas -- and
5 I didn't know him, but Mr Keane would have been part of
6 the surgical service of the City Hospital. And I don't
7 know what their structure was.
8 Q. That's all right, Dr Gaston, we'll take that up perhaps
9 with Professor Savage.
10 Anyway, you were saying that you regarded them as
11 being independent because they were from the Children's
12 Hospital, as it were, and not ATICS?
13 A. Yes. Absolutely.
14 Q. Let's have a look at this report; do you remember when
15 you saw it?
16 A. I don't remember when I saw it. I would have seen it
17 fairly early on, but I don't remember when.
18 Q. What did you understand by it when you did see it?
19 A. I understood ... Well, I'm seeing it now and I'm seeing
20 it -- and you know, what I understood with the report
21 was that barring this issue with the -- which I know is
22 not the Siemens but the ... I'm not sure. Barring that
23 one incident, which would have been reported, I presume,
24 to the paediatric directorate and the paediatric
25 service --

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

1 I think that's again a -- I will try to clarify that
2 actually. It didn't maybe come through in what I said
3 yesterday. ATICS had responsibility I think for 13
4 operating theatres, which were based in what was
5 A block, which were based on main theatre block, which
6 were based in the eyes and ENT clinic. The
7 responsibility for the purchase and maintenance,
8 et cetera, of equipment in maternity and dental and the
9 paediatric directorate and the cardiac directorate was
10 the responsibility of those directorates.
11 Q. I understand.
12 A. Now, we would have worked quite closely with maternity
13 and the paediatric directorate -- sorry, maternity and
14 dental. We would have actually worked quite closely.
15 They had the responsibility. They decided what money
16 could be spent, but we would have been involved with
17 them and advised with [sic] them. The only role that
18 we would have had -- and it wasn't a role as part of
19 ATICS management -- is that some of our anaesthetists --
20 and Dr Peter Crean, probably -- would have been the
21 person most ... They would have been involved in
22 assisting the paediatric directorate purchase the
23 equipment, service the equipment and follow up, and they
24 had their own technical service to do that. And same
25 with cardiac; cardiac was completely separate. We had

1 nothing to do with that. Sorry, that might not have
2 been clear yesterday.
3 Q. I'm sure I didn't pick it up properly, but I understand
4 now. But in any event, you did get this at some point
5 and what you would have seen by the fourth paragraph
6 in relation to the Siemens patient monitor --
7 A. That's the one I was talking about yesterday.
8 Q. This isn't the pin point; this is a different point.
9 This point is that this monitor is currently out for
10 repair. A new display screen is being fitted, so the
11 monitor that was actually used for Adam's surgery is not
12 the monitor that is being inspected.
13 A. That would appear from that report, yes.
14 Q. And it would seem that Mr Wilson and Mr McLaughlin are
15 only looking at things from the perspective of Adam? In
16 their evidence, they don't appreciate that there are two
17 other cases.
18 A. I can't answer that now. I'd be very surprised if that
19 was true given the remit that they went with.
20 Q. Yes. We will go to their witness statements if we have
21 to to show it. But in any event, when you read this,
22 you would appreciate that whatever else they were
23 looking at and were being satisfied about, they couldn't
24 be satisfied about the performance of the Siemens
25 patient monitor because they are not looking at the

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

1 management and they had nothing to do with the technical
2 service in the paediatric -- or they may have met them.
3 I mean, one of the things that did happen is that in
4 terms of their own continuing professional development,
5 et cetera, I think as a group they would have met. But
6 as an organisation and as an operating -- they were
7 completely separate operating units.
8 MS ANYADIKE-DANES: So at some point you would have got this
9 report and Dr Gibson's report?
10 A. I would have done, yes.
11 Q. Did you feel, when you got those reports, that you now
12 had a clear view of the anaesthetic equipment position?
13 A. Well, I presume I did, but I don't know. This report
14 actually, I think, went back to Dr Murnaghan and I think
15 I -- I'm certain I got it actually. I probably got
16 a CC, even though it doesn't say that. That's where
17 I would imagine I got that. I certainly -- looking at
18 it now, I remember this report and I don't remember,
19 I must admit, the issue around the Siemens monitor,
20 actually. I don't remember that at all.
21 Q. Okay.
22 A. But I clearly see it now. I certainly didn't know
23 that --
24 Q. If it's any help, Dr Gibson doesn't appear to have
25 picked it up either. If we go to 059 --

1 A. It may well have been that that wasn't picked up at the
2 time and I have a ... It may well be that this was
3 information that came after they had done their visit.
4 It may possibly be.
5 Q. Sorry?
6 A. It is may be a possibility -- and thinking back now,
7 again, my memory's being triggered a little bit by it --
8 that the issue -- the reason they didn't see it at the
9 time was that they were unaware that that was the other
10 monitor and was not the monitor that had been used in
11 Adam's case or -- yes, I think, Adam's case -- and that
12 it had been returned to Siemens to correct problems.
13 Q. I understand you're doing your best with recollecting
14 something. If you weren't directly involved in that,
15 then it may not be helpful for you to try and speculate
16 on that. We do have the witness statements of
17 Mr McLaughlin and Mr Wilson. They seem, by their
18 report, to have been aware at the time that they weren't
19 looking at the relevant Siemens monitor. If one pulls
20 up their witness statements very, very quickly, it's
21 witness statement 110/2, page 8. This is the second
22 witness statement and if one looks at (j), just above
23 question 21. This was a point I had asked you before
24 and you said you would be surprised:
25 "Were you investigating more than one incident?

1 I was asked to check equipment and was not aware of the
2 incident or if there was more than one incident. My
3 role was to verify that the equipment was functioning
4 correctly."
5 That's what he said that he was asked to do. And
6 he was simply, it would appear, noting -- although how
7 he knew what the given day was -- that was not the same
8 monitor.
9 A. I would have taken from his statement that they were
10 asked to look at -- and I suspect they were asked to
11 look at the equipment in all the paediatric theatres.
12 And I would suspect that might well have been the case.
13 Q. Well, we certainly haven't received anything to that
14 effect.
15 A. Sure.
16 Q. But in any event, what I was asking you is, at whichever
17 point it came to you, you got those two reports.
18 Whether you now thought you had a clear picture on the
19 anaesthesia -- and I think you said you thought you
20 had -- did you consider that Dr Gibson's report was an
21 adequate report for your purposes?
22 A. That initial report, I did, yes.
23 Q. We'll look at 059-069-162:
24 "High degree of vigilance. Found nothing at fault
25 in relation to the cases in question."

1 Well, if the monitor is not there to be viewed and
2 that's something that the technicians themselves can
3 see, then it's -- doesn't that call into question
4 whether you can know whether the monitor was functioning
5 appropriately in any of those cases?
6 A. First of all, you have to make the premise that that
7 monitor was -- that same monitor was used for all three
8 cases, which I don't think was the case. In fact,
9 I think that was [inaudible].
10 THE CHAIRMAN: That's what makes it worse, doesn't it?
11 A. In terms of?
12 THE CHAIRMAN: Does anybody really know what monitor they're
13 talking about?
14 A. Well, that would have been the link that Mr --
15 THE CHAIRMAN: You see, the monitor which was out, it wasn't
16 out for service, it was out for repair according to the
17 technical report.
18 A. That's right.
19 THE CHAIRMAN: So it's out for repair because there is
20 something wrong with it.
21 A. Yes.
22 THE CHAIRMAN: So how then is Dr Gibson reliably telling you
23 that:
24 "The technical checks demonstrated a high degree of
25 vigilance and found nothing at fault in relation to the

1 cases in question."

2 When the monitor which was used in Adam's case is

3 out to be fixed?

4 A. I just don't have the memory to be absolutely -- to

5 clarify that point.

6 THE CHAIRMAN: Well --

7 A. I can see --

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

9 A. That?

10 THE CHAIRMAN: That you can say there was nothing at fault

11 found in relation to the cases in question when the

12 monitor, the Siemens monitor used in Adam's case, is out

13 for repair.

14 A. I think it might be useful for my memory to look at

15 Dr Gibson's report. Does she mention the monitor at

16 all?

17 THE CHAIRMAN: This is her report.

18 A. Right, sorry.

19 THE CHAIRMAN: The bit that's highlighted in yellow is the

20 technical checks. She's saying in the previous

21 paragraph it was Messrs Wilson and McLaughlin who

22 carried out the checks on the equipment. She then says:

23 "The technical checks demonstrated a high degree of

24 vigilance in this area and found nothing at fault

25 in relation to the cases in question."

1 We now know, because we've just looked at it, that
2 the Siemens monitor which was used during Adam's
3 operation was out to be fixed. Not to be serviced, but
4 to be repaired.
5 A. I have no memory of the details in regard to this.
6 THE CHAIRMAN: Okay.
7 A. And I have no knowledge now as to whether Dr Gibson knew
8 that.
9 MS ANYADIKE-DANES: I understand. If we just stay with her
10 report there, the bit that we can see is the only bit
11 that's really relevant to us, which is Adam's case that
12 she summarises. It says pretty much along the lines
13 that the chairman read out in Dr Taylor's letter:
14 "Full records of all monitored parameters are
15 available on this case and show that no untoward episode
16 took place and that a very stable anaesthetic was
17 given."
18 One way of reading that is if you looked at the
19 records, you wouldn't able to tell anything was amiss,
20 but two things follow from that. One -- and we're going
21 to look at it now -- his anaesthetic record. The
22 inquiry's experts -- and not just the inquiry's experts
23 but the nephrologist at the time, Professor Savage and
24 Dr O'Connor -- were all able to conclude that something
25 was awry in relation to the amount of low-sodium fluid

1 that was administered. That can be seen from the
2 records. But apart from anything else, you know --
3 because he has told you about it -- that he had
4 a concern about the CVP.
5 A. Surely.
6 Q. There is a compressed trace of the CVP which shows its
7 high levels and you have seen that. At least, I think
8 the documents indicate that you have seen it. That's
9 not a normal parameter. At least, that's the evidence
10 that the inquiry has received. So when you saw this and
11 you have just described that as you thought that was an
12 appropriate report, now you think about it, was it
13 appropriate?
14 A. I can't answer now.
15 Q. Well, this report was being prepared to go on, I think
16 you accepted, "To whom it may concern". Given that the
17 coroner is involved at such an early stage, very likely
18 to the coroner because, apart from anything else, he
19 wants the equipment to be examined.
20 A. Surely.
21 Q. So this report is going to the coroner. Dr Taylor's
22 statement, in some shape or form, is going to the
23 coroner. None of this really seems to square with what
24 you had been told or recollect being told by Dr Taylor
25 about some of the concerns and I am simply asking you

1 what you think your responsibility was.
2 A. My responsibility would have been pulling that all
3 together. I don't remember doing that, but I -- you
4 know, that would be what I would normally do. I would
5 have actually seen if there were discrepancies.
6 Dr Gibson had been chosen because she was a pretty
7 forthright anaesthetist and I would have -- she had
8 a lot of detailed knowledge. So that then -- and then
9 what became apparent in the -- whenever these came to
10 the discussions was that there were some differences of
11 opinion with regard to all of this. That was why I felt
12 that we did need, at that point -- we certainly needed,
13 before the coroner's inquest, we needed further expert
14 opinion.
15 Q. Yes, you have said that. When you say "differences of
16 opinion", do you mean there were differences of opinion
17 or differences as to some of the basic facts as to what
18 had happened?
19 A. I think there were some differences of opinion, say,
20 with regard to the fluid loss, differences of opinion
21 with regard to blood loss, differences of opinion in
22 terms of the significance of the drapes, the wet drapes.
23 Those were areas where there was some significant
24 opinion. I don't remember individual meetings in
25 detail. I don't remember when they occurred and I don't

1 remember if there was more than one, but the one thing
2 that was apparent to me was that there were some
3 differences of opinion among the people who had managed
4 this case as to how it had gone.
5 THE CHAIRMAN: Well, let's develop that because I think
6 we're moving on past Dr Gibson's report and the
7 technical report and the differences of opinion, as
8 I understand it, are what leads you and Dr Lyons to
9 suggest to Mr Leckey that he should bring in somebody
10 who turns out to be Dr Sumner.
11 A. That's right.
12 THE CHAIRMAN: Then, in terms of input into these internal
13 differences, I fully understand why you can't remember
14 how many meetings there were, who was at them and so on,
15 but when you talk about differences of opinion, do you
16 remember, for instance, was Dr Savage one of the people
17 who had an input, did Dr Taylor have an input? Who had
18 an input?
19 A. I remember at various times the surgeon having an input.
20 When I say "various", I remember on one occasion
21 definitely the surgeon had input. I know there was
22 some, say, disagreement about blood loss, as there would
23 be between surgeons and anaesthetists. It's a pretty
24 standard thing.
25 THE CHAIRMAN: When you say "the surgeon", who are you

1 referring to?

2 A. I am referring to Mr Keane. Is that his name? The

3 transplant surgeon who I had never met before that.

4 There was some difference of opinion. He felt it had

5 been more straightforward than had been suggested.

6 MS ANYADIKE-DANES: Who was he differing with?

7 A. It would have been with Dr Taylor. The things that

8 Dr Taylor had mentioned to me during the meeting,

9 I raised those or actually I felt that those needed to

10 be clarified. So those were raised and there was

11 differences of opinion with regard to the blood loss.

12 There was [sic] differences of opinion in terms of

13 things like irrigation. It was important these were

14 discussed. So I would have prompted, because I knew

15 that, and there would have been differences of opinion

16 as to whether this was a longer surgical operation than

17 normal.

18 Those would have been issues that would have been --

19 that, say, we would have either -- Dr Taylor would have

20 issued or I would have raised and said: was there more

21 of this or this particular --

22 Q. And who else would have been there? Would you have

23 brought in Mr Brown, for example? He was a senior

24 surgeon.

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

1 they were going ahead. I don't -- I can't answer
2 whether Mr Brown was at any of the meetings. The people
3 I remember who had been at some of the meetings would
4 have been Professor Savage, Mr Keane, certainly on one
5 occasion, and Dr Taylor and myself and Dr Murnaghan.
6 Those are the people that I remember, but there may have
7 been more.
8 THE CHAIRMAN: It makes sense, obviously, for Messrs Savage,
9 Keane and Taylor to be there because they were the
10 people who were most directly involved. Mr Brown you
11 can't remember. But --
12 A. There might have been someone from the paediatric
13 directorate. And I'm not -- I'm slightly confused as to
14 who was the clinical director of paediatrics at that
15 point in time. I'm not sure.
16 MS ANYADIKE-DANES: Conor Mulholland, I think, was acting.
17 A. I don't remember Dr Mulholland. I can't remember him
18 being at meetings, but that doesn't mean he wasn't.
19 Q. I appreciate that.
20 MR FORTUNE: Can we find out from Dr Gaston how many
21 meetings Professor Savage is said to have attended? And
22 if Dr Murnaghan was present, whether any notes still
23 exist or indeed whether Dr Gaston has any notes?
24 Because at some stage, sir, you're going to have to make
25 determinations of fact. And frankly, it is a matter

1 entirely for you. You may ask yourself: am I being
2 assisted by this conspicuous lack of clear recollection?
3 THE CHAIRMAN: Well, I'm being assisted to the extent that
4 Dr Keane told us last month that he waited in the City
5 for the phone to ring and nobody rang him and he had no
6 input. And I'm now being told by Dr Gaston that whether
7 directly to Dr Gaston or through others, meetings he
8 isn't entirely sure who was at and when they were held,
9 but that Mr Keane did have an input.
10 A. I'm almost certain that -- I mean, I'm ... I feel
11 he was present at some -- at at least one of the
12 meetings. I'm pretty sure.
13 THE CHAIRMAN: Well, would you be pretty sure that you were
14 at that meeting, which is why you remember?
15 A. Yes. That's why I -- I mean, if I hadn't been there,
16 I wouldn't have had the ... Because I think that was
17 the first time I ever met Mr Keane. I didn't know him
18 at all. I'm not sure.
19 MS ANYADIKE-DANES: In fairness, Mr Chairman, although we
20 will get the reference for you, I think in his evidence
21 Mr Keane said that he -- it's either his evidence or his
22 witness statement. He believes he was at one review,
23 didn't attend any others because it was to do with
24 paediatrics and that's what he wasn't going to carry on
25 doing or do very much more of, if I can put it that way.

