Wednesday, 18 September 2013

(10.00 am)

(Delay in proceedings)

(10.14 am)

THE CHAIRMAN: Good morning. Ms Anyadike-Danes?

MS ANYADIKE-DANES: Good morning. I call Dr Taylor, please.

DR ROBERT TAYLOR (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning, doctor.

A. Good morning.

Q. You've given evidence a number of times -- I think in almost every section -- and also provided witness statements in relation to the other children's deaths. The witness statement that you provided in relation to Raychel, the reference is 330/1, and it is dated 22 May 2013. Can I ask you, as I've asked you on each occasion, do you adopt that as your evidence, subject to anything that you say to the chairman today?

A. Yes.

Q. Thank you very much. I wonder if I might start with something that we have touched on before in your evidence, which is what did you consider the Children's Hospital's role to be in relation to other hospitals in the region? And I'm asking this in relation to 2001.

A. To other hospitals we were a resource that could be used by professionals, by anaesthetists -- and I suppose paediatricians, but mostly anaesthetists -- to come and share some skills and some knowledge that we would have.

Q. Yes. The Children's Hospital was commissioned as a regional resource by the other boards at that time?

A. I don't know about the structures so well, but what I knew, what I know, is that the paediatric intensive care is a regional resource. I don't think the whole Children's Hospital is a regional resource. Some services in the Royal Belfast Hospital for Sick Children -- I could be wrong about this, I don't know. I think children's neurology is a regional service, I think children's intensive care is a regional service. I don't think the whole hospital is a regional service.

Q. I don't have to deal with you in detail about that, if I just for the purposes of reference say that Dr Carson gave evidence about it, and the transcript for it is 11 June 2013. It starts at about page 141 where he talks about the commissioning arrangements for the Children's Hospital.

A. He'll know that better than I.

Q. From your point of view, the paediatric intensive care, where you worked, that was a regional resource?

A. Yes.

Q. Would you say that, along with providing the care to the region as a whole for that type of child who required it, that along with that would go providing advice in relation to treatment for children who required that kind of service?

A. Yes.

Q. And if one looks at it in that way, would it be fair to say that if, as a result of the work that was being done at PICU, there were concerns about practices from referring hospitals, let's put it that way, that that was something that PICU, those who work there, really ought to be communicating?

A. Yes.

Q. And not just in an ad hoc way, i.e. I happen to have seen this child and I'm a little bit troubled about her care, but to the extent that we, as PICU intensivists or anaesthetists, have a concern about what's happening in relation to any particular part of care in the district hospitals, then that's something that we should perhaps be drawing to people's attention in a more coordinated way?

A. Can I just caveat my three yeses that I gave previously with the fact that it was my knowledge that the anaesthetists, intensivists, should share that knowledge. I don't know if there was a formal structure

where you give PICU a sort of structure, an institution. I'm not sure if there's an institutional arrangement for ... Am I taking it too far?

Q. No.

A. As I understood, my yeses were that I, as a doctor working in PICU -- and I'm sure if my colleagues would see that if a concern was noticed by us, we would have a responsibility, if you like -- maybe an obligation -- to share that information with colleagues.

Q. And to the extent that that concern could be distilled into a guideline or a set of recommendations that might be helpful, in the way that you've produced the meningococcal guidelines, for example, that is something that you would see as a step that those in PICU could take?

A. I think that's a good example because, as you know, the meningococcal guideline was developed as a lead through us and including stakeholders. You can't -- what I have found over my years was that it's not very good drawing up a guideline from the Royal and telling everybody to follow it. That's not my experience of working with people. Home ventilation would never have been developed without involving stakeholders. So any guideline or help that I was to give for paediatricians and anaesthetists working in Northern Ireland would be

better for the fact that we would include doctors and nurses and physiotherapists from other hospitals, and their input was valuable. If you could sell it to the people at that, if you like, working group or that committee, then it was much more likely to be taken seriously and adopted.

Q. But that was certainly an activity that you developed in relation -- I think you had two guidelines that emerged out of the sick child liaison group --

A. That's right.

Q. -- but that was certainly something that you could do and it was something that, in general, could happen.

A. Yes, and I think I've given another example where I was quite interested in programming, a little computer programming when I was in Toronto and I went to a few night classes in computer programming. But I developed a dose calculator, so all you had to do was type in the patient's body weight, 9.8 kilos, and all the drugs that were commonly used -- it was complicated drugs like adrenaline, noradrenaline, those would just get printed out on an A4 sheet and that's a little program that I give to paediatricians and anaesthetists on request, and sometimes not on request, in the hospitals throughout Northern Ireland, and the feedback was that that was very useful, that in the heat of battle during

resuscitation of a sick child they would be able to type in a very simple body weight and everything would come printed out. I think that's another example of maybe what you're getting at.

Q. So in principle, if those at PICU had a concern about fluid management, to bring it home to what we're discussing, and could see a way how something could be developed which might assist the referring hospitals or district hospitals, that is something that the clinicians in PICU could have developed into a guideline and could have disseminated?

A. Yes.

Q. Thank you. And in fact, in 2001, there was, was there not, sufficient information about the risks that some children might be exposed to with the use of low-sodium fluids in intravenous therapy, there was enough knowledge about that and, in fact, maybe even concern about practices in the district hospital for such a guideline to be produced in 2001?

A. I have no recollection in 2001 that that was a concern.

Q. Well --

MR UBEROI: I wonder if it could be time marked more clearly within 2001. Are we talking pre or post the death of Raychel Ferguson?

MS ANYADIKE-DANES: Let's say before Raychel's death.

A. I can't remember being concerned in PICU about the administration of fluids other than what was coming through from Arieff and then obviously the lesson of the week from Dr Halberthal and his colleagues, which was on 31 March 2001. And I think that's an article that was a seminal article.

Q. Let me see if I can help. Firstly, you know that there has been an issue that the inquiry has been investigating in relation to a change in the practice of the use of Solution No. 18 at the Children's Hospital.

A. Yes.

Q. You're aware of that. And how that came to our attention more specifically was because Dr Nesbitt said that he made contact with Dr Chisakuta and Dr Chisakuta gave him certain information in relation to there having been such a change. It was put at about six months before Raychel's death. Dr Chisakuta doesn't remember that, but you know that that's the evidence that --

A. I have read the transcripts, yes.

Q. And you know that he said that not only did he have a conversation with Dr Chisakuta like that, but he also had a conversation with Dr Anand, who attributed that sort of thing to a change in practice at Tyrone. Dr Anand can't now remember that, but you know that that's the evidence?

A. Yes.

Q. And you know that we have sought corroborating evidence for the use of Solution No. 18 and we have been produced various figures, which seem to indicate that there was a reduction at some point. You have seen that information as well.

A. I think it's clear there was a reduction in the dispensing of fluids from the pharmacy. I'm not sure that exactly correlates, as I've said before, with the usage of the fluid. I don't think you can exactly correlate the two, but there's no doubt there's a big reduction and I agree that there was a big reduction in the dispensing of the fluid from the pharmacy to the RBHSC. There's no doubt that that is accurate data.

Q. You might not be able to make an accurate or even any real correlation, save to say that those who are going to administer Solution No. 18 are getting it from the pharmacy and the pharmacy has a very significant drop in its dispensing of it.

