THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS:

CLAIRE ROBERTS / LUCY CRAWFORD AFTERMATH / RAYCHEL FERGUSON

WRITTEN SUBMISSIONS ON BEHALF OF DR TAYLOR

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The Inquiry into Hyponatraemia-related Deaths

Written Submissions on behalf of Dr Taylor:

Claire Roberts / Lucy Crawford Aftermath / Raychel Ferguson

Introduction

1. It is intended that these submissions be read in conjunction with the previous written arguments submitted to the Inquiry, regarding the Adam Strain hearings (both the original, and supplementary submissions).

2. These submissions follow the following structure: Firstly, a group of overarching submissions have been set out, which permeate various aspects of the Salmon letters which Dr Taylor received. Thereafter, specific submissions are made with regard to (in order): Claire Roberts, the aftermath of Lucy Crawford's death, and the aftermath of Raychel Ferguson's death.

General

3. It is submitted that it is vital the Inquiry places Dr Taylor's role as Paediatric Audit Coordinator in its proper sphere. Only then can his actions in that role be fairly assessed.

4. Dr Taylor set out his understanding of the role during various parts of his evidence:

> Q: So when you became audit coordinator in succession to Dr Shields in December 1996, what did that role entail?
> A. That role entailed many elements. Of course, it was a voluntary appointment, it wasn't a job. I was continued in a full-time, quite busy specialty. But it involved chairing the audit half-days, according to a rolling calendar that was published by the Eastern Health & Social Care Board. It involved facilitating other projects from other clinicians. It ensured coordinating -- so as audit coordinator, audit

facilitator and audit chairman -- to ensure one doctor wasn't repeating the work of another doctor, that they could get together to make sure that the clinical audit department of the Royal Trust, at that stage, wasn't overwhelmed with requests for chart reviews and pulling charts…[1]

...

But it's absolutely correct,
one would look at current practice, mostly prospectively -- doctors don't like retrospective analysis because one can miss certain things, as we know, but one would look as much as possible to look prospectively over this current week or current month at how one is complying with a guideline. That's a good audit.
One then looks to see if one's deficient at achieving that standard, inserts an action plan where one wants to come up to that standard and re-audits. The big thing I was teaching as audit co-ordinator was: don't stop your audit, just as you've said, by doing a snapshot of your practice; look to improve through the audit cycle or, as I was fond of saying, the audit spiral, and come back continuously to look at a re-audit of one's practice, re-action plan it, and make it better so that one increased the quality of care to one's patients. That's the audit process as I understood it.[2]

5. Dr Taylor therefore drew a clear distinction between the macro, clinical audit section of the role, and the separate, sub-category of the mortality discussions, which took place within the half-day timetable:

Q. And in terms of auditing the mortality cases, how were those cases selected for audit?
A. Number one, they weren't audited. Clinical audit is, as I've already described, you pick a national standard, whatever that may be, Caesarean sections, whatever your area is, and you compare your own practice to the practice that's in publication. Obviously, you want to get a good guideline, the NICE guidelines, or some other important standard that you would pick. You would audit through a series of statistical analyses, you would look at your own practice, and if your own practice didn't meet the standard that was set by some authority, then you had an action plan, you implemented an action plan that would re-audit and bring you up to those national standards. So that's what I understood and that's what I practised with clinical audit.[3]

[1] Evidence of Dr Taylor; 11/12/12; p113(18) – 114(9)
[2] Evidence of Dr Taylor; 4/6/13, p196(12) – 197(5)

6. It is submitted that the above distinction is crucial to bear in mind at all times, with regard to the Governance evidence. It is submitted that neither Claire nor Lucy's death (nor Raychel's death, albeit it would have been discussed at a point after Dr Taylor had stepped down as Audit Coordinator in any event), should ever have been subject to an individual audit, because individual deaths are not "audited".

7. It is submitted there is an understandable potential for confusion in the mind of a layman as to the connotations of the word "audit", carrying with it the suggestion in normal language of some form of 'root and branch' review. However, it is submitted that the evidence made plain that the medical use of the term is entirely separate. Individual deaths are not audited, they are investigated, and it is axiomatic that where deficient treatment may have resulted in death, it is incumbent on any or all of the clinicians involved in the delivery of care to take steps to ensure an accurate understanding of what went wrong is reached. That obligation exists (and existed) under the GMCs Good Medical Practice Guidance, as well as being a matter of common sense. The "macro" process of audit, involving as it did a benchmarking process against which guidelines or outcomes are measured, is not the process by which deficient care should be uncovered.

8. Various witnesses made this point to the Inquiry. For example Dr Nesbitt (during his evidence on the aftermath of Raychel Ferguson's death), stated:

> That is not an audit. An audit is where you look at lots and lots and lots of cases. That is a review of that one case and the things that we put in place following it. Audit to me is a much bigger thing when you take, you know, over the last year how many of these cases have we got, or whatever it was, and then you compare your results with someone else.[4]
> …
> No, it's -- you can audit trigger lists that show if there's a potential for something to happen. So it is gathering data and audit isn't much more than that.[5]

[3] Evidence of Dr Taylor; 11/12/12; p114(16) – 115(6)
[4] Evidence of Dr Nesbitt, 3/9/13; p62(7-13)

9. Dr Nesbitt's evidence was thus consistent with that of Dr Taylor:

> Audit is not really a benefit in terms of mortality review. Audit is a system, as I've explained, of looking at the macro ---
> looking at the larger numbers of patients coming through the service and comparing that to national standards.[6]

10. The process of clinical audit that was extant at the time was thus a separate process to the discussion which occurred during the mortality section of the half day audit meeting. This is because, on Dr Taylor's understanding of the term, the Mortality sub-section of the Clinical Audit meetings represented: "*a review of the deaths, it wasn't an investigation into the death. It was a review of the finality of the final statements, reports.*"[7]

11. It is submitted that this was the function of mortality meetings which was understood at the time, both by Dr Taylor, and by the other clinicians. The primary function of the mortality meetings was to review the settled position which had been reached after a death (for example after the post-mortem), in order to learn lessons where possible. It is accepted that if an individual death is discussed then inherent to that discussion there will always be an opportunity to isolate errors or queries, but it is submitted that the opportunity for the identification of errors is entirely separate from any (erroneous) suggestion that the identification of errors was the purpose of the mortality section of the meetings. The two concepts are entirely separate.

12. In support of that submission it is observed that one could hardly think of a less ideal set of circumstances through which to uncover clinical deficiencies. This is because:

    12.1. the "treating consultant" had complete control of the presentation given in the mortality meeting – the meeting was thus easily influenced by

[5] Evidence of Dr Nesbitt, 3/9/13 p227(12-14)
[6] Evidence of Dr Taylor; 12/12/12, p144(15)
[7] Evidence of Dr Taylor: 12/12/12; p118(10-13)

the content of the presentation, and the features that clinician chose to highlight;

12.2. consistent with this point, the clinicians did not have a copy of the patient's notes. Instead the usual practice was for the presenting clinician to present "summarised slides" of their case[8];

12.3. the mortality meeting was multi-disciplinary. Were a neurologist to present and discuss a death which he /she attributed to a neurological cause, an anaesthetist (for example) would be singularly ill-equipped to challenge that conclusion. That anaesthetist would be straying outwith his/her area of competence. This would equally be the case were a pathologist to attribute a child's death to bronchopneumonia;

12.4. Not all clinicians would be present at any given meeting (for example, if the demands of emergency work took them elsewhere);

12.5. Each case was discussed for an average of 10-15 minutes only.

13. As a result of these factors it is submitted the mortality section of the audit meetings would have been a singularly inappropriate forum for any "investigation" of a child's death to take place.