1 There is, I think, a reference to it. I can find that
2 for you, but I think he only acknowledges attending
3 once.
4 A. That would be my perception too.
5 THE CHAIRMAN: Okay.
6 MS ANYADIKE-DANES: Since we are at these meetings,
7 we have --
8 THE CHAIRMAN: Sorry, let's just follow up Mr Fortune's
9 point.
10 You're having the same difficulty as we anticipate
11 others will have in remembering about who was there, how
12 many meetings took place and so on. Do you remember
13 taking any notes or do you --
14 A. No, as I said I don't remember taking any notes. And
15 my -- I would have anticipated that either Dr Murnaghan
16 or ... I don't know if his ... The manager who worked
17 with him ... I would have anticipated that -- and
18 it would have been normal practice for Dr Murnaghan to
19 take notes actually. That would have been why
20 I wouldn't have been the specific person to take notes.
21 MS ANYADIKE-DANES: Can I, just before we leave Mr Keane
22 entirely, pull up 059-036-070? This is a letter from
23 Mr Keane, 1 May, to Dr Murnaghan. He refers to
24 a regional meeting. Do you know what that means,
25 "a regional meeting"?

1 A. No.

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

5 "The blood loss was 1,500 cc."

6 Again, in the summing-up it states that.

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

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

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

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

1 people, you have Dr Gibson's report, you have spoken to
2 Dr Taylor, but it's because differences are emerging
3 between people who were directly involved that you
4 suggest to Mr Leckey that he should get -- who turns out
5 to be Dr Sumner. So the meetings you were talking about
6 a few minutes ago and, for instance, at which you're
7 pretty sure Mr Keane was at one and you were pretty sure
8 you were at the same meeting, the regional meeting which
9 is referred to here, which comes much later, that is
10 much further down the line than --
11 A. That is much further down the line.
12 MS ANYADIKE-DANES: But is the issue or the difference the
13 one that you were referring to us?
14 A. Yes, there was a discussion about blood loss.
15 Q. Does this mean therefore that what Mr Keane is drawing
16 attention to is that somehow the information that has
17 gone to the pathologist reflects the 1,500 cc as blood
18 loss and not his point, which he was making in these
19 early discussions, that actually it wasn't all blood,
20 there was urine, peritoneal fluid, irrigation and so
21 forth? Is that the point so far as you understand it?
22 A. Sorry, I'm beginning to get a little tired here.
23 I apologise.
24 THE CHAIRMAN: We will break in a few minutes for lunch.
25 I think the point here is that what Ms Anyadike-Danes is

1 asking you is whether the point which is being made by
2 Mr Keane in this letter is, in effect, a repetition of
3 the point which he had been making some months earlier
4 about the extent of blood loss.
5 A. Yes. My memory is that there were a series of meetings.
6 I mightn't have been at all of them and that at one
7 point there was this issue between the surgical opinion
8 of blood loss and the anaesthetic opinion of blood loss.
9 That would be something that would be very common,
10 actually. But the exact volumes and the exact things,
11 I don't remember.
12 THE CHAIRMAN: Okay.
13 MS ANYADIKE-DANES: I understand. We have been able to find
14 dates of meetings.
15 A. Right.
16 Q. And it may be that you can help with which ones you
17 think you attended. The first is 17 April 1996.
18 We have that from 059-043-098. You are included there
19 as part of the ...
20 A. I don't ...
21 Q. Actually --
22 A. I don't think my name's on there.
23 Q. No, your name's not on that, sorry.
24 THE CHAIRMAN: Leave that for a minute. Let me see who is
25 at that: Mr Brangam, Mr Keane, Mr Brown, Webb, Savage

1 and Taylor. Okay, thank you.
2 MS ANYADIKE-DANES: Can we go perhaps to 059-030-061? That
3 seems to be another meeting and you're not at that
4 either. That's 23 May.
5 A. There was quite a long period when I would not have been
6 involved in meetings at all, but I'm not sure how the
7 dates go. I would have actually been not involved in
8 meetings for quite a long period.
9 THE CHAIRMAN: Sorry, pause. There's no reason for
10 Dr Gaston to be at that meeting. It's a pre-inquest
11 consultation and Dr Gaston is not a witness at the
12 inquest; isn't that right?
13 MS ANYADIKE-DANES: No, I'm simply trying to identify the
14 records of meetings that we have and whether he can
15 assist us as to whether his meetings effectively came to
16 an end at the point when they start to prepare for the
17 inquest.
18 A. I think ...
19 Q. 059-017-043. There you are. That is circulated to you.
20 This is also a pre-inquest meeting. Then there's some
21 correspondence received from the Trust solicitors
22 that is to be discussed and the reports from doctors
23 Sumner and Alexander. That meeting has been arranged
24 for 5 June. Do you recall being at a meeting where
25 those documents were present and discussing them?

1 A. I recall being at a meeting around that time. I don't
2 recall the details of it at all, I'm afraid.
3 Q. Right. Can we go back to 059-024-051? It is a file
4 note, 31 May:
5 "Dr Murnaghan met with Dr Gaston and Dr Taylor at
6 1 pm at Dr Murnaghan's office."
7 That's 31 May. Do you recall a meeting like that?
8 A. I recall a meeting and I'm having difficulties actually
9 at the minute -- can you remind me when the date of
10 the coroner's inquest was? It's difficult to remember.
11 Q. 18 June.
12 A. I do recall being asked by Mr Brangam to attend the
13 inquest because, as clinical director, there might have
14 been some issues that I might have been the only person
15 that could have provided information.
16 Q. I am actually trying to get to before that period.
17 A. I think because of that there was a point at which I was
18 asked to attend a meeting with the people who -- with
19 Dr Murnaghan and, I think, Mr Brangam. There was
20 a meeting at some point in advance of that. I can't
21 remember, actually, the details.
22 Q. We might be able to help a little bit, although the
23 documents on this are rather sparse, so I'm sorry if I
24 put things to you and you say, "I certainly can't
25 remember that".

1 What I was trying to see is whether this series of
2 dates -- and it seems that we have only identified three
3 of them -- where you might have been involved in
4 a meeting. I think you have said that that might have
5 been part of the run-up to the inquest in getting
6 yourself prepared and so forth. It seemed though, when
7 you were answering my questions and also addressing the
8 chairman, that you were talking about meetings much
9 earlier than that.
10 A. Yes, there were meetings earlier.
11 Q. So these would be in the early part of 1996; is that
12 right?
13 A. Maybe even actually in December.
14 Q. In December also?
15 A. I'm absolutely certain. That's why, in a way, whenever
16 I'm looking back, I know that there was far more
17 discussion and involvement in terms of looking at this
18 than I now can remember.
19 Q. Yes, I do understand that.
20 A. So I mean, I know there was. I can't remember, say, the
21 structure. I don't remember who would have been at the
22 meeting. But I think -- and it has been difficult
23 probably to get this across -- the idea somehow that
24 this event was left floating up in the ether with
25 nothing happening, that actually wouldn't have been

1 true. It is just that I have great difficulty now of
2 saying how that was actually done to be quite honest.
3 Q. I do understand that. Maybe it would help if you did it
4 in this way: can you recall what you thought your role
5 was in those meetings?
6 A. My role was, first of all, to actually look at us
7 getting to the bottom of the story. I felt that this
8 was -- there was more to this than just that event that
9 had happened.
10 Q. Sorry, what do you mean by that?
11 A. I meant that there were issues about, you know, things
12 like the organisation of the transplant service, there
13 were issues about the fact that we had -- there had been
14 a shortage of anaesthetists at that time. There were
15 issues about the laboratory, the ability to provide
16 accurate sodium levels during the surgery. There were
17 issues about the differences of opinion with regard to
18 fluid. And I felt quite strongly -- and this goes back
19 to my original sort of remit in a way. I felt that the
20 full risk-management issue needed to be addressed and
21 I also will say that I felt that issues that had been
22 raised by Bob, Dr Taylor, with me -- it was important
23 that even though there was a discrepancy, it was
24 important that those were not lost, they needed to be
25 discussed. So my role would have been -- first of all,

1 I wanted this to be proper, to be investigated in a way
2 that I have identified where there might be things
3 in the structure, in the process, that we could actually
4 put right. And secondly, also, of course, look at
5 exactly what had happened that had caused Adam's death.
6 Q. Did that mean you would have welcomed a formal
7 investigation?
8 A. I would certainly have welcomed that, yes. I don't have
9 any feeling of anybody not welcoming that.
10 Q. Did you maybe discuss, "Maybe we'll have a formal
11 investigation"?
12 A. No, I don't remember discussing that. I think we did
13 discuss -- and this goes back to that ... The number of
14 people, myself and a number of people [inaudible] it
15 wasn't a symposium that we were going to have --
16 Q. Seminar?
17 A. A seminar. That was the first step to try to look at
18 that. But I mean -- I ... I go back a little bit to
19 where I was coming from yesterday about risk management
20 and I talked about Professor Reisen. One of the things
21 Professor Reisen says is that an incident like this is
22 like a Swiss cheese. You have a series of holes in
23 a Swiss cheese, but the probe generally will not go
24 through more than one or two. But in a certain very
25 rare circumstance, the probe will go all the way

1 through. And that is when something goes wrong. It's
2 when it went wrong with the Piper Alpha, it went wrong
3 with the satellite and with the ... NASA.
4 In fact, when you have an incident, when something
5 goes wrong, it's very rarely one catastrophic mistake;
6 it is nearly always a series of things. And whenever
7 those holes line up is when it goes wrong. And I felt
8 that this was one of those circumstances where we needed
9 to look at why -- what were the holes that lined up and
10 how did we plug those so that that didn't happen again.
11 And I felt that that was a way -- and I had no sense
12 that anybody didn't want to do that.
13 I think there was a real challenge. This was -- it
14 wasn't a culture that was embedded in organisations,
15 actually probably in the UK, and it was a -- this was an
16 opportunity to -- this was an opportunity to engender
17 the culture that looked at it. It's what has come now
18 with root-cause analysis, which came towards the end of
19 my career, but was in industry for much longer. That
20 sort of forum didn't exist at that point in time and
21 I felt that this was an exercise that would address the
22 issues, but would also help us to identify where,
23 theoretically, the holes were, and I think that is maybe
24 what this inquiry is doing now.
25 MS ANYADIKE-DANES: Thank you very much.

1 Mr Chairman, I'm conscious that I think Dr Gaston
2 said he was getting a little tired. I was going to move
3 on to look at Dr Sumner's report.
4 THE CHAIRMAN: Yes. We'll do that at 2.05. Thank you,
5 doctor.
6 (1.05 pm)
7 (The Short Adjournment)
8 (2.05 pm)
9 MS ANYADIKE-DANES: Dr Gaston, why wasn't there a formal
10 investigation?
11 A. I don't know. I do not know. I don't think -- I have
12 no memory that there was anything to block it or any
13 concept of not having one. I honestly do not know why
14 it didn't happen.
15 Q. But why wouldn't there have been one? You thought it
16 was a good idea. In fact, you actively wanted it. You
17 didn't receive any opposition from anyone else. So why
18 wouldn't there have been one?
19 A. I mean, I ... The only thing I remember was that we had
20 the seminar, which was to go ahead, and I have no
21 recollection of that happening.
22 Q. Yes, but a seminar is not an investigation.
23 A. No, but I think that would have been to my mind the
24 start to how that would go ahead.
25 THE CHAIRMAN: Can I just ask you, a seminar can have

1 a number of --
2 A. I'm not sure that terminology --
3 THE CHAIRMAN: Whatever we call it, whether we call it
4 a seminar or a symposium or a gathering, what did you
5 envisage that was going to happen at that gathering?
6 A. Well, what I envisaged when I was there -- and that
7 terminology came later -- was that I was very keen that
8 we would have a full, open review of this. And I can
9 say that I have no recollection of any opposition to
10 that. Why it didn't happen, I don't know. I actually
11 thought that that seminar was actually the start of that
12 process.
13 THE CHAIRMAN: Yes.
14 MS ANYADIKE-DANES: Okay.
15 THE CHAIRMAN: Sorry, you were expecting it to happen?
16 I think it was to take place, wasn't it?
17 A. Yes, it was.
18 THE CHAIRMAN: And when it didn't take place, did you
19 suggest or say to Dr Murnaghan, "Look, we do need this"?
20 A. I cannot -- I mean I know from Dr Murnaghan's statement
21 and I know that there was an issue because it was very
22 close to holiday time. Pulling things together like
23 this is quite difficult given that a lot of these
24 doctors were working in different places and then it
25 came into holiday time, which made it even more

1 difficult. Then Dr Murnaghan had gone ill, had been off
2 ill. It didn't happen after that. I think it's a --
3 one of the issues is that so much of your time was taken
4 up with what was going on day by day that eventually it
5 went out of my mind. It shouldn't have done, but it
6 did.
7 MS ANYADIKE-DANES: Yes. Well, let me ask you about how the
8 issues were developing from the time, really, when you
9 are starting to get into the discussion, if I can put it
10 that way --
11 A. Surely.
12 Q. -- on the whole matter. That, as you rightly pointed
13 out, actually happens quite early.
14 A. Yes.
15 Q. I was in error to suggest to you that it really wasn't
16 until the early part of 1996 because in fact it was
17 happening in December, wasn't it?
18 A. That's my recollection. As I say, I don't have any
19 formal details to support that.
20 Q. That's fine. There are some bits of documents that help
21 us with it. There was a meeting of 3 December, we know,
22 with the coroner, Dr Murnaghan, yourself,
23 Dr Samuel Lyons. We know that meeting happened because
24 that was where there was the suggestion that there
25 should be another paediatric anaesthetist because

1 although the coroner had made steps to instruct
2 Dr Alexander, you weren't entirely sure that he had
3 sufficient paediatric expertise for this kind of case.
4 A. That's right.
5 Q. If that's the case, as the chairman was raising with you
6 before, then somebody has turned their mind as to what
7 kind of case we have and, therefore, who is an
8 appropriate expert to assist with it.
9 A. Surely.
10 Q. And that only happens because either you have been
11 discussing things with the clinicians involved and/or
12 you have looked at the recent notes that will disclose
13 what kind of case we are dealing with.
14 A. Yes.
15 Q. And in fact, the person that ultimately -- I think it's
16 both you and Dr Lyons want is Dr Ted Sumner.
17 A. No, we -- what happened was that I didn't, nor did
18 Dr Lyons, we didn't have any names. We didn't know. We
19 got the name from Dr Crean and one from the Association
20 of Paediatric Anaesthetists.
21 Q. That kind of discipline is what you wanted actually?
22 A. Yes.
23 Q. And his particular kind of discipline is somebody who
24 has experience in electrolyte disturbances and so forth.
25 A. Absolutely.

1 Q. So if you're content that he's the appropriate person,
2 even if somebody had asked you, "Is it to be
3 Dr Sumner?", you don't particularly know him, but once
4 you know what his experience is, you're happy that
5 that's an appropriate person?
6 A. Yes.
7 Q. And that means that you have not only turned your minds
8 to the fact that you have a paediatric anaesthetist
9 issue, if you like; you have a particular kind of issue
10 within that, which is fluid management.
11 A. Yes.
12 Q. So whatever you had been discussing with whomsoever at
13 that time you all -- at least you and Dr Lyons -- had
14 formed a view that that was the issue in Adam's case,
15 whatever else there might be that was an issue in his
16 case?
17 A. Yes.
18 Q. Thank you. Then I am going to try and see if you can
19 help us with how that issue actually developed and what
20 your views were. You have had those meetings, the
21 equipment is investigated and so forth. I had read you
22 out a series of dates when I thought that you might have
23 had meetings, which is after that now, coming into the
24 run-up for the inquest, if I can put it that way.
25 If I can pull up 059-032-064. That is a handwritten

1 note, I think, by Dr Murnaghan:

2 "I will have further discussions with Dr Taylor

3 about the various potential problems that may arise

4 at the inquest and will probably [I think it looks like

5 'involve'] Dr Gaston prior to these."

6 Then at 059-027-058 we have a letter from

7 Dr Murnaghan to the Trust solicitors. If you look

8 at the third paragraph:

9 "I will have further discussions with Dr Taylor

10 about the various potential problems that may arise at

11 inquest and will probably consult with Dr Gaston prior

12 to these."