A. That's correct.

Q. I don't know if you've seen it, but we had a letter from DLS dated 23 August 2013. The information for that letter came from Dr Crean, who said that certain parts of it weren't entirely accurate. I can pull it up so that you have it in case you haven't seen it. It's

321-073-001.

You can see in that first large paragraph, about two-thirds of the way down:

"We are instructed that the change of practice most likely refers to intraoperative fluids prescribed by anaesthetists and not post-operative fluids."

I think Dr Crean has said that he's not sure he's entirely accurate as to his logic, but what doesn't seem to be being denied is that there was a change of practice in the use, or rather the prescribing, of Solution No. 18.

And furthermore, we had a statement from Paul Loan volunteered to us. Are you aware of Paul Loan?

A. Yes. He was a former colleague of mine in the Children's Hospital.

Q. If we pull that up, it's quite short. If we can pull up, please, witness statement 360/1, and pull up pages 2 and 3 next to each other, please. In fact, this is the entirety of his statement; page 1 is just the cover sheet for it.

So he had heard the evidence in relation to the changes in the use of Solution No. 18 and he volunteered this statement, where he tries to explain his experience. We can pick it up firstly in the first substantive paragraph where he says that he returned to

Belfast having been in Toronto, the same unit you were in; is that correct?

A. Yes.

Q. He returned in January 1997. And then if we go, so that you've benchmarked when he's coming back, and he has the information about the different attitude to the use of prescribing Solution No. 18 than had been common when he was in Northern Ireland and was still prevalent amongst the paediatricians when he returned.

Then if you see the middle paragraph:

"I found it difficult to challenge ..."

The third sentence there says:

"However, soon after my return to Belfast I became educational supervisor in anaesthesia for the Children's Hospital. I consistently taught my approach to fluid balance in children to these groups, which included the risks in relation to Solution No. 18."

And then he goes on in the penultimate paragraph to say:

"It is possible that my efforts to teach what I believed to be a rational approach to IV fluids in children may have resulted in some of the reduction in the use of Solution No. 18."

Then he goes on, in the latter part of that paragraph, to talk about Mr Trevor McNulty. You're

aware of who Mr McNulty is and was?

A. Yes, he's a friend of mine.

Q. Yes, and he was appointed the resuscitation training officer and he was a vigorous proponent of the APLS style of fluid management and he says that his approach, which was in line with his own views, may have been more effective than his own in changing practice. And then -- and this is what I particularly want to draw your attention to in terms of something concrete about the change in practice -- there came a point where:

"Mr McNulty wanted to rationalise and standardise the contents of the resuscitation trolleys in the Children's Hospital."

Dr Loan suggests that:

"... the accidental use of hyponatraemic fluids during resuscitation would be counterproductive and dangerous and that they should be removed from the trolleys."

And he thinks that Mr McNulty accepted that argument. So that's one certain thing, according to Dr Loan, that happened. They got removed from the resuscitation trolleys.

Then he goes on to say:

"Following this, I heard that the removal of hyponatraemic fluids had been extended to the entire

emergency medicine department in the Children's Hospital for similar reasons."

Were you aware of that?

A. Yes. Again, like him, I'm not aware of the date. It's possible it followed the introduction of the Department of Health guidelines wall chart. I'm unaware of the date that changed. But yes, I was aware it was taken off the resuscitation trolleys.

Q. If it were to follow the introduction of the Department of Health guidelines in March 2002, you wouldn't be restricting that to simply the entire emergency medicine department because those guidelines were to take effect wherever children were going to be treated. And I would have thought that if that's what he meant, his statement would read rather differently. So if I can put it to you this way: you were aware that that change happened; is that a change in line with what you had said earlier, that you think ought to have been communicated to other hospitals?

A. Um ... Well, yes.

Q. Yes?

A. It would have made good sense to communicate that to other hospitals.

Q. Thank you. And if anybody had drawn up any guidelines or protocols in order to assist the doctors in those

units about that, that's something that should go along too? That would be the logic of it, wouldn't it?
A. Yes. Can I just illuminate the resuscitation carts? There's, I think, two bags of fluid on a resuscitation cart and it's not used unless in the event of a cardiac arrest. So this is not ward prescribing of normal saline; this is to be used in the rare, the relatively rare, event that a child would arrest on a ward. So there's about ten areas, maybe 12 -- I'm not sure of the exact number, don't quote me -- resuscitation carts in the Children's Hospital, so that would account for maybe 20 bags of Solution No 18 being removed.

The emergency department mainly looks after children who come in with bumps and scrapes and sore tummies, not every child that attends the emergency department of the Royal Belfast Hospital for Sick Children would have fluids erected or prescribed. Most children go home after a period of treatment.
Q. Dr Taylor, that's not actually the force of my comment to you. Why I'm really asking, although that's helpful to know that --
A. I thought you were looking for why the -- I had read this to being why the numbers tailed off so dramatically and that doesn't, to me, tally in with why this practice would have dropped the numbers so dramatically.

Q. I understand you to be saying that. Dr Loan is trying to help the inquiry by giving an explanation. Why I'm asking you about that is because it seems to indicate a change in practice and I was putting it to you, because of what you said earlier, that given that there had been a change in practice, that that is a change in practice that ought really to have been communicated to the other hospitals, and I think you've just agreed with that.
A. Yes. The practice of resuscitation was to be done with normal saline. That was the APLS guidelines, which was promulgated throughout all the departments doing paediatrics and anaesthetics in Northern Ireland.
Q. I appreciate that. What I'm trying to ask you is: there came a point in time when the Children's Hospital decided that it was going to remove Solution No. 18 from resuscitation trolleys and it was going to remove it from the emergency medicine department. My only question to you is: if you had made that decision, then that -- and I think you have agreed with me twice now -- is the sort of decision that should be communicated to the other hospitals.
A. And I believe it was in terms of APLS guidelines.
Q. From the Children's Hospital. Did the Children's Hospital communicate the fact that they had

done that to other hospitals?
A. The APLS course was run from the Children's Hospital.
Q. So you believe that the Children's Hospital had made that decision?
THE CHAIRMAN: I'm not sure you can follow that because the doctor made the point at the start of his evidence by saying that the communications don't necessarily and probably don't best come from the Children's Hospital. And I think the point you were making was it wasn't effective practice just for the Royal to send out "we're changing things and this is why we're changing things", that you would -- that works better if you engage with other hospitals in that process.
A. Yes.
MS ANYADIKE-DANES: I'm sorry, Mr Chairman. Perhaps I can frame it another way.