14. Nonetheless, as a result of the discussions which were inherent to the mortality meeting process, certain trends were spotted. For example, after "*a cluster of deaths around meningococcal disease*" were presented, it was decided that beneficial work could to be undertaken and this was taken forward by the Sick Child Liaison Group, which produced a Northern Ireland Guideline on Meningococcal Disease[9]. For this process to unfold, however, the cause of death would have been accurately ascertained and presented to the meeting by the treating clinicians. There is no suggestion that the relevant cause of death in those cases was somehow uncovered during the mortality meeting.

15. It is within the above distinction that the views and hypotheses of Dr Macfaul – the Inquiry's expert – must be assessed. In summary, after an initial report which repeatedly stated "it is not evident" that certain audit activity was being carried

[8] Evidence of Dr Taylor; 12/12/12; p125(3-10)
[9] Evidence of Dr Taylor 12/12/13; p129(2) – 131(1)

out in the paediatric department, it transpired that the reason such activity was not evident was because the Trust had not disclosed such documentation to the Inquiry. Thus Dr Macfaul had not been briefed with it. Such documentation was therefore located by Dr Taylor and provided to the Inquiry (for example – the *Worksheet of Audit Activity* dated 15 March 2000 that described the range of clinical audits undertaken throughout the Trust and in the Paediatric Directorate specifically, and which underlined Dr Taylor's diligence as paediatric audit facilitator.)[10] The further documents submitted led Dr Macfaul to express his amended view unequivocally:

> "*The information provided on behalf of Dr Taylor is most helpful and shows a good quality of audit activity within the Trust coordinated by him… In the light of the documentation received I wish to modify sections of my report to read as follows:*
> *para xvii …… The process for reporting audit activity and it's monitoring within the Trust appears satisfactory. On the other hand, in my opinion the mortality meetings were not adequately minuted, so that significant outcomes of discussion were not recorded and there does not appear to be a process of aggregating or analysing trends on issues raised during discussion of deaths…*
> *…*
> *para 721: Save for the comments I make on the mortality section, in my opinion , the structure and processes for annual and regular monthly reporting of audit activity was up to standard for the time within RBHSC.*[11]

16. Thus Dr Macfaul:

16.1. Concluded that Dr Taylor's clinical audit work was entirely satisfactory;

16.2. Maintained the opinion that some form of minuting should have been carried out during the mortality meetings, so that significant outcomes could be aggregated, and trends analysed.

[10] 324-006a-003-018
[11] Dr Macfaul Supplementary Report: 250-020-002 – 250-020-003

17. On the question of minuting, it is accepted that with hindsight the production of anonymised minutes would have been preferable – if placed in the context of an overarching structure which analysed general trends. However, this was simply not the system, and it is submitted that no criticism can fairly be attributed to Dr Taylor as a result of such a structure being absent. Further to this submission:

17.1. Dr Taylor was simply carrying on the same practice (of not minuting the meetings) which his predecessor as Paediatric Audit Coordinator – Dr Shields – had practised and been instructed to carry out. He passed this instruction on to Dr Taylor[12];

17.2. As part of the additional documentation submitted by Dr Taylor, it is plain that he diligently submitted the written records of each monthly meeting to the overarching Clinical Audit Committee,[13] which oversaw the product of the Audit Sub-Committees. As discussed above, Dr Taylor's records minuted the clinical audit discussion, but simply recorded the number of deaths discussed under the Mortality sub-section heading (continuing the previous practice). It is submitted that the crucial point is that if Dr Taylor had personally been adopting a practice which was not expected of him, he would (and should) have been told so by the overarching Clinical Audit Committee, which received the minutes and met once a month. In short, his continuation of the practice was entirely transparent;

17.3. The evidence suggested that this practice in fact continued until 2012 – again offering support for the contention that Dr Taylor was simply continuing the system which was in place in the Royal at the time[14]. Thus it is submitted that any criticism could only fairly be systemic, and not personal to Dr Taylor;

17.4. In any event, other Inquiry experts disagreed with Dr Macfaul on the question of whether such minuting was to be expected during the relevant

[12] Evidence of Dr Taylor, 4/6/13, p200(19-22)
[13] 324-006a-003-019
[14] "*There's currently guidance coming through from the Trust. We had a presentation at the last audit meeting but one, where a doctor presented the guidelines that are under consultation at the moment to minute the mortality aspect of the meetings"* – Evidence of Dr Taylor, 12/12/12, p123(5-9)

period. Professor Lucas offered evidence about the practice which his hospital (the now Guy's, King's and St Thomas' Hospital, where he has been a Professor of Histopathology since 1995[15]) adopted at meetings which took place to discuss the outcome of consented autopsies. He stated: "*In the old days they weren't minuted"*, but observed there had been a "*general trend*" towards minuting the meetings "*in the last decade*."[16]

17.5. Professor Swainson was also of this view, stating: "*I can well accept that those might not have been recorded. In 2001 those were not commonly recorded or reported through the organisation. It was seen, I think, as a largely professional domain."*[17]

18. Further, Dr Macfaul's view was that the minuting of the mortality meetings would only have been of use "*if somebody, maybe a clinical director, might have been aggregating these over a period – this is hypothetical – but aggregating them over a period of time."*[18] There is no evidence that the Trust, or the individual Clinical Directors, ever attempted to put such a system in place. Had they done so and explained the system to the Audit Coordinators, no doubt Dr Taylor would have fully complied with such a system.

19. It is thus submitted that while with hindsight more might have been recorded during the mortality discussion, this observation should not be a personal criticism of Dr Taylor. Rather, any criticism should be of the system which pertained at the time, and which Dr Taylor simply faithfully followed. It is submitted that to be criticised for volunteering for an unfunded role and carrying it out in accordance with the system one is asked to follow, would be manifestly unfair.

Dr Taylor's work with the Sick Child Liaison Group

20. Separately, Dr Taylor did take forward two issues which were observed in the mortality meetings. This work led to the creation of guidance on meningococcal

[15] Evidence of Dr Lucas; 18/12/12, p157(25) – 158 (5)
[16] Evidence of Dr Lucas; 2/7/13; p127 (12) – 128 (4)
[17] Evidence of Professor Swainson; 19/9/13, p81 (4-7)
[18] Evidence of Dr Macfaul; 19/12/12/; p62 (8-22)

disease, and bronchiolitis. These areas were addressed through the vehicle of the Sick Child Liaison Group. The suggestion was occasionally raised in cross-examination that this Group may have been an outlet for Northern Ireland wide discussion of dilutional hyponatraemia (the SCLG's original composition included a consultant paediatrician and anaesthetist from the main hospitals in each Board area. It was established in 1999 but, with attendance dwindling, it no longer met after 2005[19]). It is submitted that it would be highly unfair, and perverse, to criticise Dr Taylor for not addressing the issue of dilutional hyponatraemia through this Group. This is because:

20.1. The SCLG was not a formal body created or funded by the Trust. It was established by virtue of Dr Taylor's own initiative. It met out of working hours, and its aim was to consult on the transfer and admission of critically ill children[20];

20.2. It would be extraordinary for a clinician's hard work and personal efforts in one, more straightforward area (for example – the meningococcal guidance) to be used retrospectively as a tool to criticise them for not doing more in a separate area. It would be criticism which has only been arrived at through the use of hindsight in order to transpose the effect of one set of good actions, to another area;