13 What were those problems that he was going to

14 consult with you about?

15 A. I don't remember now actually. I just don't remember

16 the details of that.

17 Q. Right. Well, so far as you were concerned, after the

18 equipment had been inspected and after you'd received

19 that report and received Dr Gibson's report, which

20 seemed to, on the face of it, exclude the anaesthetic

21 and the anaesthetic equipment, what were then the

22 problems that you foresaw?

23 A. Well, I think one of the -- sorry, excuse me, can I get

24 my glasses?

25 Q. Of course. Sorry. (Pause).

1 A. Can you just develop that again?

2 THE CHAIRMAN: It's the paragraph that highlighted in yellow

3 where Dr Murnaghan is saying to Mr Brangam:

4 "I will have further discussions with Dr Taylor

5 about the various potential problems."

6 And you said you didn't recall what the various

7 potential problems were and you were then asked:

8 "After the equipment had been inspected, after you

9 had Dr Gibson's report, what were the problems which you

10 foresaw?"

11 A. Right. I think one of the issues, and a very important

12 issue -- we had asked an independent person in Dr Sumner

13 and there were issues that he raised with regard to the

14 fluid management.

15 MS ANYADIKE-DANES: So you'd seen his report at this stage?

16 A. I think so, yes. I think so.

17 Q. Right.

18 A. In fact, I'm sure I saw it, actually.

19 Q. Okay.

20 A. And these were issues which Dr Taylor needed to look at.

21 Q. Okay.

22 A. And he needed to actually think how he was going to

23 respond to the accusation. So I think that's what

24 we were talking about.

25 Q. Had you seen Dr Armour's report on autopsy at that

1 stage?
2 A. Yes, I had.
3 Q. Right.
4 A. I mean, I think that was -- I got that report fairly
5 early on.
6 Q. Very good. Let's go to that quickly. So we will see
7 the sort of things that were in your mind that you're
8 discussing. 011-010-041. There you are. Sorry,
9 I should say this is the end of her report. This is
10 where she has a commentary section and this is the
11 latter part of that; okay? She starts off with a highly
12 complex case in the same view that you have expressed.
13 Then if you look at the third paragraph:
14 "In this case, the volume of urine output was
15 greatly increased and the urine was also dilute. This
16 was probably due to the fact that the kidneys did not
17 function and their ability to concentrate the urine was
18 minimal."
19 Then she goes on to discuss those issues. We get to
20 the various readings. Then she goes into:
21 "Also, during the operation the sodium was low along
22 were the haematocrit. It is known that a condition
23 called dilutional hyponatraemia can cause rapid and
24 gross cerebral oedema. There is no doubt in this case
25 that the sodium level was low during the operation."

1 Then she goes on. She culminates [sic] that with:
2 "It seems likely therefore that the hyponatraemia in
3 this case was the cause of the cerebral oedema and most
4 of the intravenous fluids given in the cases cited in
5 this paper [she's referring to a paper she had seen]
6 were administered as 280 mmol of glucose per litre in
7 water."
8 Then she goes on to deal with the CVP and, finally,
9 I think she concludes in that paragraph starting
10 "another factor":
11 "Therefore, the most likely explanation is that the
12 cerebral oedema followed a period of hyponatraemia and
13 was compounded by impaired cerebral perfusion."
14 So what she's talking about there is that Adam had
15 dilutional hyponatraemia, which means he received too
16 much low-sodium fluid for him.
17 A. Well, on those readings he had dilutional hyponatraemia.
18 Q. Yes.
19 A. I can't speculate as to the reason.
20 Q. So you saw that. Then if we go to Dr Sumner's report,
21 011-011-063. And his penultimate paragraph:
22 "To summarise, I believe that on the balance of
23 probabilities Adam's gross cerebral oedema was caused by
24 the acute onset of hyponatraemia from the excess
25 administration of fluids containing only very small

1 amounts of sodium. This state then was exacerbated by
2 the blood loss and possibly by the overnight dialysis."
3 In any event, both of them are pointing to Adam
4 receiving too much low-sodium fluid.
5 A. Yes.
6 Q. You accept that?
7 A. Yes.
8 Q. So that's what you knew about as you're going into these
9 meetings to discuss, or there are going to be meetings
10 to discuss the potential problems. Just a minute ago,
11 you said that Dr Taylor would have to address that
12 point.
13 A. Yes.
14 Q. But that's not an issue that you have to address, save,
15 "How are we going to deal with the fact that we have had
16 an incident that's arisen in that way?" Dr Taylor has
17 to account for himself --
18 A. He has to address it. I couldn't address it.
19 Q. Yes. So what then were the discussions that you were
20 going to have with Dr Taylor or that were going to be
21 had with Dr Taylor about the various potential problems?
22 A. That obviously was one because I know it's there.
23 I can't remember -- I mean, I think the things that
24 Mr Brangam was talking through with Dr Taylor -- and
25 I was there listening in -- were the issues he was going

1 to have to deal with and I can't remember what those
2 were. I do remember, obviously, Dr Armour's report and
3 Dr Sumner's report were two things that he had to deal
4 with. And he had to be able either to agree with them
5 and point out why he agreed or, if he disagreed, why he
6 felt that his fluid management was appropriate. And
7 I think that was something that he had to -- he had to
8 address. I could not address that.
9 Q. Did you agree with Dr Sumner and the pathologist in the
10 post-mortem report that there had been too much
11 low-sodium fluid administered?
12 A. I can say that that was the report, that was what it
13 said. As to whether I agreed or not, I can't answer.
14 The thing that I believed that Bob needed to address, or
15 Dr Taylor, was what his fluid management had been, what
16 he did, what were the issues, and how did he look at
17 that in light of what had been the information that was
18 provided by Dr Sumner.
19 Q. But it's not just Dr Taylor. You're the clinical lead.
20 Dr Murnaghan is also a lead of a directorate. The child
21 was treated by a hospital within the Trust. So it's not
22 just Dr Taylor for himself.
23 A. No, I'm not saying that I didn't need to look at this
24 in the future and, of course, we did with regard to how
25 one would look at the management of hyponatraemia,

1 dilutional hyponatraemia particularly.
2 Q. Let's look at the --
3 THE CHAIRMAN: Sorry. Did Dr Ian Carson, who you have told
4 us also was an anaesthetist, as the medical director,
5 was he involved in some of these decisions?
6 A. I have no memory. I can't remember whether he was or
7 not.
8 MS ANYADIKE-DANES: By the time you get to the stage where
9 you've got, so far as the anaesthetic equipment is
10 concerned -- that seems to have been discounted although
11 there's an unfortunate thing in relation to the fact
12 that they hadn't seen the right monitor, but that seems
13 to have been discounted.
14 A. I think that's fair.
15 Q. You have a surgeon who's saying: actually, the blood
16 loss wasn't as high as your anaesthetist seems to
17 suggest it was. You have the anaesthetist who has
18 numbers of issues as to why the thing should have been
19 as complicated as it was and may explain why things went
20 the way they did without necessarily conceding any fault
21 on his part. You have the report on autopsy, which
22 seems, fairly squarely, to put the cause of the cerebral
23 oedema down to dilutional hyponatraemia, caused by too
24 much low-sodium fluid as well as an exacerbating factor
25 to do with cerebral perfusion.

1 The independent expert who you particularly wanted
2 to have brought in because you foresaw the need for that
3 expertise, very clearly has said, "This is about
4 dilutional hyponatraemia, too much low-sodium fluids".
5 So you have all of that. Is this not a time to bring
6 in the medical director?
7 A. As I said, there was a normal line of communication,
8 which was through -- me through Dr Murnaghan. And
9 it would have been my impression that if Dr Murnaghan --
10 the perception would have been that if Dr Murnaghan
11 would have ongoing discussions with Dr Carson -- I don't
12 know if he did or not -- but to inform him of where the
13 case was and what were the issues. I'd be surprised if
14 he didn't, but that would have been the normal --
15 Q. I accept that.
16 A. I would have expected that would have been the mechanism
17 of it.
18 Q. But you very fairly said to the chairman in answer to
19 the question that whatever was the normal reporting
20 lines, if I can put it that way, there was absolutely
21 nothing to stop any clinical lead going to the medical
22 director with an issue?
23 A. No.
24 Q. And in fact you said that you had very good
25 relationships with him.

1 A. That's right.
2 Q. So this is something that, whatever might be the way the
3 structure operates, it is within your directorate.
4 A. Surely.
5 Q. Why did you, at this stage, serious as it is, given
6 you have an independent opinion now, not bring in the
7 medical director on your own volition?
8 A. Um ... I don't actually know why I didn't bring in the
9 medical director. I think the other thing that was
10 quite important in regard to this -- and it is something
11 that actually, I think, was mentioned yesterday by
12 Mr Keane, which was that there were a lot of colleagues
13 who would have known the case. There were colleagues
14 within the Children's Hospital, there were anaesthetic
15 colleagues. At no point did anyone say to me ever
16 before during or after, "We have concerns about
17 Dr Taylor's management". Ever. There never has been.
18 There is not a single complaint ever come to me in
19 my time as clinical director before, after or subsequent
20 of any single nurse, technician, doctor, anaesthetist,
21 surgeon putting in a complaint about Dr Taylor's ability
22 to deliver his anaesthetics. Never. And I think that's
23 very, very important. And sometimes that is -- this
24 case wasn't hidden, people knew about it. But nobody
25 ever once within our operation, within Northern Ireland,

1 questioned Dr Taylor's ability to deliver anaesthetic
2 services.
3 And I think his record since actually
4 substantiates -- I am not saying that he didn't have
5 difficulties in this case, but there never was a single
6 complaint by any of the anaesthetic surgeons [sic]
7 brought to me. I don't know if there's any went to
8 Dr Murnaghan, I don't know if there was any went to
9 Dr Carson. So that didn't happen.
10 The mechanism for alerting Dr Carson would normally
11 have been through Dr Murnaghan. Did I speak to
12 Dr Carson? I can't say. I don't remember.
13 THE CHAIRMAN: Let me explore this with you, Dr Gaston,
14 because this is important generally for Dr Taylor and
15 for others. Your evidence to me then is that before
16 Adam's operation and since Adam's operation, during the
17 time that you worked in the Royal, you had no cause to
18 worry about Dr Bob Taylor's competence?
19 A. Not only did I have no cause, I was constantly being
20 reminded by the quality of his work.
21 THE CHAIRMAN: Okay. Let me take you on to the next step.
22 I really do not want you to go into names, but were
23 there other doctors or other occasions from time to time
24 when somebody came to you, "I am a bit worried about
25 Dr X or Dr Y"?

1 A. That was not uncommon and in the situation when
2 Dr Murnaghan was there, I would frequently have talked
3 that through with him and/or Dr Carson. And when
4 Dr Murnaghan took up his next position, I would have
5 talked to Dr Carson. I think the thing that is missing
6 is that somehow or other, the Trust didn't have
7 a mechanism for -- they didn't have a written mechanism,
8 to the best of my knowledge, for identifying
9 underperformance in -- we did. There were mechanisms
10 whereby -- it might be a technician who worked with an
11 anaesthetist who would speak to someone. It might be
12 a surgeon who would speak to someone. It might be
13 a junior anaesthetist who would speak to someone. And
14 that just didn't -- that applied across. In other
15 words, if we had concerns, as an anaesthetist, with
16 a surgeon, we would -- I would have gone to the director
17 of surgery and said, "Look, it's been reported to me.
18 It's not in my -- I don't have the experience to deal
19 with the surgical thing, I'm reporting it to you, it's
20 up to you to decide how you're going to handle it and do
21 that in consultation either with Dr Murnaghan and
22 Dr Carson".
23 THE CHAIRMAN: I understand that, and look, that's very
24 helpful for me to know. As I understand what you're
25 saying, it means that there's any number of channels

1 through which word can get to you or your fellow --
2 A. And it did.
3 THE CHAIRMAN: -- directors that there's a problem with
4 various people working in the hospital, if that is the
5 case.
6 A. I'd like to clarify. I think there were two points you
7 explored very nicely yesterday through my past
8 experience. I had to deal when I was chair -- we talked
9 about my role of chair of anaesthetics. I had, on one
10 occasion, to investigate a complaint involving my senior
11 colleague, who at the time had a very senior role within
12 anaesthesia in North America. And I had to do that and
13 I did do it. It was a complaint about his attitude to
14 patients. It was an complaint and there was certainly
15 some concept within the hospital that he would have had
16 a pretty brusque manner with patients.
17 What we did with that is I spoke to him, I spoke to
18 the head of his department, I spoke to the patient
19 separately and then we came together. We had
20 a conference in which there was an agreement on how to
21 manage it.
22 I'd like to look at another case, which was in -- we
23 talked about the audit in the King Fahad on the basis of
24 the quality assurance. And I talked about the Audit
25 Committee meetings and the fact that we had incidents --

1 you can call them critical incidents, but actually they
2 were to do with identification of where practice didn't
3 appear to be right.
4 We had a meeting in which we had a very frank
5 exchange about one of our colleagues. He was present.
6 We had the record, that record showed that the standard
7 of care was not met. And the other thing that we had is
8 we had a -- I had with the chief a profile of every
9 anaesthetist in the department. That was available. In
10 other words how many standard of cares -- when you had
11 a query, how many were accepted as standard of care met,
12 how many were standard of care met with variants and how
13 many were standard of care not met.
14 We had, and I can't remember exactly -- the only
15 thing I do know is if standard of care was not met, you
16 were not expected to have any and they were in limited
17 number. That was available to every hospital in North
18 America. If they wrote to the hospital, they could get
19 my profile or any other profile. He had a profile that
20 showed to me he had had several episodes. I was acting
21 chairman, I felt for the safety of the rest of the
22 patients I had to suspend him immediately, which I did.
23 And then whenever the chairman of anaesthetics came
24 back, his contract was terminated immediately.
25 So I had had to deal with these. And in all of

1 those cases, I had other information coming to me
2 that --
3 THE CHAIRMAN: Okay. Let's move forward then because
4 I understand the general background that you've
5 described from your own experience and I also understand
6 the evidence that you have given about how good an
7 anaesthetist Dr Taylor is.
8 A. Absolutely.
9 THE CHAIRMAN: Let's then look forward to what happened with
10 Adam in 1995. Clearly, something went very badly wrong.
11 A. Yes. We now know that because --
12 THE CHAIRMAN: It's not just that you now know it, you knew
13 it, for instance, from Dr Sumner's report.
14 A. Sorry, yes.
15 THE CHAIRMAN: And you said before lunch that there were
16 internal differences of opinion.
17 A. Surely.
18 THE CHAIRMAN: And we've heard something of that over the
19 last few weeks of evidence and, to put it probably too
20 crudely, we've heard Dr Savage and Mr Keane both in ways
21 pointing the finger at Dr Taylor; right?
22 A. Yes.
23 THE CHAIRMAN: The internal differences of opinion that you
24 heard in 1995/1996 were, I assume, along the same lines.
25 A. I think, broadly.

1 THE CHAIRMAN: Okay. And then you have Dr Sumner's report,
2 which is along the same lines. And then, whether you
3 intervene at that point before the inquest or whether
4 you wait until after the inquest, you then have an
5 inquest finding which is on the same lines.
6 A. Surely.
7 THE CHAIRMAN: This is a slightly different problem to ones
8 you were describing before.
9 A. I agree.
10 THE CHAIRMAN: On your evidence, this is a good doctor --
11 A. Yes.
12 THE CHAIRMAN: -- who has made a pretty terrible mistake or
13 two --
14 A. He certainly had.
15 THE CHAIRMAN: -- and has led to a child's death. So what
16 happens?
17 A. Well, I felt that that was best investigated in
18 a broad-based investigation, or a broad-based -- input
19 from the surgeons, input from the pathologist, input
20 from the -- both of the surgical specialties, both the
21 transplant and also input from the clinical director.
22 THE CHAIRMAN: You see, the biggest concern I have listening
23 to all this evidence is Dr Taylor has eventually come to
24 the inquiry and admitted that he made a lot of mistakes.
25 That's an admission that he did not make in 1995 or at

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

1 A. Yes, I think that having had -- I mean, it was clear
2 that an expert like Dr Sumner had made that. That was
3 an accepted statement. Yes, I accepted that.
4 THE CHAIRMAN: And frankly, once the coroner returns that
5 verdict, you can't really go behind it. You are stuck
6 with it; isn't that right?
7 A. It would have been inappropriate, yes.
8 THE CHAIRMAN: So even at that point, does somebody not have
9 to sit down with Dr Taylor and say,"Look, this is now
10 confirmed, you have had your say at the inquest,
11 you have had your say internally, you got it wrong. How
12 are we going to move forward?". But you don't need the
13 surgeons there for that. You don't need the
14 nephrologists there for that.
15 A. I certainly don't have any recollection that I had that
16 discussion.
17 THE CHAIRMAN: What I'm really asking is: why not? You were
18 the head of anaesthetics. You would also have been
19 supported by Dr Carson, who is the medical director and
20 an anaesthetist.
21 A. Yes.
22 THE CHAIRMAN: So why not have that discussion at that point
23 with Dr Taylor?
24 A. I don't know. I mean, I don't know. I may well have
25 spoken to Dr Carson as well. I can't remember.