So far as you're aware was the fact that the Children's Hospital had effected that change and the reasons behind it communicated to the other district hospitals?
A. In terms of phoning other consultants in other hospitals, I don't believe that happened.
Q. Thank you. Are you able to offer any explanation for the information that was given to Dr Nesbitt, which is that the Children's Hospital had changed, in round

terms, its practice about six months prior to Raychel's death and was no longer using Solution No. 18 because of the risks involved in low-sodium fluids? Other than those specialty areas like renal problems, for example.
A. I don't recall any guideline that told us to stop using No. 18 in the Children's Hospital six months before Raychel died.
Q. I don't necessarily mean a guideline. Can you offer any explanation for how such information could have been given to Dr Nesbitt?
A. No.
THE CHAIRMAN: There does seem to have been a move away from the use of Solution No. 18 or a reduction in the use of Solution No. 18; would that be right?
A. I agree, sir. I can't explain it other than I believe, looking back, that the Halberthal paper, the lesson of the week, BMJ, 31 March 2001, was a very sentinel document, and I think that stung us all. The key learning point from that was that no child should be given hypotonic fluids with a sodium of less than 138.
MS ANYADIKE-DANES: When I was putting to you what the Children's Hospital might have communicated, I was discussing with you the particular points that Dr Loan mentioned, which related to resuscitation, and I think when I put that to Dr Crean he could see very good

reasons why you would do that, and you've developed that by saying that some of that was coming out of the APLS.

A. I think it was directly related to APLS.

Q. If I may extend that a bit to ask you about some of the other concerns because I think you weren't entirely aware that there were concerns at the time just prior to Raychel's death about the use of Solution No. 18, other than in the way that we've just been discussing.

I wonder if you might consider this, for example. If we can please pull up 036a-055-141. This is a letter from Dr Kelly, who is the medical director at Sperrin, and he is writing following a meeting of medical directors. He says, in the course of that meeting, that he was made aware a recent death in paediatrics, but it's what he goes on to say. He says:

"The medical directors present were able to report a number of near misses round the Province and we have been made aware of an article in the BMJ [that's the one I think you referred to]. It also appears that the Children's Hospital has changed its guidelines and no longer uses Solution No. 18 post-surgery or for rehydration in paediatric medicine."

That is a meeting of the medical directors. So presumably, your medical director would be there. Unfortunately, we don't have the minute for that

meeting. We've asked for it but it doesn't appear to exist. But he's writing that as if that was discussed and that had in no way been challenged in the course of that meeting because what emerges out of that meeting is this view that he has. Can you explain how that could be a view that emerged out of a meeting at which, let us say, your medical director might have been present, that the children's hospital had done that?

A. I haven't read this paper before.

Q. Sorry. If I give you a few minutes to look at it.

A. Looking at it, it does seem strange that the RBHSC on 21 June 2001, which is the date -- it says the RBHSC has changed its guidelines. I wasn't aware that we had guidelines to change. I wasn't aware -- I've been working in the Royal since 1991 -- that we had guidelines for giving fluids and that we changed them. Maybe I'm in the dark on that.

THE CHAIRMAN: What actually happened at that meeting, doctor, was that Dr Fulton had come down from Altnagelvin -- this is just a few days after Raychel's death.

A. Yes.

THE CHAIRMAN: He came down because there happened to be a pre-arranged meeting of medical directors, which on this occasion was not taken by the CMO, but taken by

Dr Carson, just as it happened.

A. Yes.

THE CHAIRMAN: And Dr Kelly was one of a number of people who were discussing this around the fringes of the meeting, but then he wasn't there, he wasn't able to stay to the very end, and Dr Fulton's evidence to the inquiry was that when he and Dr Kelly and others were discussing this -- and I think including a Dr Loughran from Daisy Hill, Paddy Loughran -- the response which they got when they discussed it, and Dr Fulton said he got, was that people were not saying to him "I've never heard of that", it was" I know something like that". For instance, Dr Loughran remembered there was some incident in Dublin that he'd heard about, that he was able to mention just off the top of his head, and Dr Fulton mentioned it to Dr Kelly, Dr Kelly responded in terms which were not entirely clear; it may have been referring to Lucy, but not as a death.

So the conversation which took place that day was a bit unsatisfactory, but the gist of it, as reported by Dr Fulton, was that other doctors who were there were familiar with a concern about severe hyponatraemia leading to seizure activity and coning in the context, perhaps, of Solution No. 18.

A. Right.

THE CHAIRMAN: And I think what Ms Anyadike-Danes was asking you was: do you remember that coming back to you from that meeting? Was any information about that brought back in to the Children's Hospital?

A. I can't remember, but I know that -- I'm sure you'll come to it. At the sick child liaison group on 26 June, I informed the members of that, the small number of members of that group, that there had been a death. So I knew about that, obviously working with Dr Crean, that Raychel had died on 10 June. I made a comment that there was to be guidelines from the department .So I must have had some information from this meeting.

THE CHAIRMAN: These things are all happening at about the same time.

A. Yes.

THE CHAIRMAN: And it might be that the Halberthal article has had a major effect, but Solution No. 18 was certainly on the radar by June 2001, wasn't it?

A. After Raychel's death, I think. I think it was a shocking event.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: Actually, doctor, I'm still working on the period just before that because if medical doctors are able in June 2001 to apparently have been reporting a number of near misses around the Province, then that's

something that doesn't have to logically, but it seems it would be plausible to suggest that those near misses are events happening before Raychel's death --

A. Yes.

Q. -- given when she died in relation to this.

A. Yes.

Q. And I'm just talking about, as the chairman has alluded to, a feeling that might have been abroad that there is a concern about Solution No. 18, either because it can be so disastrous if it is not properly managed or that it's wrong in principle to use it. There's a concern about Solution No. 18 in relation to the potential risks.

So if I can put to you another meeting. This is a meeting dated 2 July 2001. This is a meeting of the directors of public health.

Dr McConnell is there, and of course he knows about Lucy. And if I bring up the last page of that, which is what's relevant, 320-080-005. You can see under "any other business", hyponatraemia is there, and it is Dr McConnell who highlights a recent death in Altnagelvin. Of course, he's had a death in the Erne.

And then you can see:

"Current evidence shows that certain fluids are used incorrectly post-operatively. It was agreed that

guidelines should be issued to all units."

So in fact, this is a concern that Dr Crean had given in evidence, which is it's not so much Solution No. 18 itself, it's the consequences of it if it's used inappropriately, and his evidence was that he did know that it was used inappropriately from time to time, as did you, did you not, from children being referred from district hospitals whose fluid management might give rise to some concern? You knew that happened, didn't you?

A. I can't remember cases. I can't remember what I knew in front of Raychel's death, but I certainly, as I keep saying -- the lesson of the week had a big impact on what ... and then when Raychel died, looking back to the lesson of the week was a very salutary --

THE CHAIRMAN: Let me test this with you: did the lesson of the week come completely out of the blue or does the lesson of the week reflect that there is -- I'm not quite sure how you would describe it -- a developing concern or developing issues about Solution No. 18?

A. It seemed to be a very sentinel event. I knew obviously of Arieff and I knew of Adam, and I think Adam, as we've said, was unusual because I was treating polyuria, which was a very uncommon presentation and had miscalculated his urinary output. I think even though in 1995 when

I was managing Adam there was a move back then by anaesthetists -- and this has come through from the transcripts -- that I think us anaesthetists, adult and paediatric anaesthetists, were really moving away from sugar-based solutions in the operative period, that is for children who were in shock before they came to theatre, children with septicaemia. We would be more in control of what fluids we wanted to give those children to resuscitate them so that we could make them fit for anaesthesia.