20.3. The question of the meningococcal guidance was apparently far more straightforward than, for example, any putative dangers inherent to the misuse of solution 18. Firstly, any fluid or medicine is dangerous if misused. Secondly, there was a long history of clinical use of solution 18, with paediatricians being particularly attached to its use.[21] The two issues simply cannot be compared;

20.4. It was noted by Ms Anyadike-Danes QC, in her Opening to the Raychel Ferguon Governance stage of the Hearings, that the SCLG had provided a forum for the discussion of fluid management in the aftermath of Raychel Ferguson's death[22]. But for the observation to be pertinent one must

[19] Evidence of Dr Taylor – WS 2801/1, pg 8, q7
[20] Evidence of Dr Taylor: 4/6/13; p175(7) – 176(9)
[21] Evidence of Dr Taylor: 4/6/13, p182(16) – 183(8)
[22] WS 008/1 pg 15

ignore the relevant context of that discussion, which was the immediate aftermath of Raychel Ferguson's death, and the news that the Hyponatraemia Working Party was to be established. These had provided the impetus for the discussion;

20.5. Furthermore, if the hypothetical question is whether, in a perfect world, papers such as Arieff's 1998 article could have been presented to a body of clinicians before Raychel's death, it is submitted that more directly relevant evidence was offered by Dr Chisakuta. For Dr Chisakuta did present the Arieff paper to a meeting of the Western Anaesthetic Society, on 30 September 1998. His evidence was that his presentation included a discussion on postoperative hyponatraemic encephalopathy.[23] Dr Nesbitt of Altnagelvin Hospital confirmed that he was present at the meeting[24];

20.6. In short, the issues which have been explored by the Inquiry are of great subtlety and complexity and simply could not have been remedied through a presentation by a single clinician. Dr Chisakuta's talk evidences this very point.

21. It is submitted that what is absent is any documentation or evidence to support the contention that Dr Taylor should have discussed dilutional hyponatraemia at the Sick Child Liaison Group's meetings. Only if such documentation existed, would any criticism be fair. Otherwise, such comment relies entirely on the hindsight of convenience.

Claire Roberts

22. It is submitted Dr Taylor played a limited role in the events which are of relevance to the Inquiry in this section of its work.

23. As far as clinical matters are concerned, his only encounter with Claire occurred: "*after her first set and before her second set of Brain Stem tests which indicated that she had suffered from brain death.*[25]*"* This highly circumscribed role would

[23] Statement of Dr Chisakuta; WS 283/3, pg 2, 7, 8
[24] Evidence of Dr Nesbitt; 3/9/13, p7(3-12)
[25] WS 157-2, q34

have taken place within a PICU ward that was most probably full[26], and with other patients also requiring necessary care. Sadly, the action would also have taken place in a PICU which saw approximately 25 deaths per year (a reality inherent to its clinical role and function).[27]

24. In light of this limited role, it is submitted there can be no realistic suggestion that Dr Taylor should have reported Claire's death (to anyone), or himself ensured it was the subject of any extraordinary scrutiny. That responsibility plainly fell on the clinicians involved in Claire's care, and any suggestion that it also fell on Dr Taylor's shoulders would involve a level of hindsight and speculation which:

    24.1. Ignored the clinical reality of Dr Taylor's role, and the landscape of care in a busy PICU, described above; and

    24.2. Applied a retrospective view of events from a perspective which is solely focused on hyponatraemia as a result of the Inquiry's work, and which is therefore unrealistic.

25. If Dr Taylor had formed concerns about Claire's care, no doubt he would have spoken to his clinical director. This was the course he adopted after the death of Adam Strain (going to speak to his clinical lead – Dr Gaston). This is the avenue which was available to all of Claire's treating clinicians – all of whom could have chosen to speak to their clinical lead, should they have had concerns. But it was not for Dr Taylor to do it, given the limited knowledge that he had.

26. It is submitted it is impossible to suggest Dr Taylor's role in the treatment of Adam Strain should in some way have instilled in him a heightened sense of awareness of dilutional hyponatraemia, that was in any way relevant to Claire's circumstances. The evidence does not support this argument, for the following reasons:

[26] Evidence of Dr Taylor: 4/6/13; p167(16-22)
[27] WS 157-2, q26. There were 26 deaths in PICU in 1995, and 23 deaths in 1996.

26.1. Claire's case presented in a very different fashion – with encephalitis or SIADH apparently being considered by the clinicians – neither of which were present in Adam's case;

26.2. This was a point made by Dr Taylor in his written evidence, when he stated: "*I cannot recall any learning from Adam's case which was used in my care of Claire Roberts. They appeared to differ from each other in that Adam was a child with chronic renal failure having a kidney transplant operation and Claire was being treated for encephalopathy and seizures*[28]*"*;

26.3. This was a point reiterated by Professor Young during his oral evidence at the Claire Roberts hearings: "*I would certainly accept those comments.*[29] *Although I'm not aware of the details of the other cases, I suspect myself that Adam Strain's case was a very unusual, special set of circumstances. And I think I can half understand why that didn't necessarily strike the doctors as having much wider applicability*."[30]

26.4. Dr Macfaul made the same observation: "*I think that is difficult to say, but from the information I have had Adam was a surgical problem, a complex problem with his kidneys and so on. So in a way, electrolyte disturbance is very problem [sic]. Claire had an acute encephalopathy, a different condition altogether, different clinical team. Raychel Ferguson was treated in a district general hospital with a surgical condition and Lucy in a district general hospital with gastroenteritis. So it's difficult to see a pattern there."*[31]

27. Nor can it fairly be suggested that Dr Taylor, with the limited involvement described above, can bear any responsibility for the failure to refer the death to the Coroner. It is submitted that this point was plainly dealt with in a reasonable fashion by Dr Taylor during his evidence:

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[28] WS-157/1 q20; See also Dr Taylor's oral evidence, 11/12/12, p73, ll 1-11: "*I think, as I remember at that time, in the mid 1990s… I wouldn't say many, but it was not an uncommon presentation to intensive care to have seizures, encephalitis, and to die as a result of that. That's changed with vaccination and better care, recognition of meningitis, these days. But clearly, it appears that I was under the presumption that the cause of her illness was encephalitis, meningitis. That's what she has been treated for and that was the overriding diagnosis, I believed, at that time."*

[29] This is not a direct reference to Dr Taylor's comments specifically – rather Professor Young is discussing the issue generally.

[30] Evidence of Professor Young: 10/12/12. p176, 12-17.

[31] Evidence of Dr Macfaul; 19/12/12; p66(6-14)

> I think I've answered the question before. I was in PICU on the day Claire died. I looked after her amongst my other PICU patients. My involvement with her, clinically, was to prepare her from the first set of brainstem tests to the second set of brainstem tests. I don't recall any conversation I had with the other clinicians involved and it was only after my duties finished around 5.30 that day that the other doctors convened and performed the brainstem tests and made the decision about death certification. I do not believe I was involved or ... I was not cognizant with her underlying diagnosis, that was a neurological paediatric diagnosis. I'm not a trained paediatrician, nor a neurologist. I'm an anaesthetist by training and that's a decision I would have left to the more appropriate authorities.[32]

28. Unsurprisingly after 17 years and in the apparent absence of records being retained by the Trust, there is a lack of certainty as to whether or not Claire Roberts' death was ever discussed at the mortality section of the Paediatric Clinical Audit meeting. The evidence disclosed:

    28.1. That Dr McKaigue had an apparent recollection of Dr Steen presenting Claire's death at an audit meeting: "*Dr Steen presented Claire's death at the audit meeting at which I was present. I do not recall who else was present at that meeting, or the date of the meeting. I did not make a note of this meeting;*"[33]

    28.2. Against this, Dr Steen had no recollection of presenting the case. Nor, for that matter, did Dr Webb (the other clinician who could have presented the death);

[32] Evidence of Dr Taylor: 12/12/12: p109, 3-18
[33] Statement of Dr McKaigue:1156/2 q22

28.3. Dr Taylor had no independent recollection of Claire's death being presented at the mortality section of the Audit meeting, one way or the other. It is submitted that this is entirely unsurprising and natural, because the relevant meeting would have occurred approximately sixteen years prior to his evidence;

28.4. Adding to the uncertain chronology is the fact that Dr Taylor did not assume the role of Paediatric Audit Coordinator until 10 December 1996.[34] It is thus possible that Claire's death may have been presented prior to his assumption of the role (and specifically at the November 1996 meeting).