1 THE CHAIRMAN: Well, what I'm going to ask you is this: in
2 a sense, were you reluctant to have it because generally
3 he was a very good doctor and therefore, even though
4 he'd made some awful mistakes, which had certainly
5 contributed to some extent to Adam's death, however
6 that is finally resolved, you were reluctant to take him
7 on in a sense because he's a good doctor?
8 A. No, I wasn't reluctant to take him on. That may have
9 been a factor in the decision, not in terms of
10 reluctance to take him on, but in terms of how he took
11 forward in terms of -- he had to continue to work.
12 There was nothing that said to me, apart from this, that
13 he should stop giving anaesthetics. If he did, we
14 probably would have had the collapse of anaesthesia and
15 ICU in Northern Ireland. That was probably what was
16 going to happen. So I had to actually look at the time
17 and I think we had to look at the time -- was this an
18 incident that was going to actually in any way impair
19 Dr Taylor's ability to deliver anaesthetics? Yet,
20 looking at it back as I do now, it didn't.
21 THE CHAIRMAN: Yes, but --
22 A. But part of that was, I think, the way it was managed.
23 In other words: yes, it would have been better to have
24 had an investigation, better to have a discussion, but
25 it was important that Dr Taylor's confidence and his

1 ability as an anaesthetist was not damaged by the
2 process. And I still believe -- and I believe that
3 today and I think history backs that up.
4 THE CHAIRMAN: Okay. I understand the point, doctor, that
5 since then there have been no adverse incidents
6 involving Dr Taylor.
7 A. And there hadn't been prior to that either.
8 THE CHAIRMAN: I really don't understand how you could have
9 decided in 1995 or 1996 that his ability wasn't impaired
10 when you had an inquest verdict and an expert report,
11 which said that he had made so many mistakes and he was
12 denying that he had made any mistakes. Denying in the
13 face of Dr Sumner's evidence, never mind the other views
14 held internally. How could you be reassured about his
15 ability in light of the fact that in essence he was
16 standing alone?
17 A. Standing alone in?
18 THE CHAIRMAN: On the issue of the cause of Adam's death.
19 A. I think one of the things when you find yourself in
20 a situation like that -- and I hadn't ever been there,
21 but I had had situations where ... I think you need
22 a time to accommodate to what you have just found out.
23 THE CHAIRMAN: Okay.
24 A. And I think that takes some time. Usually it's -- and
25 I didn't know this because I ... I didn't know that

1 Dr Taylor had found this difficult to accept for so
2 long. I think that that is something that, in a way,
3 one needs to accommodate to. It's probably difficult
4 explaining this because from a clinical point of view,
5 but when you have something like this happen, it is
6 utterly devastating. If you are a highly conscientious,
7 very highly motivated person, as a doctor, this is an
8 extremely undermining -- and of the people who I knew,
9 and I had one in Canada who had that problem. It didn't
10 destroy his career, but it made it very -- he never had
11 the same confidence again. In terms of what was the
12 service that would be provided to the people, the
13 children of Northern Ireland, to have in any way
14 destroyed Dr Taylor's confidence, I think it was
15 important that he had -- he had to look at this himself.
16 The facts were there. He had to come to that
17 accommodation himself. And I feel ... Yes, we
18 needed -- we needed to look at this as a whole issue.
19 And from what I've seen, the inquiry has looked at this.
20 We needed to look at: was it appropriate to have
21 been doing those cases? Was it fair to Dr Taylor to
22 have been asked to do that case? Had he had the
23 experience? There weren't many people in
24 Northern Ireland, there were no anaesthetists other than
25 Dr Crean and Dr Taylor who had any experience, and from

1 what I hear, I have read, Dr Taylor hadn't done that.
2 There weren't actually, I think, probably -- I think
3 Mr Keane said he hadn't that much experience.
4 So the question that probably needed to be
5 asked: was it unfair that Dr Taylor was put into the
6 position in the first place? Was the fact that we were
7 so short of anaesthetists, was the sense that the show
8 must go on -- did that precipitate Dr Taylor into
9 a situation? I had then to look -- and I think it was
10 important that everybody looked at why were we doing
11 these cases in the Children's Hospital? I had never
12 been part of any discussion that said that. If one of
13 the anaesthetists had come and said, "Look, we're
14 unhappy about this, we're unhappy about doing these
15 cases, we are not sure that we actually have the
16 experience to deal with it", I would have reacted, but
17 I think -- I definitely would have reacted. I would
18 have said, "We need to discuss about this".
19 THE CHAIRMAN: Sorry, these are all the range of issues that
20 you would have liked to have discussed at your
21 gathering?
22 A. Absolutely.
23 THE CHAIRMAN: The end result is that none of them was
24 discussed, Dr Taylor continued to work, the paediatric
25 renal transplants continued to take place and, in

1 a sense, Adam is forgotten about.

2 A. Adam ...

3 THE CHAIRMAN: Okay, if you're going to suggest to me that

4 Adam wasn't forgotten about, in what way was anything

5 learned from Adam's death?

6 A. Well, I mean, I think ... I was very aware of

7 dilutional hyponatraemia. I actually was very aware of

8 that condition because it had been a situation in

9 Atlantic Canada in the early 80s that two children

10 having tonsillectomies which were complicated had died

11 with what was dilutional hyponatraemia. They had been

12 given 5 per cent dextrose with no salt. There was also

13 another death on that, that was the same GP anaesthetist

14 in the same hospital with no supervision other than his

15 father, who happened to be the surgeon. There was

16 a young woman who died having a procedure. There were

17 three deaths in that hospital. All three died having

18 had 5 per cent dextrose and low sodium. And the Arieff

19 paper, as far as I remember, identifies two risk groups:

20 one was small children and the other was young women.

21 So here were three healthy children that died and it was

22 due to dilutional -- that ended up with the equivalent

23 of Panorama picking up that and it was discussed across

24 ...

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

1 fellowship when it was current. I was then asked to
2 look, on behalf of a colleague, at a case of another
3 young woman aged about 32 who had had an abdominal
4 hysterectomy. She had just been given 5 per cent
5 dextrose with no saline. And she had died in the
6 immediate post-operative period. So I was very aware of
7 this. I was aware that this wasn't something that
8 happened -- didn't happen just in transplant surgery.
9 So I felt that this had been a one-off, but there
10 were lessons that needed to be learned. And we needed
11 to look at those lessons. Yes, it had -- it was
12 dilutional hyponatraemia. I think there were issues
13 round how difficult it had been for Bob to actually
14 decide on the correct level of sodium during the
15 surgery. One theory was the fact -- and this was
16 certainly my perception on the main site -- that the
17 blood gas analysis machine was not a reliable place to
18 get sodium from, apart from the fact that if you used
19 heparin with sodium in it -- which was what was
20 available most of the time -- that would screw the
21 results up. So I can understand why there was some
22 perception that this wasn't an accurate way to do it.
23 And of course, there were issues with regard to the
24 laboratory, the term "near-patient testing" wasn't
25 really appropriate at that time, but in terms of

1 satellite laboratories, they could only function when
2 you had the right staff in place and they weren't in
3 place out-of-hours and --
4 So these were things that I felt needed to be
5 addressed because these are things that could have
6 impacted --
7 THE CHAIRMAN: But the frustrating thing is you have gone
8 through a list, which -- we have sat for a number of
9 weeks and spent years preparing for these hearings, but
10 that list that you have given, you knew that list in
11 1996 and you said you thought there were lessons to be
12 learned, but is there any evidence that lessons were
13 learned?
14 A. I can't say there wasn't any evidence that they were
15 learned because, in the meantime, I think if one was to
16 revisit, I think many of the issues that were issues
17 then have been addressed, whether due to the fact that
18 standards have changed in the interim or whether as
19 a result of that, I can't answer. But I think many of
20 the issues probably have been corrected over that period
21 of time, whether as a result of this ...
22 THE CHAIRMAN: You see --
23 A. Sorry.
24 THE CHAIRMAN: The frustration here is that there's parents
25 here in this chamber today whose daughter came in the

1 following October for treatment. Claire Roberts came
2 in the following October. And what I'm looking to see
3 is if there's any evidence that, by October, lessons had
4 been learned which, if those lessons had been learned,
5 Claire's life mightn't have been lost.
6 A. I'm not sure which patient that is.
7 THE CHAIRMAN: Claire came in in October 1996 -- a few
8 months after Adam's inquest, about 11 months after he
9 died -- and she also died and dilutional hyponatraemia
10 was a major factor in her death.
11 A. Is she the one that was admitted directly to the Royal
12 Hospital or did she go somewhere else and come in?
13 THE CHAIRMAN: Sorry, the point about Claire is that you're
14 sitting here saying all of the lessons which you
15 identified at that time which should have been talked
16 about and lessons learned and changes implemented and,
17 with all due respect to, what you're saying to me is
18 those lessons have been learned at some time since then,
19 but you're not sure if they were learned from Adam's
20 death. Whereas the point is you think they could have
21 been learned from Adam's death and that is why you
22 wanted the gathering, to learn the lessons, to implement
23 changes to make things better.
24 A. Certainly within the Royal, I did feel that changes
25 needed to be made. I think that ... It was difficult

1 for me, and I don't want to -- it was difficult for me
2 to take this forward. I certainly would have voiced my
3 opinion that these needed to be issues. When they
4 didn't occur, well, maybe -- in fact, I should have
5 done, I should have actually stimulated that process.
6 I couldn't do the process myself.
7 THE CHAIRMAN: Let me make it clear to you that I'm not
8 singling you out, but does that mean that there is
9 really a collective responsibility here for not learning
10 the lessons?
11 A. I think that it was a collective responsibility. It was
12 probably a responsibility for the whole organisation to
13 actually look at ...
14 THE CHAIRMAN: Different individuals had different
15 opportunities to force it along and to make some greater
16 input, but it just didn't happen?
17 A. I think that's a fair comment.
18 MS ANYADIKE-DANES: Thank you.
19 The chairman has taken you really to the kernel of
20 the issue in terms of the lessons learned and the
21 dissemination. We are also interested in the path, the
22 travel, and why it was that people had concerns that
23 actually didn't materialise into anything that was
24 likely to come out of, from the point of view of the
25 public, out of the hospital. And we pick up some of the

1 attitudes -- and I did note that you said that there was
2 a real concern that Dr Taylor's confidence shouldn't
3 have been dented. There was a real --
4 A. That was my concern.
5 Q. I understand that. And that there was a real need for
6 experienced consultant paediatric anaesthetists and so
7 forth. And there's undoubtedly going to be an issue as
8 to where the balance lay. If we pull up 059-020-047.
9 It is the second page of a letter from the Trust
10 solicitors to Dr Murnaghan, dated 30 May 1996. In fact,
11 just so that we don't get into difficulties, can we pull
12 up the first page of it, 059-020-046 alongside.
13 There you see this is the Trust solicitors referring
14 to a recent meeting with Dr Murnaghan, Mr Savage and
15 Dr Taylor regarding the inquest. So we know that the
16 inquest is coming, they've had their meeting, and if you
17 look at the second page, they know exactly what the
18 issue is. The essential issue, of course, relates to
19 the fluids, which were given to the child:
20 "And I know with retrospect that Mr Savage feels
21 that the child may have received excessive fluids.
22 I presume that Mr Savage will hold to that view if asked
23 at the inquest and, again, I believe it is of critical
24 importance that we obtain Dr Taylor's specific
25 instructions on that point."

1 That sounds like rather defensive mode, wouldn't you
2 agree? Just reading it, it sounds like defensive mode.
3 A. Yes, it sounds like that.
4 Q. Thank you. Then if we go forward to 059-014-038. There
5 are three pages of this letter so we can't get it all in
6 one go. 059-014-038. There has been a meeting, which
7 we saw was being set up from some of the dates that
8 I put to you before and the documents:
9 "I refer to the discussion of fifth instant with
10 Dr Taylor and Dr Gaston."
11 So this is a letter from the Trust solicitors to
12 Dr Murnaghan, referring to that meeting at which you
13 were present and it's in relation to the forthcoming
14 inquest:
15 "As you know, there has been a substantial number of
16 issues contained in the experts' reports which will
17 require to be carefully and exhaustively examined and
18 investigated. In that regard, I have already had the
19 benefit of very detailed instructions from Dr Taylor and
20 these have now been reinforced to me by Dr Gaston."
21 Does that mean that you were agreeing with
22 Dr Taylor's position?
23 A. No, it doesn't mean that actually. It neither means
24 that I was or I wasn't. What I did -- what I would have
25 done, as I had done right at the very beginning, I would

1 have ensured -- I would actually ensured that Dr Taylor
2 actually was able to express the views that he had held
3 up to that point. It was then, I think, that a decision
4 by the coroner, having got the points of view that were
5 made -- it was the coroner's decision to actually say
6 what the balance of the evidence suggested.
7 Q. Well, wasn't it the Trust's responsibility to the
8 patients that it had to embark upon some sort of
9 investigation so that the Trust could satisfy itself
10 that patients were not being put at risk?
11 A. I'm not sure that I follow that line of -- there was no
12 evidence that ... Other than this one case, I don't
13 think there was evidence at that point in time that the
14 patients were being put at risk.
15 Q. What you have at that point in time is you have the
16 independent experienced expert that you wanted to bring
17 in. I'm not saying the name necessarily, but the
18 discipline that you wanted to bring in, and he has, from
19 the beginning of that year, submitted a report, which
20 indicates that the problem is cerebral oedema caused by
21 dilutional hyponatraemia, too much low-sodium fluid and
22 that he has identified errors made by the anaesthetist.
23 A. Yes.
24 Q. So that's what you have. You wanted that independent
25 opinion. It could have gone the other way. It could

1 have said he was fine and it was something else, but it
2 hasn't. That's where it's gone.
3 A. And that's why we wanted an independent person.
4 Q. Did you, when you received that, accept Dr Sumner's
5 conclusion?
6 A. Yes, I accepted his conclusion, but I felt that
7 Dr Taylor had made -- he had been in the case, he had
8 done it, he knew exactly where he was. I felt he needed
9 an opportunity to put the reasons why he had made the
10 decision. He was the anaesthetist who was there.
11 He was the anaesthetist who knew the patient. He was
12 the anaesthetist that followed it through. And he
13 needed -- he had the opportunity to put his points of
14 view and I think that was important when it went to the
15 autopsy that he did that.
16 Q. Yes. But the issue here is that you may have
17 a consultant paediatric anaesthetist who doesn't
18 properly appreciate the polyuric condition and the
19 implications of that. That's what you might be dealing
20 with. Certainly, when he gave his evidence later on --
21 admittedly, to the PSNI under caution -- it became quite
22 clear -- and he has himself conceded that point in
23 evidence here -- that he did not properly understand.
24 He made irrational decisions or gave irrational
25 explanations as to what he was doing. So he did not

1 properly understand what was going on. So you have
2 somebody who may not appreciate that condition, who may
3 come across that condition again in a patient before
4 the coroner has had an opportunity to do whatever
5 the coroner is going to do in the finding of his
6 verdict. Is it not for you as part of the Trust to
7 satisfy yourself that any patient with that condition
8 that he is likely to come across will be safe?
9 A. Yes.
10 Q. Yes. Thank you. And if it was for you to do that, what
11 did you do to satisfy yourself that that would be the
12 case?
13 A. I do not remember, actually, now at all.
14 Q. Well, are you aware of seeking to do anything to satisfy
15 yourself that that would be the case?
16 A. I'm not aware of either. There may well have been
17 a mechanism that said that while this case was going on
18 and if, in fact, a renal transplant came up, that either
19 Dr Savage, as he then was, or one of the anaesthetists
20 would have said, "Look, let's discuss that". And
21 certainly with regard to elective transplants --
22 Q. You mean discuss whether he should be anaesthetist in
23 another --
24 A. [OVERSPEAKING] should go ahead -- even with any of the
25 anaesthetists to have gone ahead. I would have felt

1 that that was something which might well have been
2 communicated. If there had been a renal transplant in
3 the period in between, I would have thought, given the
4 circumstances, that there was some -- a significant area
5 of doubt with regard to this, that that would have been
6 highlighted -- it wasn't something that would have been
7 written down, as I said, but I would have been very
8 surprised if, in fact, someone had not or someone had
9 not been ensuring that there was actually consideration
10 given during that period of time to whether that
11 transplant should have gone ahead.
12 Q. You see, the difficulty is you have these --
13 MR FORTUNE: Is it suggested that Professor Savage should
14 have taken responsibility, bearing in mind Dr Gaston's
15 position?
16 A. No, I'm not suggesting that at all.
17 MR FORTUNE: That was the implication.
18 A. No, what I'm suggesting was that in light of this case,
19 it would have been surprising if somebody had not
20 said ...
21 MS ANYADIKE-DANES: Who could that person have been other
22 than the clinical lead or the medical director?
23 THE CHAIRMAN: I think you should be careful because
24 I think, with all due respect to Dr Gaston, I'm not sure
25 if even Dr Gaston isn't just guessing this evidence.