I don't think we were giving hypotonic solutions in the operating room, and that's because we were using boluses of fluid during operations for surgical bleeding and for the operative losses. We were, I think, all on the same sheet at that stage throughout the UK, even globally, that even for children -- apart from young babies who needed sugar to prevent hypoglycaemia -- but I think the big issue here for you, sir, and your investigation is how were the post-operative fluids managed after the anaesthetist really had handed the child over.

THE CHAIRMAN: It's more than that because Claire and Lucy aren't post-operative.

A. That's correct, and I think the paediatricians were more reluctant. We weren't reluctant at all to not use sugar

solutions, but I think the medical paediatricians and the surgeons who were managing patients and using much more fluid in terms of quantity dispensed to the Children's Hospital. Even after the guidelines, I recall resistance to moving away from a solution that had proved beneficial in the management of -- can I say "beneficial"? -- in the management of many children over the years. And I agree with Crean, it wasn't the solution itself; it was a mixture of vomiting, dehydration, blousing. Those were the -- he called it misuse of the fluid, but it was other losses.

THE CHAIRMAN: And not measuring electrolytes?

A. That's correct.

THE CHAIRMAN: And people just failing to spot what was really happening in front of them, people going on assumptions.

A. And perhaps if 10 ml of Solution No. 18 was good for you, 20 ml would be even better for you. I think there was a possible naivety. But this was a fluid that was very commonly prescribed and it was very hard, even after evidence, even after lesson of the week ... I think we welcomed the lesson of the week. It gave us -- it was written by an anaesthetist, it was written by Des Bohn and his colleagues.

MS ANYADIKE-DANES: Can I just pull it up so that people can

see the bit that you are referring to? It is 036a-056-142.

A. But how that would have led to a drop in the use, the dispensing of Solution No. 18 to our hospital I fail to completely comprehend because the paediatricians did not welcome a change in their practice as easily as we did.

Q. If we look to the marginal note of that, that's I think the bit that you also cited verbatim:

"Do not infuse a hypotonic solution if the plasma sodium concentration is less than 138."

That was obviously a banner headline and the logic of the thing is something that you say that, at least in the Children's Hospital, the anaesthetists were already of that view.

A. Yes.

Q. And if you like, this helped them -- I'm interpreting now from what you said -- in putting forward their argument because now this was another thing that they could use to support their view; would that be right?

A. Well, I'm speculating. I can't remember, obviously, what I thought 12 years ago, but it had a big impact and, of course, after the unfortunate death of Raychel, this was really very important.

Q. Yes, but if we just don't quite get there yet. This came out, I think, in March.

A. 31 March, I think.

Q. Yes. This comes out in March 2001 and because it's the lesson of the week, so you're going to see it pretty quickly, I would imagine. What's the immediate response or reaction to it to what one should do about it?

A. Well, I can't remember. I certainly recall we discussed it. I recall that this was in line with our practice.

Q. From the point of view of the anaesthetists, this wasn't really news. It might be news to set a target level which helps if you want to devise some guidelines, but the logic of it was not news to you and your colleagues in the Children's Hospital at that time. So if it's going to have an impact, where it needs to have an impact, is it not, with the paediatricians?

A. Yes.

Q. So when you see this, you and your colleagues see this at the Children's Hospital, what do you do with it or how does it help the professional difference that you're having with your paediatric colleagues?

A. I can't remember.

Q. Did it get used like that to try and effect change?

A. I can't remember. What I do know is that even in 2002, when we'd moved on, and even after the case of Raychel was well-known, there was still a reluctance to stop using No. 18 --

Q. But in any event, where, I think, the chairman --

A. -- or to ban it.

Q. -- was putting to you that it wasn't just as simple as the fluids used during the operation or even in preparation for the operation, the document that I had up just before that, which was the minutes from the meeting of the directors of public health, explicitly referred to certain fluids that are used incorrectly post-operatively. So they've identified that. And this is something that doesn't appear to be being recorded as if it's news; it seems to be being recorded in much the same way as you've got the evidence before saying, "We're aware of near misses".

So from your point of view, did you have any knowledge or any awareness that it was used inappropriately post-operatively at that time? From time to time; I don't mean necessarily routinely.

A. Well, you see, when we finish an anaesthetic we go to see the patient post-operatively and we wouldn't -- we obviously see how the patient's doing, but we wouldn't -- if a patient's on the fluids for maybe 24 or 48 hours, that would be beyond our prescription of that post-operative --

Q. It would if it happened in your hospital, but if you're seeing a child who had had a procedure in a district

hospital being referred, then you might be seeing them in paediatric intensive care trying to address an error or poor practice that had happened in another hospital, because that's exactly what happened in relation to Raychel.

A. Yes. I don't recall there being such a post-operative case transferred to us, who had mismanaged fluids. I don't recall such an event.

Q. Even without dealing with a case directly yourself, were you aware that that was happening?

A. I can't remember. It certainly didn't trigger a memory when I think back.

MR UBEROI: Sir, before we go on, I'm not suggesting it needs to be put to Dr Taylor, but perhaps for the record, to remind you of the Halberthal article and the evidence you heard, I think from Dr Jenkins, but how those articles were disseminated around the medical profession, and obviously, so there's no misunderstanding about it, it doesn't simply come into the Royal and rest there with the responsibility for dissemination; it goes to all clinicians through the Province.

THE CHAIRMAN: Yes, and one of the inevitable problems, in the same way as lawyers might know the New Law Journal or whatever it is, some get it, some don't, some

read it, some don't --
MR UBEROI: Absolutely, and that was Dr Jenkins' point as well.
THE CHAIRMAN: -- so how do you pick it up?
MR UBEROI: Yes, sir.
THE CHAIRMAN: If that's right, Mr Uberoi, and this comes out on 31 March, it's even more difficult to explain the sudden plummet of the use of Solution No. 18 in the Royal because -- I don't have the figures in front of me, but I think the real drop is in April, May, June. If this is published on 31 March and the drop in the use of Solution No. 18 is tied in as closely with the article as Dr Taylor's speculating -- and I accept that he is speculating -- it's an immediate plummeting of the use of Solution No. 18.
MR UBEROI: Yes, I do accept that on the point of the use of Solution No. 18, sir. It may be I was --
THE CHAIRMAN: It seems a bit odd.
MR UBEROI: I agree, sir. It may be I am foreshadowing the point that my learned friend is not to take, but I simply wanted to remind everyone, for the record, of the way the BMJ articles work and the way they're disseminated.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: Thank you.