29. Given the uncertainties inherent to the evidence, it is submitted that it would be unfair to subject Dr Taylor to any criticism on the question of whether Claire Roberts' case was presented at a mortality meeting, and / or on the separate question of why subsequent steps were not taken. This is because:

29.1. The discussion would only have been as useful as the presentation given by the relevant clinician;

29.2. If Dr Steen had not recognised the role of dilutional hyponatraemia in Claire's death, it is axiomatic that she would not have presented it as a hyponatraemia-related death;

29.3. This point was raised by Dr Macfaul, when he stated: "*In 1996, the problem is that Claire's death was not identified as a major event. So the first step in any investigation, of course, of a major event is to know that it has happened."*[35]

29.4. It would be unfair to mistake the mortality meetings for any kind of proxy "investigation" of a death. This was simply not their function. It is submitted that the legitimacy of this observation is plain from the fact that an individual such as Dr Taylor:

29.4.1. Had no training in how to "investigate" a clinical incident; and

29.4.2. Was presiding over a multi-disciplinary meeting. It cannot be reasonably suggested that an anaesthetist could "challenge" either a

[34] 305-011-591: Minutes of Meeting
[35] Evidence of Dr Macfaul**;** 19/12/12; p54(12-15)

paediatrician, or a paediatric neurologist, if a death was presented and described as (for example) having been caused by encephalitis;

29.4.3. Nor was there any audit which could (or should) have sensibly been undertaken in light of Claire's death, given the fact that clinical audit was a macro-process which as a concept was not relevant to unpicking the circumstances of individual deaths.

30. Finally, Dr Taylor's Salmon letter suggested a potential criticism of him centred upon the issue of "*whether there was any effective system for the use of clinical coding and recording of the causes of Claire's death, either in 1996 /7 or in 2004/6."*

31. It is submitted that it is likely this area of potential criticism (correctly) fell away, as the oral evidence was heard. The suggestion that Dr Taylor – a busy and practising consultant paediatric anaesthetist – could in any way have carried responsibility for either the clinical coding system organised and funded by the Trust, or for the way it was in fact applied in Claire's case, is plainly impossible to sustain. It is submitted that neither issue remotely involves Dr Taylor (he did not organise the Trust's clinical coding system, and nor was the specific coding of Claire's death anything to do with him, in light of the fact that he was not involved in her treatment).

Raychel Ferguson Preliminary (aftermath of Lucy Crawford)

32. There is again uncertainty as to whether Lucy's death was discussed at any mortality meeting, in the aftermath of her passing away in the RBSHC.

33. The Trust originally suggested her case was discussed at a mortality meeting of 10 August 2000, because her death was listed for presentation on that day.

34. It is submitted it is likely, on the balance of probabilities, that Lucy's death was not discussed on 10 August 2000. This is because (in contradistinction to Claire's death), the information on her death certificate (duplicated in the clinical notes) was clearly alarming. Despite this, no relevant clinicians recall a discussion of the

case. For example, Dr Hicks was present at the meeting of 10 August 2000, and yet has no recollection of the discussion. This is in spite of Dr Crean's observation that:

"If it was left just the way it has been described on the death certificate, I think people would have been jumping up and down asking all sorts of questions: this doesn't make sense."[36]

35. Dr Taylor was also of the overall view that the case was not presented or discussed on this date. This was because:

35.1. The relevant clinicians were not listed as attending the meeting on that day, as their names did not appear on the attendance register. Specifically, Dr O'Hara and Dr Hanrahan did not attend the mortality meeting;

Well, yes. I wasn't there for her treatment, I wasn't there at the time of her death, I don't recall her presentation. I don't even know if her presentation was on 10 August as stated because the people presenting it were not on the attendance register and I would not have allowed, as the chairman of that session, a case to be presented without at least two of the three major people involved. So I fail -- it defies logic to conclude that her case was discussed at that meeting.[37]

35.2. Dr Taylor therefore stated that it "defies logic" to conclude that Lucy's death was discussed on 10 August 2000, as a result of neither Dr Hanrahan nor Dr O'Hara attending the meeting.

36. Dr Hicks echoed Dr Taylor's evidence. On the specific question of whether Lucy's death could have been discussed at the meeting of 10 August 2000, in light of the attendance register showing that the key clinicians (such as Dr Crean, Dr Hanrahan, and Dr O'Hara) were not present, she agreed with Dr Taylor:

[36] Evidence of Dr Crean: 4/6/13, p153 (17-20)
[37] Evidence of Dr Taylor; 4/6/13; p208 (17-25)

Q. Would you be surprised about a mortality meeting going ahead in relation to a case where the senior clinicians who had been involved were not present?
A. I would think it highly unlikely. I can't see how it would happen, really.[38]

37. In view of Dr Taylor and Dr Hicks' firm evidence on the question of whether the discussion occurred on 10 August 2000, it is submitted the relevant succeeding questions become:

    37.1.1. Was Lucy's death presented subsequently?

    37.1.2. If not, why not?

38. As to the first question, it is again of relevance that the clinicians do not remember Lucy's death being presented, at any point.

39. As to the second question, the evidence made plain that it was not for Dr Taylor to organise and administer the list of cases to be discussed / deaths to be presented (or, for that matter, to ensure a case was re-listed). Put simply, it was not his responsibility. Rather, the PICU secretary organised the list and ensured each death was presented. Dr Taylor made the arrangement a condition of his agreeing to take on the role of Paediatric Audit Coordinator:

Yes, the PICU secretary --- was delegated the responsibility of the mostly administrative task of running the mortality, and I again remember discussing whether I should take over the audit facilitator or not, because I was a very busy person and Professor Shields was keen to give it up, and one of the selling points that he told me was that -- the ways not to sell me the thing was he said the mortality was a major administrative task and he found it very difficult to keep it going. So I discussed it with the PICU secretary. I said that I would like her to take on the role of recording every death that came, mostly through PICU, so she was recording -- or she had access to those deaths anyway, and that would she please take on the role of administering that task, contacting the relevant

[38] Evidence of Dr Hicks: 7/6/13, p128(17-21)

> consultants, picking a date when they would all be present for the presentation and doing all the necessary arrangements, which was a lot of telephoning and organising, and leaving me free then to concentrate on what I thought I would prefer to do and be skilled to do and be trained to do, which was actually encourage my colleagues to undertake the clinical audit process.[39]

40. It is submitted that such an arrangement was plainly reasonable. Indeed, it is further submitted that any suggestion Dr Taylor should himself have been responsible for organising the list of cases for discussion is absurd. Dr Taylor was and is a busy consultant paediatric anaesthetist. To be involved in the minutiae of what was a purely administrative task would have been;

    40.1. unrealistic;

    40.2. a waste of his clinical skills and time; and

    40.3. a waste of resources.