1 A. I think that's fair.

2 THE CHAIRMAN: Am I wrong, doctor?

3 A. No, I think that could have happened, but I think that's
4 conjecture. I think that's probably fair.

5 THE CHAIRMAN: Let's not go too far. We have some
6 established facts, we have some uncertainty about
7 others, but there's a limit to how far we go away from
8 what you can actually recall and what we can document,
9 so ...

10 MS ANYADIKE-DANES: Perhaps I can put the question to you in
11 this way, although I entirely accept what the chairman
12 has said.

13 Given your position, given your experience in
14 handling these sort of quality assurance, risk
15 management issues, what do you think should have
16 happened in that intervening period?

17 A. I think that, as a Trust, we should have actually looked
18 at suspending doing the renal transplants until this had
19 all been clarified.

20 Q. And what would be the mechanism for doing that? What
21 would be the forum where that sort of decision --

22 THE CHAIRMAN: Sorry again to interrupt. Is that something
23 that you have thought of at the time or is that
24 something which you're looking back on now from 2012,
25 which you're thinking would have been an appropriate

1 response?
2 A. I think I probably didn't think it at that point in
3 time, but I think I thought it in the interim. Not just
4 now.
5 MS ANYADIKE-DANES: Do you know when you formed that view
6 that that would be a good thing to do?
7 A. I don't know actually.
8 Q. Before or after the inquest?
9 A. No, it was well after that. It would be something that
10 when I look back on this case, you know, from my own
11 point of view, at the time and also as we've looked at
12 it now, I have looked at the things that I could have
13 done differently. I've looked at the things that, as an
14 organisation, we could have done differently and
15 I think, in light of what was in place at that point in
16 time, yes, I think -- what became apparent in later
17 years as governance changed, I think that this would
18 have been handled differently.
19 THE CHAIRMAN: That's undoubtedly true, doctor, but one of
20 the things I have to be careful about is not judging the
21 Royal or the individuals within the Royal for what they
22 did in 1995/1996 from the perspective of 2012 or 2008 or
23 2005; okay?
24 A. I agree entirely.
25 THE CHAIRMAN: So let's be careful again about where we're

1 moving to with your evidence. You did not think at that
2 time in 1995/1996 that it would have been an appropriate
3 step --
4 A. Not that I remember.
5 MS ANYADIKE-DANES: The obvious question is: why didn't you
6 think that?
7 A. I don't know.
8 Q. If we go over the page -- in fact, we can get these two
9 pages, page 2 and 3 of this letter, next to each other.
10 So this, as I said, is this letter from the Trust
11 solicitors, going to Dr Murnaghan. All the reports are
12 in and dealing with the implications of them, if I can
13 put it that way, in the run-up to the inquest. So
14 you've had one reference made to yourself in the first
15 page which I took you to and you feature on both these
16 pages.
17 If we go through it, you see there are a number of
18 issues or veiled criticisms which the solicitor takes
19 from Dr Sumner's report. You can see them there, but
20 that's not really what I want to take you to. It's the
21 final paragraph on page 2:
22 "Dr Gaston has indicated that during the course of
23 the procedure, Dr Taylor did not have an opportunity of
24 accurately measuring urinary output due to the fact that
25 the bladder had been opened early on in surgery. This

1 point will have to be made in very trenchant terms to
2 Dr Sumner and he will be asked what other opportunities
3 the anaesthetist had to measure urinary output."
4 The first point is: when did you first appreciate
5 that that might have been a difficulty for Dr Taylor?
6 A. I don't remember.
7 Q. You don't remember?
8 A. No.
9 Q. On what basis did you form the view that he might not
10 have had an opportunity of accurately measuring the
11 urinary output?
12 A. I don't remember when, but I think that was something
13 which Dr Taylor raised actually.
14 Q. Sorry, I appreciated you said you didn't remember when,
15 so what I was asking you was: on what basis did you form
16 that view?
17 A. It would have been on the information that Dr Taylor
18 would have provided to Mr Brangam.
19 Q. That he didn't have that opportunity?
20 A. Yes.
21 Q. Well, you're an anaesthetist. In an operation, is it
22 not possible for an anaesthetist simply to ask for
23 a catheter to be inserted if he doesn't feel he's going
24 to do it himself?
25 A. It wouldn't have been routine in most situations for an

1 anaesthetist to put in a catheter. That would have been
2 very, very rare. He could ask, yes. I'm not sure if,
3 say, the surgeon may not want to do it. He may have
4 wanted the bladder to be extended as part of easing his
5 re-implantation or the implantation process. I can't
6 answer that in terms, but yes, he couldn't put it in,
7 but he certainly could have asked the surgeon to do
8 that.
9 Q. And in fairness, we have had some evidence in relation
10 to that, but the point that you have answered is: one,
11 he could; two, you don't really remember the basis any
12 more upon which you formed this view.
13 A. Surely. Sorry.
14 Q. Then if we go to the next page:
15 "I will put one additional point raised by
16 Dr Gaston. I think it's related to the potential for
17 this child, for whatever cause, to absorb fluid into the
18 brain. I would like to see some literature which might
19 help us in propounding such a theory -- and I emphasise
20 only as a theory and as something that simply cannot be
21 excluded from the present position -- and in particular
22 that, in some individuals, the physiology that such an
23 occurrence can happen. Obviously, if we suggest such
24 a potential, then that of itself would be a factor which
25 might, to some extent, explain the oedematous state of

1 the brain."

2 Where did you form the view that there might have

3 been a difficulty with Adam's brain in absorbing fluid?

4 A. I have no idea now. I mean, I might have known

5 something at that point in time, but I don't know now.

6 I don't know where it came from.

7 Q. One way of looking at this is what's really happening in

8 this stage, preparing for the inquest, is that Dr Taylor

9 is being supported and not just in the sense of he's

10 a colleague. Obviously, it's very distressing for him

11 so we want to give him support as a colleague, but he's

12 being supported in the sense of people trying to find

13 potential explanations, defences and deflect, perhaps,

14 from the clear position that Dr Sumner has concluded in

15 his report?

16 A. No, I don't think that is right. I think there was

17 a perception that Dr Taylor had to answer certain

18 questions and that there would be issues that he needed

19 to look at in addressing. And I think those were

20 suggestions that would have been made. I have no idea

21 where that comes from now. I don't know.

22 Q. We will see and take it up with Dr Taylor to the extent

23 to which, in any of his statements, he addressed the

24 issue that a problem for him was that he wasn't able to

25 put in a urinary catheter and we will see whether there

1 is any evidence of somebody suggesting that Adam might
2 have had a difficulty in absorbing fluid into the brain
3 at that stage.
4 A. That comment doesn't mean anything to me now at all.
5 Q. Okay.
6 THE CHAIRMAN: I think, Ms Anyadike-Danes, from yesterday's
7 questioning, this morning's questions and this
8 afternoon's, I have now got a clearer and clearer idea
9 of what it is that Dr Gaston can help us with. I'm not
10 sure that it's going to progress the inquiry to go
11 through -- I understand why you had intended to go down
12 this line, but we've slightly jumped ahead and I am not
13 sure it's going to necessarily be helpful to go through
14 these letters and documents paragraph by paragraph.
15 MS ANYADIKE-DANES: I understand that, except to see if it
16 could be revealed the view that the Trust was taking and
17 to what extent the Trust was taking a position that
18 might have been helpful or not to the coroner. As it
19 happened, the coroner formed his view from Dr Sumner's
20 report.
21 THE CHAIRMAN: But the first page of that letter was asking
22 for what Dr Taylor said in response to what Dr Savage
23 was likely to say. So I get the general picture, which
24 is Dr Taylor's going to be under some pressure at this
25 inquest, he's going to have a lot of questions to

1 answer, some of them are coming from Dr Savage, some of
2 them are coming from Dr Sumner. Dr Taylor will have to
3 give evidence at the inquest and these are the points
4 that he will have to address.
5 MR FORTUNE: Sir, did you mean Dr Savage or Dr Sumner?
6 THE CHAIRMAN: I think, on the first page, a few moments ago
7 or -- maybe it's not this letter but an earlier one --
8 there was a point being made about what Dr Savage would
9 say at the inquest.
10 MR FORTUNE: That I accept, yes.
11 MS ANYADIKE-DANES: There is a further letter --
12 THE CHAIRMAN: Maybe it was a letter we looked at a few
13 moments ago, not the first page of this one.
14 MR FORTUNE: Thank you.
15 MS ANYADIKE-DANES: Yes, it is the letter that we dealt with
16 earlier. There is a letter from Professor Savage, which
17 we can deal with with him, but just to say that
18 Dr Gaston was copied in on it. It's 059-003-005. Then
19 if you see in handwriting at the top, point 3, "Copy
20 this to Dr Gaston before next meeting".
21 So this letter was going to be copied. Are you
22 aware of having discussed this letter at a meeting?
23 A. I cannot remember that letter now. I'm sorry, I just
24 don't remember it at all.
25 Q. Well, maybe that's something that we'll take up with

1 Professor Savage and Dr Taylor. Then, if I take you to
2 one point that I would like your assistance with.
3 I think that you have said that you did accept what
4 Dr Sumner had concluded. It's just that you felt that
5 Dr Taylor ought to have an opportunity to be able to
6 express the things that he felt that he was having
7 difficulty with.
8 A. I believe that was right, yes.
9 Q. Then if we go to your first witness statement for the
10 inquiry, which is 013/1, page 2. You will see that the
11 main question is:
12 "Describe your input into the assessment of and/or
13 comments on the likely cause of Adam's death."
14 And you say that:
15 "[You] did express your views at a number of
16 meetings to discuss the management of the case."
17 And you say who you think attended them. And you
18 then -- I think it's the final sentence in that
19 paragraph:
20 "I expressed my view that Adam's high-output renal
21 failure was extremely rare and his surgery had been
22 complicated. But while the patient did suffer from
23 hyponatraemia, it was simplistic to assume that Adam had
24 too much fluid, particularly low or non-salt containing
25 fluid."

1 But he did have too much fluid, too much low-sodium
2 fluid.
3 A. I think what I was saying there is it was too
4 simplistic, given the information that Dr Taylor had
5 provided to the autopsy or to the coroner's inquest, how
6 he had detailed his fluid management and how he had
7 given the details of how he'd done it, why he had
8 calculated what he did. I felt that there actually
9 still were issues that needed to be clarified.
10 Q. Of course. But in terms of cause of death, why he had
11 the difficulties that he said he did is one thing. But
12 in terms of cause of death, Dr Sumner was very clear on
13 the cause of death. The cause of death was essentially
14 too much low-sodium fluid.
15 A. I think -- well, I can't remember the actual wording of
16 that.
17 Q. Of his report?
18 A. I do remember -- yes, I can't remember the exact report
19 of the coroner. I must apologise.
20 Q. It was one I took you to just a minute ago.
21 THE CHAIRMAN: I don't think we need to go back to it. Does
22 that answer in paragraph 1 not refer to an earlier
23 stage?
24 A. That was an earlier -- I'm not sure. I'm not sure what
25 it refers to.

1 MS ANYADIKE-DANES: I think the bald question is: describe
2 your input into the assessment of and/or comments on the
3 likely cause of Adam's death.
4 THE CHAIRMAN: Yes. Okay.
5 A. I'm not sure when that statement was made.
6 MS ANYADIKE-DANES: But in any event, in terms of the cause
7 of Adam's death, did you agree with Dr Sumner on the
8 cause of it?
9 A. I agreed that this was dilutional hyponatraemia.
10 I think there was some issue over the discussion with
11 regard to the fluid given to do that. I think the
12 diagnosis or the autopsy -- sorry, the coroner's inquest
13 conclusion I accepted, yes.
14 Q. If we then move forward to around the time of the
15 inquest, you didn't give evidence at the inquest.
16 A. No.
17 Q. Did you attend the inquest?
18 A. I was present, yes. I say I was present. I certainly
19 was present -- I can remember part of it. I have no
20 memory of, say, Dr Sumner. I don't have any memory of
21 most of it. The one thing -- I remember for the first
22 time seeing the family. For me, that was quite
23 important because all of this was something that we were
24 dealing with in a -- I was dealing with it as a process.
25 And then you saw the family of what this had --

1 devastating this had had [sic]. I understood that
2 because my daughter had had, at the age of 7, an
3 abnormality of her renal tract. She'd had to have
4 reconstruction very similar to what Adam had. Never as
5 bad, but we had three or four years when she had gone
6 through -- so I actually ...
7 THE CHAIRMAN: You had a fair degree of understanding?
8 Thank you, doctor.
9 MS ANYADIKE-DANES: Thank you. Would you like a moment?
10 A. So I had two abiding memories. One was that and the
11 other was the detail that Dr Taylor had put into his
12 notes. I had said yesterday that I had seen many
13 records. By 1995, I had reviewed a very large number of
14 charts in a very large number of places and I had never
15 seen at that point in time -- and I think this is
16 something which Dr Gibson comments on. I had never seen
17 one so meticulously presented in terms of the fluid that
18 was administered and the fluid that had been given. It
19 was of a high standard, a very, very high standard.
20 I won't say never, but it was one of the very highest
21 standards of presentation. It did actually, I think,
22 contribute to the coroner making his decision. I think
23 it would have been a great deal more difficult for him
24 to have made that decision if he hadn't had the sheer
25 quality of Dr Taylor's record.

1 Q. But you --
2 A. That's the one thing I remember about it.
3 Q. Let's deal with that since you have mentioned it. You
4 know that that record keeping has been the subject of
5 some criticism itself.
6 A. I've read that from some of the comments, yes.
7 Q. Does that just mean because those who criticise it are
8 having a higher standard than you think was fair? Or
9 what is the reason why the criticisms are capable of
10 being made?
11 MR UBEROI: [Inaudible: no microphone] just to establish
12 what the basis for that comment is? In terms of this
13 anaesthetic record, Dr Haynes wasn't asked to criticise
14 it. To the extent that he passed comment on it, he
15 commended it for its detail in a similar fashion to this
16 witness. Since then -- and I mean no criticism of my
17 learned friend for this -- one issue with regard to
18 dopamine has emerged and Dr Taylor's conceded that the
19 administration of dopamine, which is not in fact an
20 anaesthetic drug, but nonetheless was administered
21 in the hurly-burly wasn't in fact recorded here. So
22 I think from that we can conclude from the evidence that
23 it's not a perfect record, but I don't think we can go
24 on to discount the view of Dr Haynes and say that it has
25 been the subject of severe criticism.