And then, we'll come to it in more detail, but trying to establish what might have been known and what you might have known. You at some point prepare a document headed "Hyponatraemia in children". We can pull that up, 043-101-223 and 224. This document has the benefit of providing some explanation for the problem, which one can see in the first four paragraphs. Then it's got some recommendations, and there are some ready reckoners here in a way. And then there is an IV fluid prescription to assist.
So now the problem, as you state it, or describe it, is not one that was appreciated for the first time just prior to Raychel's death. For a start, you have dilutional hyponatraemia being documented in otherwise healthy children. Part of your reference, as you can see it on the second page, is Arieff's work. 1998 is the one that you've given there, but if you looked at 1998, you'd be taken to 1992.
A. Yes.
Q. So that's been around for quite some time, that proposition. Then you go on to talk about what happens in the body in relation to the isotonic fluids being metabolised and so forth to become hypotonic and the effect of that on fluid shifts and so on. And then you refer to the antidiuretic hormone and that response and

the effect that it has, and then, of course, if you are giving low-sodium fluids you end up with what you refer to as a double whammy. You appreciated that before Raychel's death?
A. No, I don't think this was produced before Raychel's death.
Q. Sorry, I'm not talking about when you produced it. You appreciated what you've just recited there --
A. Yes.
Q. -- before Raychel's death?
A. Of course.
Q. Yes. And the reason why you're giving all of that is because there is an increasing concern that there are some out there who don't appreciate that double whammy and therefore there are children at risk from time to time if they happen to fit into that category to be affected like that. That's correct, isn't it? That is why this is being done?
A. I'm sorry, I'm not quite ...
Q. And that's why you have --
A. I didn't quite follow that previous ...
Q. Let me explain it. That introductory part of this document contains information that you were aware of before Raychel's death.
A. Standard literature. It's not my -- I authored this

with input from colleagues, so it's not necessarily my words. But I authored it, so I am happy to accept --
Q. It's not a matter of -- I'm not putting it to you that way. In fact, all the better if you authored it with colleagues because that shows that you and your colleagues accepted this.
A. Yes, it's standard literature. There was nothing controversial about it.
Q. There wasn't? That was standard?
A. The fact of ADH and ...
Q. Sorry, maybe you can help me with this then.
A. This was reported by Arieff and Halberthal. This was not words that we had made up. Maybe we'd added some words to illustrate the issue, but --
Q. No, no --
A. This was papers from the literature. This was developed from the literature. It's not Bob Taylor --
Q. Going back to how far back?
A. I think it's referenced, the two references.
Q. I realise you've given those two references, but how far back would this particular classification of the issue be understood?
A. The date's on there. The dates on the references.
Q. 1998?
A. At least.

Q. You wouldn't have understood that before 1998?
THE CHAIRMAN: No, at least.
A. I can't remember. Quite possibly, yes.
MS ANYADIKE-DANES: Sorry, the reason I'm pressing you about that is -- when you gave your police interview in 2006 ... Can we pull up 093-038-286 and 287 alongside each other?

"There was an issue in relation to Adam's case about isotonic/hypotonic, if I can put it that way, and you're being asked about that by the interviewing officer. In relation to Solution No. 18, right at the top of 286, you said to him that you chose one-fifth normal saline because it's isotonic. You say "yes", and then he puts to you that that is a technical point and that:

"The minute it's infused, its effect is hypotonic."

Your answer:

"It can become hypotonic, but not in every patient. It depends on their metabolic condition."

And you go on to say:

"How quickly they burn glucose, basically."

Then, over the page, you're being asked to consider Adam in contradistinction to Lucy and Raychel. Lucy and Raychel were awake and active, Adam was anaesthetised. And you say:

"Apart from the brain, which contains some activity,

the rest of the body is at rest and the glucose metabolism is much reduced, so its ability to remain isotonic is enhanced."

And you conclude with:

"It shouldn't become hypotonic to the same degree. That's another reason why the isotonic dilutional hyponatraemia theory doesn't hold for Adam's case."

So when you're giving your evidence to the police in 2006, you seem to be having a sort of a caveat or a caution for that very straightforward example that you've given and why it ends up as a double whammy effect, that there are some children, those who are being anaesthetised, where it might not have that effect. Did you mean a qualification like that in that background piece that you provided in 2001? Should it be read with that kind of qualification?

A. I can't explain.
Q. Sorry?
A. I can't explain this.
THE CHAIRMAN: I thought that rather a long time ago, Dr Taylor had accepted that a number of the things he said prior to coming to the inquiry in last spring, spring 2012, were the things that he couldn't stand over and which he regretted having said.
MS ANYADIKE-DANES: Yes, Mr Chairman.

MR UBEROI: If I may add, I'm not sure where this takes us.
THE CHAIRMAN: We're not going to go back over taking Dr Taylor through previous police statements, Ms Anyadike-Danes.
MS ANYADIKE-DANES: We're certainly not going to do that.
THE CHAIRMAN: Then why are we there?
MS ANYADIKE-DANES: The only reason I asked that is that I went to check what was being said and I couldn't see that he had moved away from this point and I simply want to clarify whether, in 2001, he and his colleagues regarded the situation as being as straightforward as he had portrayed it in that document. That's the only point I'm putting to him.
THE CHAIRMAN: Which document?
MS ANYADIKE-DANES: The document at 043-101-223, which is his background piece, where he refers to the double whammy.

So as far as you were concerned, Dr Taylor, was it as straightforward as that? We can pull it up, sorry. 043-101-223 and it was alongside 224.

A. I hesitate to go back over Adam, but as you remember I was concerned that Adam had polyuria, ADH wasn't, as I understood it then, a factor in the development of dilutional hyponatraemia with Adam.
Q. Yes.

A. I think that was probably the main factor as I saw it at the time, related to the unfortunate death of Adam.
Q. Yes.
A. I was also trying to explain that -- I need some time to think about this -- glucose metabolism is obviously a factor. If you're burning glucose quickly, you will become hyponatraemic quicker. So I suspect this document refers to normal, healthy children who have got both ADH and a normal glucose metabolism, but I need some time to figure that out.
Q. That's all right. What I was really inviting you to comment on is how you have described the situation in those four paragraphs to the left, the introductory part, that's how you and your colleagues saw it in 2001 and, for that matter, I think you told the chairman you would have seen it like that in 1998 and possibly even before that, although you can't be certain.
A. And what I --
MR UBEROI: Sorry, I'm not sure it needs clarification. I thought the witness's evidence on it was perfectly clear a few minutes ago.
THE CHAIRMAN: I'm not sure why we're going over this, Ms Anyadike-Danes.
MS ANYADIKE-DANES: I think I've explained why I've asked it, but we can move on.

THE CHAIRMAN: Let's move on.
MS ANYADIKE-DANES: Sorry, I would like to stay with that document on the screen.
Then if that was the case and what you and your colleagues understood prior to Raychel's death, a document like that could have gone out prior to Raychel's death, just with that very helpful background piece, the recommendations and an IV prescription.
A. It could have. It's terribly unfortunate that it didn't and perhaps Raychel would have still been alive --
Q. Thank you.
A. -- but that's speculation.
Q. Yes.
THE CHAIRMAN: And part of the reason why it's speculation, you say, is that even with the guidelines being introduced and even with what was going on in Altnagelvin, there seems to have been some resistance on the part of various specialties to doing away with Solution No. 18?
A. Well, as I reviewed the evidence for the questions for this preparation for this, I did read the e-mails to the hyponatraemia working party and there was a fair bit of toing and froing with different views about what should be the right prescription to use. It's actually taken up to even now before we have the ideal solution and