41. Furthermore, Dr Taylor was of course not Lucy's treating clinician at the RBHSC, and nor did he treat her at all. It cannot therefore sensibly be suggested that Lucy's death should have been at the forefront of Dr Taylor's mind.

42. Further relevant evidence on this point was offered by Dr Hicks (Clinical Director, Paediatrics), who stated:

> What we didn't have in audit was any significant resource to help administer it, and this is why I think, unfortunately, things sometimes went by the wayside, like not bringing a case back when it should have been brought. That may have happened, I don't know that that happened.[40]

43. It is therefore submitted that Dr Taylor should not be the subject of criticism for failing to ensure that Lucy's death was presented at a mortality discussion, in the event of it being found that her death was not discussed. There is no evidence that

[39] Evidence of Dr Taylor: 4/6/13; p201(20) – 202(16)
[40] Evidence of Dr Hicks: 7/6/13; p136(3-8)

the administration of the list of cases was his responsibility. On the contrary, the evidence in fact established the opposite (that it was not a task he undertook).

44. The apparent administrative oversight is all the more regrettable in light of the fact that, had Lucy's death been presented, Dr Taylor was of the view that action would have been taken by the meeting:

> Yes, I think any death where there was concern about the death certificate or concern about the cause of death – as I have already said, these meetings were not passive, people sitting, drinking coffee, they were very active meetings and, from that, serious matters were discussed and -- a recent meeting, for instance, very shortly after the start of the presentation, the clinicians present asked the presenter to please stop the presentation and take the case for a serious adverse incident and the person presenting then said, "That's what I was concerned about. It seemed a bit of a grey area for me to bring it here", and that case is currently, I believe, undergoing a serious adverse incident investigation within the Trust. So this was an opportunity for people, and is now an opportunity for people, to say, "Stop, get an adverse incident going".[41]

45. It is thus submitted that such criticism as Dr Macfaul makes of Dr Taylor is criticism which is directed at a set of circumstances which do not reflect the likely reality of events. No criticism is intended of Dr Macfaul by virtue of this submission – the evidential landscape altered significantly after he had written his Report. In a nutshell, Dr Macfaul's criticisms centred upon his disapproval of Lucy's death being presented and discussed at a mortality meeting, and yet some of the flaws in the records (such as the content of the death certificate) not being identified by that meeting. He argued that the mortality meeting "*would have been an opportunity [there] for people to say "that's not logical*",[42] and that the discussion "*would have identified that the regime in the Erne had not been appropriate for Lucy".*[43] Such an argument is not in dispute. However, the criticism begins from the starting point that Lucy's death was discussed. For the reasons given above, it is submitted that it is likely the death was not discussed

[41] Evidence of Dr Taylor: 4/6/13; p203 (21) – 204 (11)
[42] Evidence of Dr Macfaul: 27/6/13; p78 (22)
[43] Evidence of Dr Macfaul: 27/6/13; p79 (25)

due to an administrative oversight, which had its root in the factual evidence (about which Dr Macfaul was not in a position to comment, and very properly was not asked so to do). The inaction was a result of this administrative oversight – there was no relevant inaction from Dr Taylor, either during or post the discussion. It is therefore submitted there is thus no relevant clinical inaction for the original criticism to bite on. Absent the administrative oversight, Dr Taylor most likely would have taken the steps Dr Macfaul recommended in the meeting. It is further submitted that the responsibility for taking those steps would not have rested solely with him, but with every clinician present at the meeting (including the Clinical Director – Dr Hicks – who attended the mortality meetings).

Adverse Incident Reporting

46. Adverse Incident Reporting had been instituted via a new Trust policy in May 2000. It is submitted that the new policy would most likely have come in to consideration, had Lucy's case been discussed. At the very least, serious questions would have been raised in precisely the way that Dr Macfaul (and common sense) would suggest they should have been, because Dr Taylor agreed that (for example) the contents of the death certificate (as duplicated in the clinical records) was illogical:

> Yes, that would not make sense, that death certificate. If I recall, it was cerebral oedema due to dehydration. That is not a correct cause of death.
> Q. So if that had emerged in the presentation of Lucy's death at that meeting, that is something that would have concerned you and you'd presumably want to know a little bit more about what the explanation for that was?
> A. That's correct.[44]

47. The potential relevance of the adverse incident reporting mechanism was further apparent in the following extract from the evidence of Dr Macfaul:

> And if it was performing that function in the absence of having been told that there was another forum where that sort of thing -- the neurological round would happen but in a more general setting, in the absence of being told

[44] Evidence of Dr Taylor: 4/6/13; p214 (18-25)

that there was another forum, then what is it that you think should have been happening at these mortality meetings? What should have happened in relation to Lucy, for example?
A. I think a clinical summary of her condition, which had been done in preparation for the meeting, would be part of it, and that would involve a scrupulous review of the case records. In that sort of situation, a review perhaps of the literature, looking at what might have generated cerebral oedema in a child with gastroenteritis, as just part of the process. That could be done either by the consultant or on his behalf by a registrar.
Q. And is the purpose of that to try and identify the cause of death? Because at that stage that would be unclear to her consultant clinician.
A. It would be an attempt to provide as much information as might help to interpret the process of death.
Q. Do you have direct experience of those sorts of meetings?
A. Well, we used to do those in what we called critical incident meetings in our own hospital.

48. It is submitted the above passage in fact demonstrates the clear distinction between mortality discussions and the adverse incident process (despite Dr Macfaul's conflation of the two), for the following reasons:

48.1. If mortality meetings had already been performing the function that Adverse Incident investigations were introduced to perform, there would have been no need to introduce a system of Adverse Incident Reporting to Northern Ireland (and the Trust) in May 2000. The introduction of the policy would have been otiose if it was simply replicating a function already performed by mortality meetings;

48.2. Instead, it was plainly felt necessary to introduce the entirely separate (and new) Trust Policy: "Adverse Incident Reporting TP 9/00".[45] The rationale for this policy was to create "*a means of identifying the risks to which patients, staff and members of the public may be exposed*".[46] Its stated objectives included:

[45] Statement of Dr Crean: WS 292/2, p45
[46] "Adverse Incident Reporting TP 9/00": WS 292/2, p45

48.2.1. "*to provide staff with an opportunity to participate in and effect changes in practice and procedures"*; and

48.2.2. *"to provide information to allow effective evaluation and monitoring of patient care and procedures".*[47]

48.3. The Adverse Incident Reporting Policy was introduced by the Trust's Chief Executive, William Mckee, in May 2000 (TP 9/00 is dated May 2000[48]). It is again submitted that its introduction and stated aims would not have made any sense, if the mortality meetings were already fulfilling the functions described above. Its introduction is further evidence that the mortality meetings were never intended to fulfil such a role, and were not doing so as at May 2000;

48.4. Dr Crean's evidence provided further support for this submission:

> THE CHAIRMAN: But does that mean
> that before the introduction and increasing adherence
> to
> this adverse incident reporting system there was, in
> effect, no system under which deaths of children were
> reported where lessons could be learnt?
> A. Mr Chairman, I'm not an expert on this, but I --
> THE CHAIRMAN: You worked through this period that
> time
> concerned with [sic]
> A. I'm not sure there was at that time either.