1 MS ANYADIKE-DANES: I'm not sure I used the word "severe".
2 MR UBEROI: "Some criticism", I do apologise.
3 MR SIMPSON: [Inaudible: no microphone] I object as well.
4 THE CHAIRMAN: I'm not sure that we need to go to it. In
5 fact, I thought I made the point a few minutes ago that
6 I think Dr Gaston has been very helpful to us yesterday
7 and today and I'm not sure whether we're not reaching
8 the end of the useful evidence that he can give. If he
9 has a view that the records are better than some other
10 people do, I'm not sure that it's necessary to take
11 Dr Gaston through that again.
12 A. I'm happy enough to take that, to explain, sir, if you
13 want. I'm happy to explain why --
14 THE CHAIRMAN: I'm not sure it's going to help me, doctor.
15 MS ANYADIKE-DANES: I accept that. I'm content to move on.
16 The only reason I would have taken the issue at all,
17 Mr Chairman, is because there is a seminar given when
18 these records are being presented, if you like, as best
19 practice. That's the only reason. Because if one is
20 talking about lessons learned and if that's being
21 presented as the way you could provide your record
22 keeping or documentation, then it becomes an issue from
23 that point of view. But I am content, Mr Chairman, that
24 you have the point --
25 THE CHAIRMAN: Yes.

1 MS ANYADIKE-DANES: -- and I won't seek to develop that any
2 further. And I suppose, Mr Chairman, the other thing is
3 if one wants to see where the instances of the evidence
4 that we have received so far in relation to the record
5 keeping, we have identified them with their references
6 in the governance opening. So it is there.
7 MR UBEROI: I'm afraid that's one of my issues in that, for
8 example, that is referring to the CVP not being recorded
9 when, in fact, the chart was present because it had been
10 printed out by Dr Taylor or Mr Shaw and Dr Haynes would
11 have known from reviewing this that the CVP wasn't
12 recorded, so I don't accept all the examples listed
13 in the governance opening. And as far as I can
14 determine, the only issue that has been determined
15 squarely as being deficient is the recording of
16 dopamine.
17 MS ANYADIKE-DANES: I'm not going to get into a debate about
18 the whole thing although I have to say that if anybody
19 had a concern about the accuracy of it, the whole
20 purpose of releasing it a week in advance is so that
21 that could happen. In relation to the CVP printout, the
22 point that is made that the guidance tells you that if
23 there are artefacts in the printout, then one of the
24 things you have to do is identify where those artefacts
25 are. And one thing that is absolutely clear is that

1 there were artefacts. That's when it dropped to zero
2 when the CVP was being re-zeroed.
3 THE CHAIRMAN: This is very easily dealt with. You have set
4 out a number of points in your governance opening.
5 Mr Uberoi, you're going to make a closing submission in
6 writing at the end?
7 MR UBEROI: I am, sir.
8 A. I would like to say something. That was that from what
9 I could see, the two governance statements, one came
10 from someone with a nursing background, one came from
11 someone with a chief executive background. I would have
12 worked with, on the King's Fund, and I would have worked
13 with one of the experts. The person who actually
14 reviewed the charts was me. If I was on a team, it
15 wasn't the chief executive officer who did it.
16 The other thing I think it's important that we say
17 with regard to this is that this was not just
18 a straightforward renal transplant. I know that we have
19 had discussions around that. Dr Taylor was really
20 involved in this case. There was a huge amount of --
21 there was a lot of challenges for him. It was a complex
22 case by his standards and by the standards in that
23 hospital. He kept what was the most important thing
24 that he had at that point in time, which was the
25 fluid -- became the fluid balance. At the end of the

1 operation, if you had been in a normal renal transplant,
2 you would have gone and sat down, taken the patient to
3 the recovery room or you would have taken him back to
4 the renal transplant unit, the renal unit. You would
5 have had time to sit down and if there were things that
6 were missing, you could put them in.
7 Dr Taylor at the end of that case had a very
8 difficult situation to deal with. I am not surprised
9 that there were certain details missing. I am not at
10 all surprised. And I think he then would have had the
11 situation of that patient going out to the intensive
12 care unit, he would have been involved in actually
13 working with that patient. So I think -- and it comes
14 from my own background, from what I remember of that,
15 I think some of the issues that have been raised,
16 I think didn't take into perspective what was a very
17 difficult clinical situation.
18 Q. I understand that. It's clear that the chairman has
19 taken your evidence in relation to certain matters, we
20 don't need to pursue those. There is simply one area
21 that I would like to review with you, and that relates
22 to the production of the recommendations that went
23 before the coroner and the press statement that was
24 released and then if you can help us a little bit
25 further with the whole issue of the seminar, which is

1 actually only referred to in passing in one document
2 that we've seen. So that's the limited area that
3 I would like to have you assist us with.
4 If we go first to your witness statement, 013/1,
5 page 1. Under previous statements:
6 "On 19 June in consultation with --
7 A. I know the statement you're referring to.
8 Q. "... I wrote a draft report on the prevention and
9 management of hyponatraemia arising out of paediatric
10 surgery."
11 A. Yes.
12 Q. And then what I wanted to ask you is: what was that
13 report that you wrote?
14 A. We wrote -- that was the report, and I think there's
15 a copy of that report in a statement somewhere. That
16 was -- I was asked to draft a report or ... Sorry, I'm
17 slightly lost with that.
18 Q. I'm simply trying to understand what you have written
19 here.
20 A. Oh right, in the prevention and treatment? Yes.
21 Q. Yes.
22 A. I was asked, as I gather from the coroner, to come up
23 with some guidelines as to how one would manage
24 dilutional hyponatraemia.
25 Q. Who told you that?

1 A. It would have come from Dr Murnaghan who would have
2 asked me to have done that. That was to be a draft
3 document. I had really quite detailed knowledge, as
4 I said, of dilutional hyponatraemia back from the 1980s.
5 But I needed a perspective from Northern Ireland and
6 particularly from the paediatric anaesthetists. So it
7 was -- I actually engaged with the paediatric
8 anaesthetists to draft that document.
9 Q. Yes. What is the report that you produced? Maybe
10 I will show you something and you can tell me if this is
11 it. Let me just pull something up and you can tell me
12 whether this is it. 060-018-035. Is that it, is that
13 your writing? That's handwritten.
14 A. That's the handwritten notes initially that I made for
15 myself as we were going through.
16 Q. To produce it?
17 A. It was then -- it was all discussed among the group,
18 actually.
19 Q. Can we perhaps go to 036; is that it?
20 A. Yes, that's correct.
21 Q. Is this your draft report on the prevention and
22 management of hyponatraemia in children having surgery?
23 A. I think I want to be clear here. When I was asked to
24 draft that, I did that in light of the case, not
25 necessarily addressed, but addressing a complex case.

1 I didn't address -- we didn't ... We did not set out to
2 produce a document that completely -- that addressed the
3 whole issue of a hyponatraemia and dilutional
4 hyponatraemia. We never set out to do that. It wasn't
5 my understanding that that was what was wanted. I think
6 if I had understood that, my attitude would have
7 been: I don't think we're the people to write a report
8 that is going to be covering every area of hyponatraemia
9 or sodium management. If that had been the case,
10 I would have said, "Look, I think this is something
11 that -- and I would have suggested the Department of
12 Health should have been asked, they should have got --
13 I would have thought a team of experts who would put
14 this together ... I was looking at this having my
15 previous experience. I had seen no evidence of people
16 using --
17 Q. Sorry --
18 A. -- 0.18 per cent sodium chloride, 4.3 per cent dextrose.
19 I had seen no evidence of anybody using that in
20 Northern Ireland at that point. I would have had a good
21 idea because all our junior staff would have rotated
22 through the province and you can be absolutely sure that
23 if they had picked up a bad habit, we'd have been aware
24 of. I was never, ever aware that this was an issue
25 outside these complex cases.

1 Q. Okay. Sorry. If I just -- the reason I asked you
2 that is because you say in your witness statement, and
3 it's your language, that:
4 "I wrote a draft report on the prevention and
5 management of hyponatraemia in children having surgery."
6 That's your language.
7 THE CHAIRMAN: He also referred to it on the next page as
8 a draft document on a policy for managing hyponatraemia.
9 MS ANYADIKE-DANES: Yes.
10 A. I think my statement that I made at that time is
11 misleading, actually. I apologise for that.
12 Q. Okay.
13 THE CHAIRMAN: It's a note, isn't it? It's a note rather
14 than a report?
15 A. It was, yes. It wasn't a formalised report. It was put
16 in draft form. At that point in time I didn't know
17 what was going to happen to it.
18 MS ANYADIKE-DANES: That was going to be my next question.
19 What did you understand the purpose of it was to be?
20 Dr Murnaghan has asked you to provide it. What did you
21 understand was going to happen with it?
22 A. My understanding was that that was, I think, going to go
23 back to the coroner. That was sort of my understanding.
24 It may have been completely wrong, but that was my
25 understanding of it.

1 Q. That this was something that was going to go to the
2 coroner?
3 A. That was my understanding, yes.
4 Q. To indicate how these matters were going to be addressed
5 in future?
6 A. Yes. And I was thinking very much, as we all were -- we
7 did not believe that, at this point in time, there was
8 any evidence that this was a problem other than in
9 complex surgery.
10 Q. Okay. And you say that you did this in consultation
11 with consultant paediatric anaesthetists?
12 A. Yes.
13 Q. And I think we know that that involved Dr Taylor,
14 Dr McKaigue and Dr Crean.
15 A. Yes, they would have been the paediatric anaesthetists
16 at that time.
17 Q. And Dr Murnaghan, of course, also saw it and had some
18 involvement.
19 A. He saw it. He wouldn't have been involved in the
20 drafting of it. That was our area where we would have
21 done, but he knew about it, yes. And it was given to
22 him.
23 THE CHAIRMAN: He says that the note was forwarded to
24 Dr Murnaghan. That's in his witness statement at
25 page 2:

1 "The report was forwarded to Dr Murnaghan and
2 Mr Brangam."
3 A. That was my -- that would have been my understanding.
4 MS ANYADIKE-DANES: I think Dr Murnaghan does say that
5 he had some involvement with its production, but
6 anyway --
7 A. I don't remember. I can't answer.
8 Q. Let's go to it anyway. It starts off with reference to
9 the Arieff paper.
10 A. Mm-hm.
11 Q. And I think you said that you were aware of the Arieff
12 paper.
13 A. I was -- as part of the whole looking at the whole
14 concept of this case.
15 Q. You were aware of it?
16 A. I had already read it. And Dr Crean had identified that
17 paper to me some time -- quite some time into it. So
18 I had read it, absolutely.
19 Q. And you would understand that that paper is by no means
20 confined to major surgery or even surgery at all?
21 A. Absolutely. There is a well-known case of an actor
22 in the West End, and I think you may know of that case.
23 Q. Yes. And then you talk about:
24 "A number of renal transplants complicated by
25 hyponatraemia leading to death in ten ... reported

1 in May 1996."

2 That information came from Professor Savage, didn't

3 it?

4 A. I don't know where that came from. It was Dr Crean who

5 gave me that information.

6 Q. Dr Crean gave you that?

7 A. Yes. Where it came from, I'm not sure. I think that we

8 did possibly look at some literature to follow it up,

9 actually. But yes, it was Dr Crean who told me, but now

10 that you have actually said to me, I think it was now

11 in -- my memory is that actually Dr Savage had told

12 Dr Crean that and that's how we knew about it.

13 Q. But you didn't actually see the details of those cases?

14 A. I'm not sure that's true, but no, I'm not sure.

15 Q. You might have?

16 A. Yes. I think there were some of those that might have

17 been available to be seen.

18 Q. Okay. In any event, that's the context and then you

19 make these three points.

20 A. Surely.

21 Q. "Major surgery in patients with a potential for

22 electrolyte imbalance should have a full blood picture,

23 which includes haematocrit value and electrolyte

24 measurement performed two-hourly or more frequently if

25 indicated by the patient's clinical condition."

1 Did that constitute in any way a change from
2 what was happening?
3 A. I think this was reinforcing.
4 Q. Yes, but if you had major surgery in a patient with the
5 potential for electrolyte imbalance, you would want a
6 full blood picture.
7 A. Absolutely.
8 Q. Right, so you didn't need to write that in there for
9 people to know that that's what they would want?
10 A. No. But I mean, I think -- yes.
11 Q. You didn't. And a full blood picture would include a
12 haematocrit value.
13 A. Yes, it would.
14 Q. And if you had a patient with an electrolyte imbalance
15 going in to major surgery, you'd certainly want an
16 electrolyte measurement.
17 A. You would want the electrolyte measurement prior to
18 surgery of any kind.
19 Q. And in fact --
20 A. Not any kind, but of major surgery you would want that,
21 yes.
22 Q. And in fact, that was part of Professor Savage's renal
23 protocol.
24 A. Yes, it would be.
25 Q. And so if you knew already that you had a patient with

1 the potential for electrolyte imbalance, you would
2 certainly be wanting to keep a weather eye on their
3 electrolyte measurements.
4 A. Well, that would depend actually as to whether you
5 expected there to be major fluid shifts during the
6 operation. You might -- once you had got someone to
7 a level of sodium which you would normally -- you
8 wouldn't have brought somebody to elective surgery or to
9 emergency surgery who came in with a low sodium.
10 I can't go into the details now from a clinical point of
11 view, but you would have actually corrected that. If
12 you thought -- and that would have been extremely rare
13 for any of the cases that we are dealing with -- that
14 that patient's sodium would have actually varied during
15 the case -- and that would be very rare -- then if you
16 did know that, then you would have actually wanted to
17 get regular sodium.
18 Q. Exactly. And if you look at how you finish it off:
19 "Or more frequently, if indicated by the patient's
20 clinical condition."
21 Of course, if the patient's clinical condition
22 indicates that you need to know what their electrolyte
23 balance is, then you're going to measure it?
24 A. Yes, but I think --
25 Q. Yes.

1 A. -- this was reinforcing something that may well have
2 been there --
3 Q. Already?
4 A. There, but it was bringing this to people's attentions.
5 Q. So then:
6 "If a serum sodium value of less than 128 mmol/litre
7 indicates that hyponatraemia is present."
8 But that was so anyway because the normal value is
9 135 to 145. The normal value is 135 to 145. So if
10 you have a serum sodium value of less than 128, you
11 didn't need to write this down for an anaesthetist to
12 appreciate that that was indicating hyponatraemia.
13 A. Well, if one took that point of view, then what was the
14 point of Arieff writing his paper if, in fact, people
15 understood that. What we were doing actually was taking
16 the key issues of the Arieff paper and other information
17 and actually making sure that people had thought about
18 it and that they realised what the implications were.
19 So I think that was where we were coming from in this
20 report.
21 Q. I understand that. Then the third point you make is:
22 "The operating theatre must have access to timely
23 reports of a full blood picture and electrolytes to
24 allow rapid intervention by the anaesthetist when
25 indicated."

1 You would want to have that in any event.
2 A. I think you would, but in circumstances that -- and
3 I think this was something that was dealt with. That
4 was an issue on this particular case for a number of
5 areas. And we felt that that was something that needed
6 to be in place. In other words, if you did have that,
7 you couldn't have a situation where you were sending
8 a blood sample off and the porter took 45 minutes to
9 take it to the laboratory and another 45 minutes after
10 they'd done it coming back.
11 And that was something that wasn't just happening in
12 the Royal Hospital; this was something that in these big
13 older buildings was a real issue.
14 Q. I understand. But that third point, that would be
15 an issue that the Trust would have to address --
16 A. Yes.
17 Q. -- to make sure that that was available.
18 A. Sure.
19 Q. So is the point of producing this so that, in a way,
20 the coroner could have confidence that things were
21 likely to change, the sorts of things that had come out
22 of, if I can put it that way, the consideration of
23 Adam's case?
24 A. That would have been correct.
25 Q. Is that the purpose?

1 A. That is the purpose.

2 Q. If that was so, how was that draft communicated to

3 people so it could be actioned?

4 A. Communicated?

5 THE CHAIRMAN: Within the Royal.

6 A. I forwarded it to Dr Murnaghan and it would have been my

7 perception that that would have been distributed beyond

8 that. I still don't know -- I mean, I don't know if

9 that was the case or not.

10 THE CHAIRMAN: Sorry, does that mean that this is one of the

11 things that would have been developed at the gathering

12 or the seminar that you envisaged --

13 A. I think there were some issues that I think one would

14 have been looking at and one would have been the access

15 to accurate, rapid measurements of electrolytes. That

16 would have been an issue, which -- it was an issue which

17 was cropping up during the case. I think it was

18 an issue that needed to be addressed.