we're actually getting some cases, I think it has been mentioned, of hypoglycaemia coming through. So we still in some ways don't have the right -- maybe we're not giving enough glucose now, ironically. So we're not there yet. I think we're all learning and we are still learning and trying to avoid harm in our paediatric patients.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: Can I take it that you think it could have helped the debate to have at least set it out?
A. We're all trying to think of things that we could have done better to prevent the death of a child. The death of a child is not good for anybody.
Q. When you were giving your evidence in relation to Lucy, you acknowledged that she appeared to have been scheduled for an audit meeting on 10 August 2000 and that there were signatures, including Dr McKaigue's, for such a meeting. But in your view, you don't think that there was any actual discussion of her case because you didn't see those who were principally involved in her case present; does that summarise it?
A. Well, as I recall, my secretary did the administrative element of the mortality part of the audit half day, and I trusted the PICU secretary to do that and to make sure the people who were going to present were there, the

chart was available, the post-mortem results were available if it had been a post-mortem, and she was very good at doing that.
Q. Yes, you said that.
A. So if she said the case was presented, I trusted her, but it -- I think I said that it seems difficult to explain how it could have been presented if neither Dr Hanrahan nor Dr Crean nor Dr Denis O'Hara were on the register of that particular meeting.
Q. Sorry, I thought your evidence concluded with the fact that, as a result of that, you didn't actually think there was a discussion of Lucy's case.
A. Yes, I don't see how it could have been done without the people who would have presented it being present.
Q. Yes. And the reason I ask you that is you were subsequently asked by Mr Walby about the audit meetings for both Lucy and Raychel, and you sent him an e-mail. It's 321-074-001. It's considerably after the event, the e-mail is dated 15 December 2004, but you do say in it:
"I can confirm that the following were discussed at audit: Lucy Crawford, audit meeting 10 August 2000; Raychel Ferguson, audit meeting 10 April 2003."
A. Well, this for your help and information, wasn't an e-mail, this was actually a letter, and it was typed by

the PICU secretary. You can see at the bottom left-hand corner is "BT/MOR", which presumably is Bob Taylor and Maureen O'Reilly, who was the PICU secretary. I don't remember writing this memo. It was written by Maureen O'Reilly, that is my signature, and I signed this after the event and I signed it after she had written it to confirm that the case had been presented, but my knowledge now is -- and I obviously signed this without reading the attendance register, which is a fault. So I signed this without confirming that the case could have been presented then. I now, as I've said earlier, am doubtful. I can't understand how Lucy could have been presented without either or all of the doctors, Crean, Hanrahan and Denis O'Hara, having been present at that meeting in August 2000.
THE CHAIRMAN: Sorry, does that mean that --
A. It could have been, but I don't understand.
THE CHAIRMAN: Your understanding then, was that based on the proposition that that was the next audit meeting after Lucy's death so that's the audit meeting at which you would expect her death to have been discussed?
A. No, I think she died in April. You don't follow it up with the first audit meeting, sir; it would be maybe years later, depending on how -- as I've said before when I was giving evidence, the mortality review, it's

not a mortality investigation. This is a review after all the information has been concluded so that the doctor can stand up, present the history, findings, investigations, and bring it to everybody's attention, the cause of death, and that would have been a conclusion as to the cause of death. The mortality review was not an investigation so it would have required all the information to be available and if you stood up and tried to present a case without all the information being presented to the doctors present, you'd have got a bit of a hard ride.

THE CHAIRMAN: If Lucy's death was not discussed in the audit meeting on 10 August 2000, when was it discussed?

A. I have been unable to find a date that she was discussed, and that's remained -- presumably that remained on the secretary's computer. I find that difficult to explain because the PICU secretary was particularly good at the administrative aspects of the mortality meetings.

MS ANYADIKE-DANES: The difficulty is -- and it's not a document in isolation because you have 319-023-005. There you have Lucy's name there. This is otherwise the list -- they have redacted the top and bottom because in fact there were five cases presented and discussed on that day, so they have taken out the references to the

others and left just this as the detail. When we see the equivalent that's done with Raychel, one can see that that's the standard form of the entry.

A. Yes.

Q. So she's entered there, I believe -- and I'll be subject to correction -- that Dr McKaigue, who did sign his name, seemed to have some perhaps recollection, although not in detail, of her case being presented at an audit meeting, and then you've got a document that confirms that it was discussed there, which you have signed. So it all seems to point to the fact that she was discussed at that audit meeting.

MR UBEROI: If I might just rise to remind my learned friend of the evidence we have heard on this. This, as my learned friend has properly pointed out, is an extract from the PICU secretary's spreadsheet. Then during the Lucy Crawford section of the hearings we saw the attendance register with a view to who was actually there on that day, and what Dr Taylor said at that stage, he would not have allowed, as the chairman of the session, a case to be presented without at least two of the three major people present. That, as I understood it, was the resting point of the evidence on this at the last section of the hearings.

MS ANYADIKE-DANES: You're absolutely right. That was

Dr Taylor's evidence, which didn't quite fit with either the documentation or Dr McKaigue's evidence. And I think he's accepted that.

MR UBEROI: It's a point for later, but it fits with the attendance register would be my response to that.

MS ANYADIKE-DANES: Then you've also confirmed that Raychel Ferguson's case was discussed at an audit meeting on 10 April 2003.

A. Well, my secretary confirmed that and I signed the document, probably without checking as fully as I ought to.

Q. What we have there -- if we can pull up 321-074-002 and 003 alongside each other. So the minutes for Raychel's meeting are in much the same format as the minutes for the one in relation to Lucy where it simply says the number of cases that are presented and discussed without identifying them. And then, if you look at the spreadsheet, you see that she is identified there.

A. Yes.

Q. And being April 2003, you've got the post-mortem report in, and it's identified as a litigation case.

A. Yes.

Q. Do you remember that case being presented and discussed?

A. No. I was no longer the audit coordinator at that stage. I resigned as audit coordinator -- and I think

there's evidence in the website to say that I stepped down on the 9th -- at a directorate meeting on 9 January 2003 and handed over to Mr Alan Bailey, consultant paediatric surgeon. So I don't remember it being discussed and those aren't my minutes.

Q. I beg your pardon. I thought our records were it was 2003 to 2006.

A. I then became --

Q. If I may just finish --

MR UBEROI: [Inaudible: no microphone] on the witness's evidence, there's witness statement 280/1, page 6, if that might be brought up, please.

MS ANYADIKE-DANES: Yes, I see it there.

MR UBEROI: In the top left, that's the information about the resignation, and I don't have a page reference, I'm afraid, but we've also submitted the minute of the meeting, which formally records Dr Taylor resigning and handing over. It's January 2003.

A. And to assist you, I became the trust's audit -- chairman of the audit committee, which was actually, again, an administrative role, where I was promoted, if you like, to being the chairman of the committee that looked -- oversaw all the different audit facilitators or coordinators throughout the Royal Trust.

MS ANYADIKE-DANES: I beg your pardon, that's exactly what

I was referring to. You were a member of the clinical audit committee between 1997 and 2006 and you were a chairman of it from 2003 to 2006.

A. That's right.

Q. And the reference for that, not that we need to pull it up, is 306-019-012. I apologise, that's exactly it.

As chairman, though, or even as a member for that matter, what does that involve in terms of knowing which deaths are being audited?