48.5. What Dr Crean did not suggest, in the passage cited above, was that the mortality meetings were somehow the forerunner to the Adverse Incident Reporting system, or point to those meetings as providing the "system" under which deaths might be investigated and questions of causation resolved;

48.6. Further support for this contention can be found in the fact that the Erne Hospital did not feel Lucy's death could or should be discussed in a hospital mortality meeting. They instead found it necessary to set up an entirely separate Review process;

[47] "Adverse Incident Reporting TP 9/00": WS 292/2, p45
[48] "Adverse Incident Reporting TP 9/00": WS 292/2, p46

48.7. It is thus submitted that to conflate the mortality meetings with Critical Incident Review meetings (as Dr Macfaul does in this passage) relies on an unsafe chain of reasoning and is not supported by any evidence.

49. Evidence was offered by Dr Taylor that this gap in the overall governance structure has since been addressed, because the Adverse Incident procedure is now firmly established (and that procedure itself is now audited):

> Q. Does that mean that, so far as you can tell, because of the circumstances surrounding the treatment that Lucy is likely to have received at PICU, that there wasn't already a standard or benchmark by which her care would be measured at one of these clinical audit committees?
> A. No, but nowadays there is also an audit, if you like, or a review, which is presented at the monthly audit committee, usually every three to six months, of adverse incidents. So the adverse incidents are all collated and they are, in a way, audited to make sure that the standard is continually improved, that action is taken about, for instance, pharmacy errors, dispensing errors, prescription errors and that, through the audit cycle, there is an attempt made to eliminate all pharmaceutical errors in the same way as there might be to eliminate other errors in the practice that's highlighted by the adverse incident reporting.
> Q. So far as you're aware, when Lucy died on 14 April 2000, even though the adverse incident reporting was in its infancy and maybe not even formally instigated, was there any way of achieving something like that?
> A. Not to my recollection at the moment. If I think of something, I will inform the inquiry.[49]

50. Dr Taylor's Salmon letter identified as a potential criticism the question of "*whether you failed to ensure that the conduct of the audit meeting was in keeping with guidance or the RBHSC practice at the time to include an adequate minute being taken, ensuring the attendance of relevant personnel and formulating planned actions following the meeting*." It is submitted that none of these potential criticisms would be fair or reasonable. Specifically:

50.1. Dr Taylor's conduct of the clinical audit meeting has been commended by Dr Macfaul;

[49] Evidence of Dr Taylor: 4/6/13; p199(11) – 200(8)

50.2. As discussed in the General section above, Dr Macfaul was of the opinion that anonymised mortality minutes would have been preferable. No doubt this opinion is sensible with hindsight but:

50.2.1. He did not suggest that the failure to keep minutes was in contradistinction to any relevant Guidance, practice or Trust policy. Such a suggestion would have been untenable because Dr Macfaul also stated the RBHSC was to be commended for attempting to review every death in the first place: "*Well, at the time, some hospitals would only examine events in detail when [they] had been reported as an adverse event. I think that the fact that the Royal examined every death is to be commended, and that was their process.*"[50]

50.2.2. Nor was the failure to take what is described in the Salmon letter as an "adequate minute" out of step with RBHSC practice at the time. On the contrary, the evidence makes clear that it continued a well established practice that existed prior to Dr Taylor becoming Paediatric Audit Coordinator (with Dr Taylor's predecessor being instructed not to keep minutes of mortality discussions), and continued after he left;[51]

50.2.3. Further, the approach to minuting adopted by Dr Taylor was completely transparent, as the minutes were submitted to the Audit Committee (chaired by Dr Mulholland). At no stage was the minuting style queried by that Committee, despite monthly meetings;[52]

50.2.4. Furthermore, as set out above, neither Professor Lucas nor Professor Swainson suggested that they would have expected the mortality discussions to be minuted, at the relevant time;

50.2.5. As to ensuring the attendance of adequate personnel, there is no evidence whatsoever that Dr Taylor had any power to compel clinicians to attend. The assertion that he held such influence is complete supposition. All Dr Taylor could do, and what he in fact did, was to not

[50] Evidence of Dr Macfaul: 27/6/13; p72(10-15)
[51] Evidence of Dr Taylor: 4/6/13; p200(19) – 201(12). See also 321-074-002 (Minutes of the Meeting of 10 April 2003 – a meeting held after Dr Taylor stood down as Paediatric Audit Coordinator - which states under "Mortality": "*4 cases were presented and discussed.*")
[52] Evidence of Dr Taylor: 4/6/13: p197(15) – 198(3)

allow a mortality discussion to go ahead, if the relevant clinicians had failed to attend and so could not speak to the case.[53]

51. It is generally submitted that in order for any of the considered criticisms to be justified, the Inquiry should have received some form of evidence that Dr Taylor was told;

    51.1. That through his position as Paediatric Audit Coordinator, he was taking on the responsibility to investigate and identify deficient clinical care, during the mortality discussions, and

    51.2. He should keep anonymised minutes, so that overall themes and trends could be aggregated by a higher authority.

52. There is no evidence that Dr Taylor was ever asked to do either of these things. It is submitted that he should not be made a scapegoat for the Trust's failure to put in place a system which possessed these characteristics, if indeed any such failure was present. Dr Taylor put forward his point of view in strident terms and it is submitted his argument is plainly reasonable:

> …again I think he [Dr Macfaul] is unfair.
> I think he's confusing the audit -- sorry, I beg your pardon -- the mortality presentation with an investigation of death. And to try and suggest that I was in some way the convenor or the investigating officer of a mortality investigation is not my understanding of my role as the audit facilitator and chairman of that meeting.[54]
> …
> Q.Is that because, Dr Taylor, by the time you got to this mortality meeting and the pathologists would be presenting together with the clinician, if you like, that the clinicopathological correlation had already taken place? So if there was an impact of what the clinicians had seen during treatment with what the pathologist was finding on autopsy, that reconciliation or correlation had already occurred?
> A. I couldn't put it better myself. Correct.[55]

[53] Evidence of Dr Taylor: 4/6/13: p208(17-25)
[54] Evidence of Dr Taylor: 4/6/13; p215(11-18)
[55] Evidence of Dr Taylor: 4/6/13; p217(3-11)

Raychel Ferguson

53. The evidence disclosed that Dr Taylor stood down as Paediatric Audit Coordinator in January 2003, handing over the role to his successor.[56] It is therefore submitted that the potential criticism of him set out in the Salmon letter (with regard to the conduct of the audit meeting after Raychel's death) fell away as the evidence was heard. Raychel's mortality meeting was scheduled to take place in April 2003, after the conclusion of the Inquest.[57]

54. It is submitted that Dr Nesbitt gave evidence which was relevant to issues which arose during the Adam Strain Governance hearings. The Inquiry will recall that Dr Murnaghan's mooted seminar did not take place in the aftermath of the Inquest into Adam's death. Additionally, Dr Murnaghan's circulation of the Draft Statement agreed by the anaesthetists was limited to the paediatric anaesthetists who had themselves drafted it, within the RBHSC. These limitations became plain during the oral evidence at the Adam Strain hearings. However, it is submitted that it is important to note that during the Raychel Ferguson Governance evidence, Dr Nesbitt (a consultant anaesthetist at Altnagelvin) was unequivocal in his view that from his perspective, there was no relevant learning from the Adam Strain case. In other words – the Adam Strain case did not possess specific learning points which he felt should have been disseminated. A clinician in the position of Dr Nesbitt – who is now intimately familiar with the details of both cases – did not recognise a link between the two:

> THE CHAIRMAN: Because there were lessons to be learnt from the circumstances in which Adam died, which could have

[56] Statement of Dr Taylor: WS 280/1 pg 6, q3; the supporting 'Minutes of the Paediatric Directorate Meeting held on Thursday 9th January 2003' were also submitted to the Inquiry, which recorded: "*Sub-Committee Reports – 1, Audit Sub-Committee (Dr Taylor): Dr Taylor announced that he was resigning as Chairperson of the Audit Sub-Committee. Dr Taylor did state that he would be available for any problems his successor would have and his secretary has still offered her services for carrying out mortality audit. Chairperson thanked Dr Taylor for carrying out his role and that audit would still have a strong place in the Divisional Structure."*

[57] 321-074-003

helped other doctors in the Royal and beyond, beyond that.
A. In terms, yes, but in Adam's case I don't know that that's actually true because Adam's case, I still would contend, is a different case in that it was an extremely difficult -- and in fact I was asked three hypothetical questions towards the end of my statement, one of them was: what would I have done if I'd been told of the death of Adam Strain. And my response to that was, I doubt that it would have had any effect because most doctors would have thought, "That's a most unusual case, it's in extreme circumstances, a child with polyuria, very experienced doctors looking after him in the Children's Hospital. That's not for me".