19 MS ANYADIKE-DANES: I think if we go to Dr Taylor's -- maybe

20 we don't have to go to Dr Taylor's deposition to the

21 coroner. There's a signed version of this that goes to

22 the coroner. 011-014-107A.

23 I wonder if we can pull the two up alongside each

24 other. The previous one was ...

25 THE CHAIRMAN: 060-018-036.

1 MS ANYADIKE-DANES: Thank you.
2 This is what goes to the coroner.
3 A. I have no recollection of ever seeing that, the one on
4 my left to Dr Taylor --
5 Q. The signed one?
6 A. I have no recollection of ever being involved in that at
7 all. I have no recollection of that. I can recall
8 quite clearly the draft, but I have no recollection of
9 that signed statement.
10 Q. It is slightly different and certainly, if one looks at
11 the second paragraph about:
12 "In future, all patients undergoing major paediatric
13 surgery who have a potential for electrolyte imbalance
14 will be carefully monitored according to their clinical
15 needs and, where necessary, intensive monitoring of
16 their electrolyte values will be undertaken."
17 So that's not so dissimilar:
18 "Furthermore, the now known complications of
19 hyponatraemia in some of these cases will continue to be
20 assessed in each patient and all anaesthetic staff will
21 be made aware of these particular phenomena and advised
22 to act appropriately."
23 This is something signed, something put before
24 the coroner. So the anaesthetic staff come within your
25 directorate?

1 A. The anaesthetic staff come within my directorate.
2 Q. Exactly.
3 A. But I go back to the fact that --
4 Q. I appreciate --
5 A. -- paediatric anaesthetists would have been auditing
6 within the paediatric directorate.
7 Q. I appreciate that. But the anaesthetic staff come
8 within your directorate.
9 A. Surely.
10 Q. So what was going to happen to make sure that:
11 "All anaesthetic staff will be made aware of these
12 particular phenomena and advised to act appropriately."
13 So far as you are aware?
14 THE CHAIRMAN: Sorry, Dr Gaston has no recollection of ever
15 seeing this document.
16 A. I never remember seeing that document at all. I have no
17 recollection of that.
18 MS ANYADIKE-DANES: I beg your pardon. Let me put it
19 another way. Were you aware of the fact, even though
20 you didn't see the document, that all anaesthetic staff
21 were going to be made aware of the dangers and
22 complications of hyponatraemia?
23 A. I wasn't aware, but clearly from my own point of view,
24 and it is mentioned in one -- I did highlight the fact
25 that the issues which had been raised at the autopsy

1 with regard to fluid management and electrolyte
2 management, that I felt this was an area where -- and
3 I addressed that, that this was an area where we needed
4 to absolutely bring our standards up because our --
5 particularly our fluid balance documentation was not up
6 to standard. And it was very important that we actually
7 had good records with regard to electrolytes and also in
8 terms of managing our fluid balance.
9 Q. And then it goes on to say:
10 "The Trust will continue to use its best endeavours
11 to ensure that operating theatres are afforded access to
12 full laboratory facilities to achieve timely receipt of
13 reports on full blood picture and electrolyte values,
14 thereby assisting rapid anaesthetic intervention when
15 indicated."
16 Even if you didn't see this statement, did you know
17 that that assurance was being given?
18 A. No, I don't. And I suspect this is actually addressed
19 to the Children's Hospital. I certainly am not
20 assured -- I have no idea if this was actually an
21 assured position. I don't know.
22 Q. Were you present at the last day of the inquest when
23 Dr Taylor gave his evidence?
24 A. I was present at one of the days and I can't remember --
25 certainly, I was there when Dr Taylor gave his evidence,

1 whatever day that was. I was there for at least part of
2 that day.
3 Q. This document was provided to the coroner. It's
4 attached as part of his deposition.
5 A. Sorry, I have absolutely no memory of that at all.
6 Q. Do you recall any discussion as to how the lessons that
7 could be -- I mean at the inquest --
8 A. No, I don't. The main things I remember -- I've already
9 stated the things that I remember so clearly for that.
10 Q. From the inquest?
11 A. Yes, and I have addressed one of them. The other was
12 the fact -- the fluid balance management, which I keep
13 going back ... The documentation of Dr Taylor's in
14 terms of his fluid balance management and the way he
15 argued his case was of a very high standard and that's
16 something that I knew there were very few of us would be
17 able to do.
18 Q. You have said that. Then a final point is that this
19 document that you produced, the draft document which you
20 thought was, in fact, the document that would go before
21 the coroner, did you think that that kind of guidance,
22 if I can put it that way, which you said you were sort
23 of reinforcing, would go further than the coroner and
24 would actually be used to guide the anaesthetists within
25 the Trust?

1 A. I would have thought that this -- I would have felt that
2 there would have been a -- this would have passed out
3 around, but -- sorry.
4 THE CHAIRMAN: I think you said that you thought you knew
5 that Dr Murnaghan had that and you thought it would lead
6 to it being actioned internally and would at least lead
7 to -- that it would lead to change or at least to
8 discussion about change.
9 A. Yes, sorry.
10 MS ANYADIKE-DANES: Was there any reason why that message,
11 if you like, in relation to electrolyte imbalance and
12 the dangers of hyponatraemia couldn't be disseminated
13 further afield than just the Trust?
14 A. There wasn't any reason, but it would not normally be
15 a situation that the Trust would do. And certainly if
16 one had been producing a document that was, as I said --
17 if you were producing a document that was
18 a comprehensive review of hyponatraemia, I think
19 it would have been a different document to what we've
20 produced. It would have been a much more comprehensive
21 one. I don't think that we, as the anaesthetists in the
22 Royal Hospital -- certainly in my case, I had no
23 knowledge of the hospitals outside the Royal because
24 I hadn't been there. I think that, you know, had one
25 realised what this was really for, if that was what the

1 coroner's idea was, then I think it would have been
2 a different document and it would have been circulated
3 as a formal approach and I think the obvious place to
4 take that was actually the Department of Health.
5 I don't think that was necessarily something that was
6 within the Trust's remit.
7 Q. But you see, the coroner had the view that somehow the
8 Royal would disseminate the lessons learned from Adam's
9 case further afield than just within its own
10 anaesthetists.
11 A. Sorry, I can't comment as to what the coroner thought.
12 I can only deal with what I knew, the information I had.
13 Q. Do you think that it would have been a good thing to
14 have done?
15 A. I think it would have been ... At that point in time,
16 I say it again, I don't think there was evidence that
17 hyponatraemia -- apart from these two cases -- was
18 a widespread issue. Of the two cases, one is Adam and
19 the other one went into the intensive care unit which
20 I had no knowledge of.
21 I don't think there was an issue out there.
22 Something -- and I don't know where it is in the back of
23 my mind and I don't want to be ... Somewhere, somebody
24 may have made suggestions with regard to fluid
25 management that, in fact, in certain situations, you

1 didn't need to use Ringer's lactate or Hartmann's, which
2 was a balanced salt solution; you could manage in
3 shorter cases with number 18 or 0.18 per cent. I just
4 wonder if that -- and if that happened some time between
5 1997 and when these other cases came to light -- because
6 I had no evidence of that at that point in time and
7 I had no evidence later. Would it have been a good idea
8 to have presented this as a subject? It would have been
9 a good idea, particularly in retrospect, but then this
10 is back to retrospect, and I think that this report, it
11 could have been a much bigger document. It would have
12 been a much more complex document, but it would have
13 addressed it, the situations where hyponatraemia can
14 occur and here's the management of it and here's what
15 trusts should have in place to assist you.
16 Q. Then finally, you have a situation where matters seem to
17 be unresolved with Dr Taylor in the sense that -- well,
18 let me ask you. Did you know whether or not he accepted
19 the coroner's verdict?
20 A. I don't know. I mean, I actually don't know what I knew
21 at that point in time and I wasn't aware that Dr Taylor
22 had held these views for so long. I wasn't aware of
23 that.
24 Q. Well, at the conclusion of that, so that you now know
25 what the coroner considered was the issue, the cause of

1 Adam's death, given Dr Taylor's fairly strong views as
2 to not only that, but to all the issues surrounding it,
3 did you not go back and say, "Where are we now with him
4 as to what he thinks now and what's going to happen?"
5 A. I don't remember actually, I just do not have a memory
6 as to -- I have really very little memory at all of
7 anything after the coroner's court and the next thing --
8 which I didn't remember, when I filled this in, but
9 I have done since -- was whenever there was ... The
10 document came out and as part of the settlement,
11 I actually don't remember much in between, and as I say,
12 I didn't actually remember that. Whenever it was part
13 of my statement, I said I didn't know. I now realise
14 that I would have seen that because I recognised it once
15 it actually was pulled up.
16 Q. Well, did you not think it was appropriate to find out
17 what Dr Taylor did now think about the issues to do with
18 dilutional hyponatraemia?
19 A. I've said I don't know whether I talked to Dr Taylor
20 about that or not. I just do not remember.
21 Q. Would it have been appropriate to find out what he was
22 teaching?
23 A. That would have been something that was not within my
24 remit. I didn't have -- I had no role within the
25 university department and the teaching.

1 Q. But was he not on the ATICS education subcommittee?
2 A. I don't know if he was or not. We did have an ATICS
3 education subcommittee.
4 Q. I think he was. I think it says on his CV that he was.
5 A. Sorry, I don't remember who was on that committee.
6 Q. But that's your education subcommittee?
7 A. It was our education committee.
8 Q. So would it not have behoved you then to find out, if he
9 is there, what is he teaching?
10 A. We had Dr Terry McMurray, who was the person responsible
11 for the teaching -- the postgraduate teaching within the
12 trust. And it was the responsibility of the university
13 through their link people in the Trust -- in other
14 words, the joint appointments -- to have actually picked
15 that information up.
16 Q. Sorry, let's go to where it says, just because you were
17 unsure. 306-019-011. If you look, you see:
18 "Member, education subcommittee, ATICS directorate,
19 1992 to 1994."
20 And then 1995 to 1997. He's also, incidentally,
21 during that time --
22 THE CHAIRMAN: Sorry, just slow down a moment. What section
23 are you under?
24 MS ANYADIKE-DANES: It's under "Management experience, Royal
25 Group of Hospitals Trust".

1 Then there's "member", which is the second line down
2 from that, "Education subcommittee, ATICS directorate",
3 and the period there, which covers this period: it's
4 1992 to 1994 and then picks up 1995 to 1997.
5 THE CHAIRMAN: Thank you.
6 MS ANYADIKE-DANES: If you look at the next membership, he
7 was also a member of the audit subcommittee of ATICS
8 directorate, 1992 to 1997.
9 A. Actually, I didn't remember and I don't remember that we
10 had an audit subcommittee. I don't remember that we had
11 that, actually.
12 Q. Right.
13 A. Obviously, Dr Taylor has said -- and there were certain
14 committees that were needed to be looked at. Most of
15 them -- like we didn't ... I now know we had an audit
16 committee. We didn't have a quality assurance
17 committee --
18 Q. Sorry, I'm conscious of the time. The particular point
19 I want to raise with you is the education subcommittee.
20 You said you didn't recollect that you had an audit
21 subcommittee. I will address that in Dr Taylor's
22 evidence. But the education subcommittee: so he was on
23 the education subcommittee of your directorate.
24 A. Surely.
25 Q. Over this period of time when, so far as you can recall,

1 you can't remember if you satisfied yourself as to what
2 he now understood in relation to his fluid management of
3 Adam Strain, that's why I ask you: don't you think you
4 should have satisfied yourself as to what he was
5 teaching and what his position was now in relation --
6 A. I go back again to the fact that whenever one
7 investigated a situation, you relied to some degree on
8 the feedback you got. One of the feedbacks that would
9 have gone to me, a little bit more specifically to the
10 university, was if they felt what Dr Taylor was teaching
11 was inappropriate, they would have had feedback from
12 that from the junior anaesthetists. There would have
13 been feedback from the medical students; there would
14 have been feedback from some of the joint appointments.
15 To the best of my knowledge, I never got any reports of
16 that. I can't speak for the university.
17 Q. Yes, but you were in a position to know what Dr Taylor's
18 understanding was about the fluid management with
19 polyuria. And to the extent that that ever arose as to
20 how you deal with polyuric patients, you were in
21 a particular position to know that at least up until the
22 inquest, if you can't recall whether he accepted the
23 inquest verdict, at least up until that point in time
24 Dr Taylor had a view as to what polyuria meant, which
25 doesn't seem to accord with what Dr Sumner understood it

1 to mean.
2 A. Sure.
3 Q. Because Dr Taylor's view was that somebody with polyuria
4 couldn't actually develop dilutional hyponatraemia, but
5 that was not Dr Sumner's view or conclusion.
6 A. I would basically go back again and say that what
7 Dr Taylor might have believed -- might have thought with
8 regard to this case doesn't necessarily mean that that
9 was impacting on his teaching of the management of fluid
10 balance and electrolytes. And I think had he been
11 teaching something that was felt to be wrong, that would
12 have been identified and it would probably -- it might
13 well have come through the ATICS education to
14 Dr McMurray, who sat on the management structure that
15 I said yesterday. That would have come back. There was
16 absolutely no feedback on that and, to the best of my
17 knowledge, the university never felt that he was
18 teaching inappropriately.
19 MR UBEROI: It's a matter entirely for my learned friend as
20 to whether she wishes to establish it with this witness
21 or not, but I'm anxious that at some point a bit more
22 flesh is put on the bones of what exactly that meant, to
23 sit on the education sub-committee.
24 MS ANYADIKE-DANES: Yes, we are going to do that.
25 MR UBEROI: A matter entirely for you. This witness or

1 Dr Taylor can obviously try and assist as well.
2 MS ANYADIKE-DANES: I am going to do that. I was actually
3 going to try and develop it with Professor Savage.
4 I think I indicated I was going to do that with
5 Professor Savage, who seems to have had a greater role
6 in the teaching side.
7 MR UBEROI: I'm grateful.
8 THE CHAIRMAN: I think we need to take a break now for the
9 stenographer and, when we come back, we will see if you
10 could work out during the break if you can work out if
11 there are any further questions required for Dr Gaston.
12 I'm anxious to let him get away this afternoon. Then
13 we can work out what we're going to do with the witness
14 schedule for the rest of this week.
15 (4.00 pm)
16 (A short break)
17 (4.20 pm)
18 THE CHAIRMAN: I think, doctor, there might be just a few
19 more questions, but we'll have you finished in a few
20 minutes.
21 A. Thank you.
22 MS ANYADIKE-DANES: One of the questions relates to Dr Webb.
23 A number of those communications that I showed you,
24 probably this morning, actually, about trying to arrange
25 meetings and so forth -- and you could see them cc'd in

1 a list. You would see Dr David Webb, who, of course,
2 was a paediatric neurologist.
3 A. I don't know him at all.
4 Q. Yes, that wasn't --
5 A. Sorry, I jumped ahead.
6 Q. That's all right. What I was going to ask you is: in
7 any of the meetings that you attended, was he ever
8 present?
9 A. I can't answer because I don't know who he is at all.
10 I have absolutely -- I wouldn't know what he looked
11 like, the name means nothing to me.
12 Q. Maybe we'll conclude the matter if I put it in this way.
13 Were you ever party to discussions to the effect that it
14 might be helpful to involve a neurologist?
15 A. No. Sorry, I don't remember.
16 Q. Then could I ask you this. If we go to your witness
17 statement 013/2, page 4, it's part of the question that
18 I was asking towards the latter part before we took the
19 break about the draft document that you wrote on the
20 policy for managing hyponatraemia. You can see that up
21 at the top at 3. Then you were asked a series of
22 questions in relation to that. Your answer to those
23 questions is:
24 "I was asked to prepare a draft document by Dr
25 Murnaghan, I believe at the request of the coroner.