A. Um ... I think I submitted documents in my previous evidence to show trust activity, audit activity, so the chairman of the audit committee wouldn't take a micromanagement of each directorate, so I would have held monthly meetings, chaired monthly meetings if I was available and not working or away. I would have chaired a meeting where the audit facilitators, the audit facilitators for paediatric surgery, gynaecology, neonatology -- all the different directorates would have their own facilitators. So I would have got them all together with my audit support team and discussed -- ensured that they were submitting minutes, that they were having meetings. The Eastern Board had actually funded quite a lot of funding so that clinics were cancelled, operating lists were cancelled to ensure consultants and junior doctors and nurses were available

to attend audit meetings.

Q. How would you know --

A. And that was a very, very heavy -- and we had to police, in a way, we had to make sure that everybody who could attend was actually pulling their weight and performing audit.

Q. Yes. How would you know if a child's death had not been submitted to audit?

A. The PICU secretary had a very systematic approach of bringing the death of every child in the Children's Hospital to the mortality meeting in paediatrics.

Q. I appreciate that and you've told the chairman that also, but if it turns out that Lucy's death wasn't submitted to audit, according to the PICU secretary's records it was, so that would be a death that slipped through the cracks, if I can put it that way, and how would you know that or anybody performing that oversight function?

A. It wasn't policed to that degree.

Q. So you might not know?

A. I might not -- I probably would not have known.

Q. And when you say that you were also trying to ensure that they produce minutes, by minutes do you mean the sort of thing that I pulled up for you just now? You

don't mean anything more substantial than that?

A. I wanted to make sure they weren't drinking coffee and having a chat. I wanted to ensure that they were performing the function to which the trust and the board had funded.

Q. I appreciate that.

A. It was an oversight to make --

Q. It's a slightly different question. What I meant by the minutes is -- under the format that I just showed you for both Lucy and Raychel ... in fact, we'll just pull up Raychel's for example, 321-074-002, and we can pull up alongside it Lucy's, 319-023-004.

Is that what constituted a minute for your purposes in satisfying yourself that there was a minute of the meeting or were you intending that there should be some more detail around the heading "mortality"?

A. I think that was regarded as being a minute of the meeting and that was satisfactory.

Q. Thank you.

A. And there were other directorates who weren't submitting any minutes and they were the ones I was more interested in trying to get --

THE CHAIRMAN: This is rather out of sequence, but the minuting of these meetings has substantially changed?

A. Yes. I had the ... I chaired the August paediatric --

because my colleague had been up all night and she asked me to stand in for her, so I chaired and wrote a minute of the four mortality cases and learning points. And that was submitted to the PICU secretary, who is a new PICU secretary because Maureen retired.

THE CHAIRMAN: I'm sorry, I don't mean it -- I'm not comparing 2000 to 2003; I'm thinking beyond that. There's now much more minuting of these meetings; is that right?

A. Yes. Just to add to that, she e-mails every single consultant in the Children's Hospital, whether they attend that mortality meeting or not, and asks them for comments or learning points or do they remember the case. So things have changed through the trust and through the medical directors, very substantially, and this obviously is not an adequate record of the cases. I accept that.

MS ANYADIKE-DANES: When you were giving evidence in relation to Lucy, the chairman was asking you about what came out of Lucy's case. This was in relation to the audit and any review that there should have been. He asked you directly whether you could help him understand why nothing of substance emerged from a discussion of Lucy's case and ultimately he put to you -- you were discussing whether there should have

been an SAI in relation to her case, whether that's how it should have been considered, and I think that you agreed with him that it should have been considered in that way, and you gave an example of when you had a case that came, although you weren't going to name the hospital, from outside the Children's Hospital when you were concerned about the treatment that that child had received and you actually instigated an SAI or made an SAI report yourself. Where one sees that is the transcript of 4 June 2013, page 210. Because one of the issues that we were putting to you is: would you do that even if the treatment was happening outside the Children's Hospital? And that was the example that you gave.

You said that:

"The child came from another hospital. The child presented with hyponatraemia, not dilutional hyponatraemia, and the child was having a seizure, which was thought to be a febrile seizure, the child was intubated, treated, transferred to us and when the child got to us I completed an adverse incident report even though the child was no longer seizing in my department."

So even though nothing untoward was happening in terms of your own care of the child within the hospital,

nonetheless you completed a serious adverse incident report?

A. Sorry, can I just correct you? Could I see that? Because I don't think that's an SAI; I think that's an incident report. An SAI --

Q. An adverse incident report.

A. There's different levels. If I can just, for the record, state that an SAI -- and there's another one ongoing at the moment from a DGH about the management of a child, not fatal and not hyponatraemia. It is a serious adverse incident, which requires a different level of investigation than an adverse incident. There are many adverse incidents filled in, it's an online version we have now, and they would be of the order -- I'm guessing -- one a day. But an SAI would be a much more different level of investigation. It's managed through a process under very senior management, people are interviewed, statements are taken and discussion is made with the DGH involved, if that is -- so an SAI is completely different from an adverse --

Q. I understand that. But the point I was getting to is: if you could fill in a form like that in relation to a child whose treatment, which causes the problem, is not a treatment that has been given in the Children's Hospital, then would you not fill in an SAI,

for example, if the treatment had had that effect but, once again, had not occurred in the Children's Hospital?

A. I don't think I or the people at the coalface decide whether it's an SAI or an adverse incident. We log an adverse incident. So if I feel this is an adverse incident, this is a potential harm or harm that could have happened to one of my patients, I'm obliged to complete an IR1 form or an adverse incident form. That goes to an oversight committee in the Children's Hospital; Dr Keaney, a colleague of mine chairs that. There's a pharmacist on it and a senior nurse on it, Paula Forrest. They review all the adverse incident reports that week or that day or quicker if it comes to their attention. They report to the clinical director, I believe -- I'm not exactly au fait with this -- and then a decision is made if this is an SAI.

Q. Yes.

A. So I don't decide it's an SAI. Obviously if a child dies, my understanding is it's an automatic SAI.

Q. That's not quite so much the point that I'm getting at. The point is that you log treatment -- a patient of yours who has come to harm --

A. Or potentially.

Q. -- or potentially has come to harm in relation to treatment that has happened outside your hospital.

That's the point that I'm getting at.

A. Yes. Now. We do that now.

Q. And I think when you were referring to that, that particular incident you gave the chairman, happened two years ago, I understand.

A. It did.

Q. Is that something that could have been done or was being done in 2001?

A. Well, I can't remember. I believe from what I've read in the transcripts that, in May 2000, there was a requirement for the trust -- had undertaken to introduce adverse incident reporting.

Q. So if that's the case, is Raychel's the kind of case which would have led to an adverse incident report in your view?

A. Yes. And probably an SAI.

Q. Thank you.

THE CHAIRMAN: If Raychel comes in from Altnagelvin, as she did, and there's a clear early view in the Royal that things have gone wrong in Altnagelvin and that this is a girl who should not be dying in the Royal, that would be an AI which would almost inevitably, in your view, become an SAI?

A. I'm using a current example again in the last few weeks. I'm not going to name it in prejudice because it's still

ongoing. But we received a child to our unit from another hospital and there was an issue about the timing of the transfer. Just to do with the timing. It was at night and there was a question mark, should it have happened earlier? So we felt that the child wasn't harmed, but could potentially have been harmed by a delay in referral to the PICU.