…

And you say to the CMO, "I was unaware of this case and I'm somewhat at a loss to explain why". Now that you are aware of the circumstances of Adam's death, do you say," I accept that there was no reason for me and my colleagues in other hospitals in Northern Ireland to be told about Adam's case because there was unlikely to be anything learnt from it which was of use to us"?
A. No, I'm pushed to give a one-word answer, but the reason I replied to the hypothetical question was in my opinion had we been told specifics about Adam's case, then we might not have done anything because we wouldn't have thought it applied to us. But if we'd been given guidance on hyponatraemia as a result of Adam's case, then it might have been a learning thing for others. But I'm not sure that Adam's care would have

generated that. That's looking back on it now with what I know. Does that -- I mean, I'm not trying to be obfuscating or anything like that.

THE CHAIRMAN: I'll take your answer and we'll move on[58]

55. During the evidence, a large amount of attention focused upon the "Incidence of Hyponatraemia at RBHSC" bar chart[59] which Dr Taylor attached to the presentation he emailed to Paul Darragh, in advance of the Hyponatraemia Working Party meeting of 26 September 2001. The bar chart does not include reference to Adam Strain's death (in 1995), or Claire Roberts' death (1996). It is therefore inaccurate. However, it is submitted that the circumstances surrounding the compilation of the bar chart provided ample explanation as to how this oversight occurred, and mitigation for the error. It is submitted that it is clear the omissions were unintentional. Further to this submission:

55.1. The bar chart was a document clearly described as a "draft" in the email to Paul Darragh – with Dr Taylor writing: "*Here are some draft documents for your consideration in advance of the meeting on the 26 September."*[60] The documents were unsolicited and the bar chart was not taken further or used in any way at the meeting. Had it been, it is highly probable that the absence of Adam's death would have been spotted, because Dr Crean was at the meeting of the Working Party for which the document was created. Thus it is clear that the inaccurate omission of Adam's death could not have been intentional – because Dr Taylor was expecting the document to be used, and Dr Crean would have seen it. From Dr Taylor's point of view, it is in fact unfortunate that the document was not tabled or used in any way at the meeting, as Dr Crean would no doubt have spotted the omission;

[58] Evidence of Dr Nesbitt: 3/9/13; p202(10) – 204(24)
[59] 007-051-103
[60] 007-051-100

55.2. The research that produced the data for the bar chart was not carried out by Dr Taylor. Rather, it was carried out by his secretary, upon his request. The pages of "raw material" data that were produced by her were provided to the Inquiry, having been retained by Dr Taylor. These pages evidence the contemporary research undertaken by the PICU secretary at the time. It is submitted that it is crucial to keep in mind that they are consistent with the bar chart which was in fact produced. The research did not supply information about any hyponatraemia related deaths in either 1995 or 1996, and this was reflected in the draft bar chart. Dr Taylor did not misrepresent the data which he received in any way;

55.3. That the data located by the PICU secretary was imperfect is unsurprising, given the database which was being used. The limitations of that database were explained by Dr Taylor in his written evidence: *"There was a PICU computer database developed in the 1980s that was used for clinical audit. This was not supported by the Trust IT Department. Data was entered and accessed on an "ad hoc" basis by the doctors and the PICU secretary ... The PICU secretary had acquired the information for this bar chart from these PICU computer records."*[61] The source for the data was therefore imperfect, to say the least (the database being the product of the best intentions of the clinicians, but also being unfunded and unsupported). It is submitted that this factor readily explains the inaccurate data which was produced by the secretary's research.

56. It is further submitted on behalf of Dr Taylor that it is vital to bear in mind:

56.1. that the bar chart (and powerpoint presentation) were not used at the meeting; and

56.2. that the absence of Adam's death did not have any practical consequences for either the conduct of the meeting, or the nature of what Dr Taylor was trying to achieve through its submission.

[61] Statement of Dr Taylor: WS 280/1 pg 6, q5

57. Further to the second point, interventions were made during Dr Taylor's oral evidence which insinuated the omission of Adam's death carried grave consequences, but it is submitted this is not the case at all. This is because;

57.1. All relevant witnesses stated that the Working Party, at its one meeting, did not attempt to discuss any individual case (save for Raychel Ferguson's);[62]

57.2. Dr Taylor's purpose in asking his secretary to produce data was so as to ensure the Hyponatraemia Working Party was aware that hyponatraemia was an issue which warranted action. His evidence was as follows:

> I accept the bar chart was based on incomplete data. What I believe I was trying to do with Dr Darragh and the members of the group was to confirm that the incidence of hyponatraemia, even without death -- but the incidence of admission to ICU with hyponatraemia was a real problem. I wanted to make sure that the working party were aware that Raychel wasn't isolated, that we had also, as well as Dr Arieff and Dr Halberthal reporting this is a growing concern worldwide, that children presenting with hyponatraemia in tragic circumstances because of hypotonic fluids -- but this was also a problem in Northern Ireland. So that gave a focus. If we had turned up at the working party and it hadn't been seen as an increasing incidence then the working party might not have concluded that the guidelines -- I don't know, I'm speculating -- would have been such an important and rapid requirement to produce guidelines. They might have waited for the NPSA or, in those days, the Medicines Control Agency, to produce guidelines. What I tried to do was the best effort that I could and I recognise that I missed important information on that. But all I was trying to do was to give a narrative and at the working party I didn't produce this graph, I gave a narrative, and my narrative was to say that incidence of hyponatraemia in Northern Ireland is as described in the literature and it's something that we have to work quickly towards resolving.[63]

57.3. It is submitted that Dr Taylor's actions were consistent with this evidence. The Bar Chart is labelled "Incidence of Hyponatraemia", as opposed to "Incidents of Hypontraemia", and individual incidents were not

[62] Evidence of Dr Crean: 11/9/13, p87(22) – 94(12)
[63] Evidence of Dr Taylor: 18/9/13, pg 96(15) – 97(17)

discussed. Had the bar chart been used, it would have helped Dr Taylor in his depiction of a scenario whereby the incidence of hyponatraemia at RBHSC was increasing. The bar chart was not being used to conceal cases of hyponatraemia – on the contrary, it highlighted its increasing frequency, in precisely the way Dr Taylor described;

57.4. It is finally submitted that there is no evidence whatsoever that Dr Taylor was aware, or could have been expected to anticipate, that Dr Nesbitt would adopt the bar chart and incorporate it into his own hyponatraemia presentation (which Dr Nesbitt gave subsequently, for example to the Chief Medical Officer). This was not discussed with Dr Taylor and he had no knowledge of it. As far as Dr Taylor was concerned, the "draft" bar chart was never tabled at the meeting, never referred to, and never used.