1 I did this in close coordination with the consultant
2 paediatric anaesthetist and the only involvement I had
3 was to forward this to Dr Murnaghan. I do not know what
4 happened after that. I had full knowledge of the Arieff
5 et al paper when I wrote this document."
6 So that's your answer to that. Then if you go over
7 the page to 013/2, page 5, right at the bottom there, if
8 you see:
9 "Queries arising from your PSNI statement."
10 And just in fairness to you, just to pull it up,
11 it's very, very short, 093-023-064. Maybe we can put
12 that alongside. It's the second page of that I think
13 you want, 065. Yes.
14 THE CHAIRMAN: You want to get rid of page 64, do you?
15 MS ANYADIKE-DANES: Yes.
16 THE CHAIRMAN: Okay.
17 MS ANYADIKE-DANES: So I think what you're telling the PSNI
18 is that you consider that the learning from the case was
19 primarily in paediatrics and it was very limited in
20 general anaesthetics due to the unique nature of Adam's
21 case. Maybe I have put up the wrong page. Perhaps that
22 was 064, I beg your pardon.
23 THE CHAIRMAN: It's the top line. It runs over the page.
24 MS ANYADIKE-DANES: I was trying to see if I could get both
25 those things juxtaposed for you. If you'll take it from

1 me -- and you can certainly see it -- that the beginning
2 of that is:
3 "At the time it was my opinion that learning from
4 this case [that's Adam's case] was primarily in
5 paediatrics. However, it was very limited in general
6 anaesthetics due to the unique nature of Adam's case."
7 Then you're being asked queries arising out of that:
8 "Please explain what view you took. You state that
9 this was your opinion at the time. Please state if your
10 opinion has changed and, if so, please state when and
11 give your reasons for the change of opinion."
12 Then if one goes over the page to 6, it says:
13 "Please state why, if the learning for this case was
14 primarily in paediatrics, that you drafted the document
15 [which is the one that we've seen, the draft document]
16 with consultant anaesthetists for consultant
17 anaesthetists."
18 Your answer to that is:
19 "I do not now have any further detail to add to my
20 original statement."
21 So I think the query that people have is that if
22 your feeling and if what you were telling the PSNI at
23 that time was that the learning from it is all in
24 paediatrics, then why, when it comes to the document
25 that you draft, are you drafting it all in relation to

1 anaesthetics, paediatrics obviously being a much broader
2 issue than the anaesthetics?
3 A. I felt that -- and I think in discussion I felt that at
4 that point in time the issue of hyponatraemia, and
5 particularly dilutional hyponatraemia, was primarily
6 confined to complex paediatric surgery. It didn't mean
7 that it didn't occur anywhere else and I have already
8 said I was certainly aware of at least two young healthy
9 ladies who had had it.
10 Q. I understand.
11 A. But I felt that from -- that would have been about in
12 1983. I felt that from the middle 80s right through to
13 that period that that issue had been addressed, that in
14 fact it was standard practice for people to use for
15 replacement fluid a balanced salt solution, which we
16 referred to in North America as Ringer's lactate and
17 I think Hartmann's solution is the equivalent here.
18 I can think of one person who I remember who would
19 have used 0.18 per cent or No.18 Solution. I can think
20 of one person, so this was not a widespread practice.
21 So I didn't feel that this was something that was at
22 that point in time applying outside the lessons to do
23 with the major surgery that was envisaged here. So at
24 that point I didn't.
25 What I didn't know and I now know, but I still have

1 doubts, is: was there an issue at that point in time,
2 which we didn't know at that point in time, with regard
3 to the use of No.18 Solution throughout
4 Northern Ireland? I had no evidence because, as I said,
5 junior doctors would have very quickly picked up --
6 either would have disagreed with it or would have picked
7 up a bad habit. I saw no evidence of it. The standard
8 practice was to use Hartmann's solution as a replacement
9 fluid and that was based on the understanding that you
10 needed to use a balanced solution.
11 Q. Sorry, let me be clear on this because I'm conscious of
12 the time and also that this is an issue that some people
13 want to have absolute clarity about.
14 A. Sure.
15 Q. At a point in time, which in fact we can locate, which
16 is 19, I think it is, June of 1996, at that stage you
17 are thinking that this, or at least what you draft
18 knowing that it's likely to go to a coroner, is all to
19 do with major surgery and managing the fluid balance
20 regime in relation to that, therefore primarily being
21 addressed towards anaesthetists.
22 A. Yes.
23 Q. And you say, though, that you knew at that stage, you
24 knew about the Arieff article?
25 A. That's correct.

1 Q. The Arieff article, of course, is not confined to major
2 surgery or -- sorry, excuse me -- indeed surgery at all.
3 A. That's correct.
4 Q. But it's there to alert people to the dangers of how
5 dilutional hyponatraemia can develop and how risky
6 it is?
7 A. Yes.
8 Q. Are you saying that you felt by the time you got to
9 1996, that paper, I believe, having been written in
10 1992, that you felt that was old hat, that people
11 understood at that stage about the fact that dilutional
12 hyponatraemia was a risk in the non-major paediatric
13 setting --
14 A. Yes.
15 Q. -- major surgery setting?
16 A. And it was a risk in terms of the management of fluid
17 balance particularly in small children who would have
18 had acute gastroenteritis, vomiting, diarrhoea. That
19 was an area which I was fully aware of because --
20 Q. No, you may have been, but did you feel that that wasn't
21 something that needed to be more widely disseminated
22 because that was already known?
23 A. Yes, and I think that would have been the case with all
24 the anaesthetists, actually, who discussed this. We did
25 not feel that this was an issue that was a general issue

1 of a problem, I think we felt that that was something
2 which was now well taught, it was clear, and that people
3 would have been aware of the management of fluid balance
4 and particularly sodium in regard to things like
5 vomiting and diarrhoea in small children and in terms of
6 replacement fluid for things like, say, an appendectomy
7 or a tonsillectomy or whatever. You needed to be very
8 careful about using a balanced salt solution.
9 Q. I understand that. The difficulty is, as the chairman
10 has alerted you to it, that within a few months of this
11 case there is a child who comes to the Royal and, in
12 fact, that child is treated with Solution No. 18 and
13 dilutional hyponatraemia ultimately is established as
14 being part of the cause of that child's death. And then
15 after that, there is another child in 2000, then there's
16 another child in 2001, and yet another child in 2003
17 where fluid management is an issue.
18 A. Surely.
19 Q. So the point that I'm putting to you is: are you saying
20 that you understood about these matters and you believed
21 that others did, which is why you didn't think you
22 needed to disseminate the Arieff issue more broadly?
23 A. Yes, I believed that and I think that was the consensus
24 among us as anaesthetists who did that, yes.
25 Q. I understand. Then when you get to your PSNI statement,

1 which is dated 25 April 2006, and when you talk more
2 broadly about the lessons in relation to -- in fact it
3 starts just as I had it there, the bottom of 64.
4 "It was my opinion that at the time ..."
5 Which sounds like at the time in 1995/1996?
6 A. Yes, that's correct.
7 Q. "... my opinion was that the learning from this case was
8 primarily in paediatrics."
9 It's that slight disconnect that people are asking
10 me to explore with you because it doesn't sound as if
11 that was your view with hindsight now standing in 2006;
12 it sounds like you had the view in 1995/1996 that the
13 learning coming out of that was primarily in
14 paediatrics. And, if that's the case, then obviously
15 people would like to know why the statement is drafted
16 in that way and why more efforts weren't made to
17 disseminate that message or those lessons more widely
18 afield than just the pool of anaesthetists at the Royal.
19 A. Well, I don't really believe that was -- I didn't
20 believe at that point in time that that was our remit to
21 circulate it; I wasn't aware of that. I have said that
22 if I had felt that this was a report that was going to
23 look at the concepts that we have discussed, in other
24 words the other situations where dilutional
25 hyponatraemia can occur, then I would have felt that the

1 remit would have included a broader spectrum of people
2 to discuss that subject.
3 THE CHAIRMAN: Yes. I think --
4 A. And the recommendations that would have come out would
5 have been looking at a number of other issues -- areas.
6 But at that point in time, we did not have any evidence
7 that dilutional hyponatraemia was a risk that was
8 actually out there. We knew there had been in the past,
9 but we thought that that had been well taught and it was
10 clear that actually people should have known about that.
11 THE CHAIRMAN: Sorry, doctor, if you look at the screen in
12 front of you, the line from your police statement, which
13 is highlighted, says:
14 "At the time [that's 1995/96] it was my opinion that
15 the learning from this case was primarily in
16 paediatrics."
17 A. Yes. That was --
18 THE CHAIRMAN: Is that right? Because I think the contrast
19 is you're being asked, had you not also said that you
20 thought it was primarily in anaesthesia?
21 A. Well, I think what that refers to is paediatric
22 anaesthesia. I don't think it's -- I'm not talking
23 about general paediatrics at that point in time, I'm
24 talking about that --
25 THE CHAIRMAN: So we read that to mean --

1 A. Paediatric anaesthesia.
2 THE CHAIRMAN: Then the other point is that you didn't --
3 you talked about your trainee anaesthetists going out
4 for various posts around --
5 A. The way they would have rotated round the province as
6 part of their training.
7 THE CHAIRMAN: Was it your understanding then that Solution
8 No. 18 was not being used?
9 A. Not for replacement therapy, yeah.
10 THE CHAIRMAN: Right. And had you gathered that from any of
11 your trainees, would that have been something that you
12 had -- well, sorry, if you had learned from your
13 trainees coming back that in Omagh or Craigavon or
14 wherever, Solution No. 18 was being used as replacement
15 therapy, you would have told your own trainees back
16 in the Royal --
17 A. I would have actually highlighted -- sorry, given that
18 I knew the problem, I would have highlighted that and
19 made sure that that was something that was discussed,
20 whether it be the area anaesthetic or whatever.
21 THE CHAIRMAN: Yes. I understand, I think, how you would
22 put it right internally in the Royal. But if you heard
23 that Altnagelvin was doing it, for instance, if you
24 heard that Altnagelvin was using Solution No. 18 as
25 a replacement fluid, how would you go about bringing an

1 end to that, or at least discussing it, to encourage
2 Altnagelvin to bring --
3 A. There was a structure and I'm slightly -- this is where
4 I'm having difficulty. There was an area -- there was
5 an advisory body at the Department of Health for every
6 specialty.
7 THE CHAIRMAN: Right.
8 A. And it was chaired for much of my period by Dr Lyons.
9 That would have -- we would have had members of our
10 trust on that. I wasn't on it, I would have attended it
11 on a number of times. To me, that --
12 THE CHAIRMAN: Would you have got people from your trust to
13 raise that under departmental --
14 A. Absolutely.
15 THE CHAIRMAN: -- which would in turn have had people from
16 Altnagelvin on it?
17 A. Absolutely.
18 THE CHAIRMAN: Okay, thank you.
19 MS ANYADIKE-DANES: I was just asked to point out that if --
20 from the explanation that you just gave to the Chairman,
21 if you read on from that sentence that starts "at the
22 time it was my opinion", you go on to say:
23 "However, it was very limited in general
24 anaesthetics due to the unique nature of Adam's case."
25 So that's the full sentence:

1 "At the time it was my opinion that the learning
2 from this case was primarily in paediatrics. However,
3 it was very limited in general anaesthetics due to the
4 unique nature of Adam's case."
5 A. That would have been my opinion then. I mean, I would
6 obviously -- obviously, I was in contact with a very
7 large number of anaesthetists on the Royal site.
8 If I had felt that there were issues here, if, in fact,
9 this was something that might be an issue in the trust,
10 then we would have had to address it, but there was no
11 evidence that this was an issue at all in the trust.
12 Q. I understand. You'll be aware that an issue was raised
13 as to education and so on. I'm just going to ask you
14 one question to see if this is your area, and, if it's
15 not, obviously we will pursue it with somebody else.
16 You were taken to Dr Taylor's curriculum vitae,
17 where it showed that he was on the ATICS subcommittee
18 for education. Did you yourself have a role within
19 either the ATICS directorate or between the trust and
20 Queen's University -- did you have a role in relation to
21 the delivery of educational training to medical
22 students?
23 A. The only role I would have had -- and it's in my C
24 [sic]. I was a member of the consultants who would have
25 taught students in theatre.

1 Q. Yes.
2 A. And there would have been a number of tutorials, one of
3 which would have been fluid balance.
4 Q. But did you --
5 A. But I didn't do that section.
6 Q. I understand.
7 A. But there was.
8 Q. I just want to make it clear because I'm anxious not to
9 detain you if this is not really your area. Was it
10 within your remit, if I can put it this way, to have an
11 oversight as to how that ATICS education subcommittee
12 was operating?
13 A. It was operated by Dr McMurray; he sat on the management
14 committee. In other words, the ATICS directorate
15 management. But he sat as a representative of that. If
16 he had areas that he --
17 Q. No, sorry, I'll get to that in a --
18 A. I didn't have a specific -- no.
19 Q. You didn't --
20 A. No.
21 Q. So you weren't in that committee, you didn't have any
22 oversight of it?
23 A. I had no oversight other than it fed in as part of the
24 structure.
25 THE CHAIRMAN: Sorry, I think you were going to say if

1 he had any issues with it -- were you going on to say
2 that he would raise them with you?
3 A. He would raise them at the ATICS directorate management
4 and he would have brought some issues to us, yes.
5 THE CHAIRMAN: So he would bring back from the ATICS
6 subcommittee any issues that he needed to bring to the
7 ATICS directorate?
8 A. That's right. He would have had some issues with
9 teaching, which he would have raised with the
10 university.
11 MS ANYADIKE-DANES: I see. But you yourself didn't sit --
12 A. No.
13 Q. -- on any cross-organisational body if I can put it that
14 way?
15 A. Not of that type.
16 MS ANYADIKE-DANES: Thank you very much indeed. I think
17 that's it.
18 THE CHAIRMAN: Thank you very much. Are there any more
19 questions? Mr Simpson, Mr McGleenan? No?
20 Thank you very much indeed, doctor, you have been
21 very patient over the last two days. You're now free to
22 leave. Thank you very much.
23 (The witness withdrew)
24 Timetable discussion
25 THE CHAIRMAN: We now get into the usual apology about the

1 schedule. Tomorrow we are scheduled to have
2 Dr O'Connor, Mr Brown and Dr Crean and we're going to
3 stick to that. I understand that Dr Taylor, who we
4 didn't reach today, can accommodate us by coming on
5 Thursday; is that right?
6 MR UBEROI: Yes, sir. Tomorrow it's clinical business.
7 THE CHAIRMAN: Yes, well, I can hardly complain. That, in
8 turn, leads, I think, Mr Fortune, to Professor Savage
9 volunteering himself to attend on Friday, which
10 we weren't due to sit on, but --
11 MR FORTUNE: It's not quite true to say he volunteered
12 himself. He had his arm twisted.
13 THE CHAIRMAN: I see.
14 MR FORTUNE: And unless there are screams from those who
15 have childcare, could we sit at 9.30 on Friday morning?
16 THE CHAIRMAN: Yes.
17 MR FORTUNE: And I hope that my learned friend will be able
18 to conclude her questioning of Professor Savage within
19 the day.
20 THE CHAIRMAN: He will finish within the day. Okay, I'm
21 sorry for any disruption. We had tried to avoid sitting
22 on Fridays for this session. It's not just because we
23 lost a few hours yesterday, but we did lose a few hours
24 yesterday and we'll have to make up for it and try to
25 contain it to this week. Tomorrow morning at

1 10 o'clock. Is it Dr Crean that needs to go first?
2 MR SIMPSON: He was sent away today and told to come back
3 tomorrow, but he would need to be told now that he's
4 first on.
5 THE CHAIRMAN: The message that got to me was that he needed
6 to be first on and we can accommodate that.
7 MR FORTUNE: Can I rise on behalf of my learned friend
8 Ms Woods because she has flown in for Mr Brown and I am
9 not sure what her movements are for Thursday, but she
10 would be expecting Mr Brown to be completed tomorrow.
11 THE CHAIRMAN: I will have discussions with my team now,
12 Mr Fortune. You've made this point to me before and I'm
13 now making it publicly. We just can't keep running over
14 all the time.
15 MR FORTUNE: Quite.
16 THE CHAIRMAN: Thank you very much. Tomorrow morning at
17 10 o'clock.
18 (4.45 pm)
19 (The hearing adjourned until 10.00 am the following day)
20
21
22
23
24
25

1

2 I N D E X

3

DR JOSEPH GASTON (continued) 1

4

Questions from MS ANYADIKE-DANES 1
5 (continued)

6 Timetable discussion 208

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25