58. It is further submitted that Dr Taylor should not be criticised for "failing" to disclose Adam's death to the Working Party given (a) the above circumstances and (b) the fact that individual cases were not discussed at the initial meeting (Dr Taylor played no part in the work of the "sub-group", which met again). It is submitted that inherent to any "failure" to disclose Adam's death must be an established obligation to disclose it in the first place. As to this:

58.1. Dr Taylor's understanding was that the other members of the Hyponatraemia Working Party would have known about Adam's death, in any event. It is not disputed that with the benefit of hindsight (and particularly in conjunction with the regrettable error on the bar chart) it would have been preferable for Dr Taylor to have ignored the overall style of the meeting and himself mentioned Adam Strain. However, it is submitted that it is highly implausible to attempt to portray a scenario in which, of the attendees at the meeting, only Dr Taylor had knowledge of Adam Strain. This contention would apply a disproportionate significance to the draft bar chart document (which was not even used) and would ignore the fact of the Inquest and attendant publicity of 1995. This was a point made by Dr Taylor during evidence:

Well, Adam's death was a coroner's inquest and, in 1996,

> when the inquest was being held, it was very well reported in the local press, and my view was that every clinician working with paediatrics was aware of the inquest and the findings of the coroner. It was very prominent[64].

59. It is separately submitted that the suggestion that Dr Taylor could have mentioned the case of Claire Roberts to the Working Party is wholly unrealistic, for the following reasons:

    59.1. Her death was not identified by the PICU secretary upon her interrogation of the PICU database, and so was not included in the raw material which was used for the bar chart;

    59.2. Her death was not known to have been caused by hyponatraemia in any event – if her treating clinicians (for example Dr Steen and Dr Webb) had not identified hyponatraemia as the cause of death in 1996, the suggestion that an individual with practically no knowledge of her case should be referring to it some five years later is patently unfair.

60. In an email written by Dr Carson to the Chief Medical Officer on 30 July 2001[65] (copying in Eva Craughwell, Dr Taylor and Raymond Fulton), Dr Carson wrote "Bob Taylor thinks that there have been 5-6 deaths over a 10 year period of children with seizures, but he has not seen any Cochrane reviews on the subject". Further to this:

    60.1. All of the evidence given by the relevant parties stated that this figure included deaths outside of Northern Ireland. This was the evidence of Dr Carson[66] (who wrote the email, and who recalled the figure as a national one),

[64] Evidence of Dr Taylor: 18/9/13; pg 91(17-22). It is noted that Dr Chisakuta stated that he was not aware of Adam's Inquest. However, Dr Chisakuta was in England working at Great Ormond Street at the time of the Inquest, with the post commencing on 1/2/96 [WS 283/1 pg 2].
[65] 026-016-031
[66] Evidence of Dr Carson: 30/8/13; p95(19) – 96(14)

and of Dr Taylor[67] (whose evidence was the figure was most likely referring to international deaths);

60.2. This reading make further sense due to the reference to 'Cochrane Reviews' which is contained in the same sentence;

60.3. It was suggested at one point in cross-examination that the figure of 5-6 deaths could be interpreted as consistent with taking all of the deaths being considered by Inquiry, and adding a separate, additional death from 1997, which is referred to on the draft bar chart. It is submitted that this hypothesis plainly stretches credulity. It requires an entirely one-eyed reading of the documentation in order for it to become a possibility, and also requires that the same bar chart which is being criticised for its inaccuracy with regard to 1995 and 1996, then has its content cherry–picked so that the 1997 death is appropriated to tally up the number of deaths and reach a figure of 5 or 6. It is submitted the contention therefore becomes impossible to sustain even before one factors in the fact that Dr Taylor did not know about (for example) the role of dilutional hyponatraemia in the death of Claire Roberts. Finally, had Dr Carson been casually referring to 5-6 deaths in Northern Ireland, all of the recipients of the email would no doubt have wanted more information. It is submitted that on any view, the figure cited plainly included deaths outside of Northern Ireland;

60.4. With regard to Dr Carson's email[68] it is noted for completeness that it is only the sentence beginning "*Bob Taylor thinks*…" which is attributed to Dr Taylor directly. The preceding lines introduce a document "*drawn up by Bob Taylor and his colleagues*", before Dr Carson writes "*The anaesthetists in RBHSC*..." In short, these lines are consistent with Dr Carson summarising a compendium of knowledge gleaned from various sources. It is submitted that the fact that one sentence is specifically attributed to Dr Taylor in fact makes it more likely that the rest of the (non-specifically attributed) content did not come from him.

61. It is generally submitted that Dr Taylor made a significant contribution to the work of the Hyponatraemia Working Party. Specifically:

[67] Evidence of Dr Taylor: 18/9/13; p110(13) – 114(5)
[68] 026-016-031

61.1. He carried out some research in the period after Raychel Ferguson's death, and prior to the Working Party's meeting, and as a result of this preparation he sent to Dr Carson the two page document "Hyponatraemia in Children"[69]. Whilst being little more than a précis of the articles which he referenced in the document (a 1998 article by Arieff, and a 2001 article by Halberthal), the document was nonetheless commended by Dr Crean as being "very good"[70] (although he viewed the short document as "*summarising what has been said in the Arieff paper from 1992 really. It's really just saying it in a different way*."[71])

61.2. Contemporaneously, Dr Taylor contacted the Medicines Control Agency to suggest that consideration should be given to the issuing of a "yellow card" with regard to solution 18[72]. In case it is of assistance to the Inquiry, it is here submitted as an aside that this was the proper way in which a clinician could seek to influence practice in hospitals. It is submitted that a clinician from the RBHSC telephoning consultant colleagues elsewhere, recommending a sweeping ban on solution 18, is likely to be given very short shrift (particularly in light of the faith which paediatricians had built up over the years in the utility of solution 18[73]). Were such an approach feasible than the responsibility on clinicians would be never ending – why, for example, did Dr Bohn not telephone around every hospital in Canada as a result of his concerns over the misuse of low sodium fluid? This was a point made forcefully by Dr Carson:

> If I had known about it and it was felt of significance, I would refer the matter to the Department of Health and it would be their decision and their responsibility to implement any guidance for the region, and rather than me as a trust medical director issuing guidance.
> Do you think every hospital's going to do everything that the
> Royal Group of Hospitals suggests is appropriate?
> …

[69] 043-101-223
[70] Evidence of Dr Crean: 11/9/13; p81(3)
[71] Evidence of Dr Crean: 11/9/13; p81(7-9)
[72] Statement of Dr Taylor, WS 008/1 p17-19; See also document 12--071f--413
[73] Evidence of Dr Taylor: 4/6/13; p182(22)-183(3)

> But I reinforce the point -- and this is not unrelated to the comments that we were making earlier about NCEPOD and SHOT. If things are of such significance and patients are at risk, the responsibility, I believe, is on the Department of Health to issue clear instruction and guidance to the service. One hospital to another hospital I think is -- leaves it open for inconsistent implementation and for inconsistent message to be conveyed to the service. Whereas if it comes from the Department of Health or the health boards or any other statutory organisation, then that is different.[74]

Conclusion

62. For the reasons given above, it is submitted that the potential criticisms which intersect with Dr Taylor's role in events, should more fairly be cast as criticism of the system, as opposed to being personal to Dr Taylor.

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[74] Evidence of Dr Carson: 30/8/13; p40(10) - 41(13)