THE CHAIRMAN: Okay.

A. It was to do with transport. It's ongoing, but what I have heard is that --

THE CHAIRMAN: Sorry, what I'm interested is who makes the adverse incident report?

A. I'm trying to help you, sir. The PICU filled out an incident report about that child because there was potential harm. It goes to the governance oversight committee. They communicate through the medical director with that other hospital and they ensure that the other hospital take it seriously and I believe they're watching the other hospital to make sure that it's regarded as an SAI. What I've also been told from my colleagues who sit on the adverse incident reporting group is that if that other hospital doesn't make it an SAI, we will.

THE CHAIRMAN: Okay.

A. I hope that's helpful.

THE CHAIRMAN: If it is being investigated in the other hospital -- let's take it away from Altnagelvin for a moment and say this is Daisy Hill -- do the doctors in Daisy Hill who have raised the concern contribute in any way to the review in Daisy Hill as to what happens, why it happened, and whether it was good enough?

A. Well, an SAI is a very serious event, obviously. It's properly constituted, there's a programme for it, every hospital has it. One of the -- having been through this myself, every clinician involved in that case -- nurses, doctors, any clinician that was involved in the care of that patient prior to the incident or during that incident, when it was being generated, are all interviewed by the trust and, in a case that I was involved in, by two experts from outside Northern Ireland.

THE CHAIRMAN: But I'm sorry, what I'm trying to get at, doctor, is this. Let me take a hypothetical example that you have raised a concern in the Royal in PICU about something that happened in Daisy Hill, and let's suppose that's a serious adverse incident or it's categorised as a serious adverse incident.

A. Okay.

THE CHAIRMAN: In effect you're sitting on Daisy Hill or Royal management is sitting on Daisy Hill to make sure

they do a serious adverse incident investigation; right? Because you're saying, if you don't do one, we'll do one.

A. Please, with respect, sir, I'm not in charge of the SAI --

THE CHAIRMAN: I understand.

A. -- I'm giving you my experience from the coalface. I think the trust would be better able to advise you.

THE CHAIRMAN: What I'm trying to get at is this: in an incident such as one which prompts you to raise a concern which leads to an SAI, perhaps in Daisy Hill or Craigavon or wherever, are the doctors in the Royal who have identified the problem and who may have something to contribute to it -- are they asked to participate in the SAI, for instance, by being interviewed?

A. I have no experience of that actual course of events, but I imagine -- I certainly, if I'd triggered the adverse incident, which became an SAI, I would personally want to know what the outcome of that was, and if I wasn't interviewed I would want to go to the people. Luckily, I know the people who sit on it and I would say to them "Has that ever been resolved?" or "Do you want anything further from me?" But by triggering it, they would have known my views. It would

be documented that I had a view on that incident. But as I say, I'm on a very different level than how the trust would have a process for this. I do believe there's a strong process for this in part of the clinical governance arrangements with each trust. But I'm not an expert.

THE CHAIRMAN: Thank you.

MR McALINDEN: Mr Chairman, I have taken specific instructions in relation to that point, and it would appear that clinicians from one trust would be interviewed during the SAI procedure if the SAI procedure was directed by the regional board to be carried out by another trust.

THE CHAIRMAN: Thank you.

A. I just don't understand exactly how it happens.

THE CHAIRMAN: In other words, Mr McAlinden, they do more than wave the red flag, they actually become part of the investigation?

MR McALINDEN: They do become part of the investigation and they are interviewed during the investigation.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: And in 2001, Dr Taylor, which is when Raychel's case would have come to the attention of the Children's Hospital and the Children's Hospital would be in a position to be able to complete, or a clinician

within it, an adverse incident report, which would then go on and, in your view, would have made its way into a serious adverse incident report. In 2001, would it have been the practice to alert Altnagelvin to the fact that such a form had been completed?

A. I wasn't part of the governance structure, so I don't know.

Q. In your view?

A. And also I don't think the term "SAI" was used in 2001. "Adverse incident" was used, was used from May 2000. It was introduced in May 2000. I know that now from what I've read.

Q. Then let's stick with adverse incident because for the purposes I'm asking you, it amounts to the same thing, which is something that's happened that has brought harm to a child.

A. Yes.

Q. So you're logging it for that reason to enable it to attract investigation with a view to seeing what went wrong, how it went wrong and what can be done to try and reduce the incidence of that happening again. That's the whole purpose of it, isn't it?

A. That's correct.

Q. If that's how, in your view, Raychel's death would have been regarded in 2001, is that something that, in your

view, would or should have been communicated to Altnagelvin?

A. Yes.

Q. Thank you. Then if we just move on now to the Sick Child Liaison Group which you referred to before. I'm going to the meeting of 26 June 2001 because what I'm trying to explore with you again is that question of who knew what about the reasons why one was having that meeting and what the position was in relation to deaths or near misses in the region prior to that meeting. Okay?

A. Mm-hm.

Q. The minute of the meeting of 26 June is 093-035-110o. If one just looks quickly at those who were attending, with the exception of Dr McAloon from Antrim, they're entirely Children's Hospital representatives; that's right, isn't it?

A. Dr McAloon's from Antrim, yes.

Q. Because on the other side, from Craigavon, Ulster, Altnagelvin and the department, they are all apologies, so they don't attend that. Dr McAloon from the Antrim is there. Under "chairman's business", under "hyponatraemia", it said that:

"[You] presented several papers, which indicated the potential problems with the use of hypotonic fluids in

children and that work was to take place on agreed guidelines from the Department of Health on this subject."

Do I understand it that you believe you would have been alerted to that from the medical directors' meeting, and that's how you knew at that stage that there was going to be any question about guidelines for the use of hypotonic fluids?

MR UBEROI: Can I rise for clarity? I'm not sure the introduction of the phrase "the medical directors' meeting" doesn't unnecessarily confuse the issue. Perhaps if the witness could be asked does he recall how he first became aware of the upcoming working party, that might be a fairer way of dealing with it, otherwise we're dragging in a meeting at which he wasn't present.

MS ANYADIKE-DANES: I beg your pardon. I thought he'd already said that in relation to that meeting when I was asking him about it.

How did you first become aware that the department was proposing to have work carried out to reach agreed guidelines on the use of hypotonic fluids?

A. I can't remember. The two people that might have told me, if I can speculate, would have been Dr Carson, who I knew in the Royal and was director of anaesthetics, or a medical director, previous director of anaesthetics,

or maybe when Miriam McCarthy had sent her apologies, she had given me information. I don't know, but that's the two obvious people that could have told me, possibly told me.

Q. And if it was going to be Dr Carson, it might be, because we've seen the letter of 21 June 2001 when Dr Kelly is writing, referring to the meeting of medical directors, which talks about the near misses and the change in practice at the Children's Hospital -- it might be that meeting that he came away from and gave you information.

A. I can't remember.

MR UBEROI: I'm not sure that line of questioning is particularly fair to this witness. He can't speculate as to what's in Dr Carson's mind. He's given his best recollection of who notified him of the upcoming work. I do suggest it confuses matters unnecessarily.

MS ANYADIKE-DANES: So you can't remember how you first got to hear. How did you first learn that Raychel had died?

A. I came to work on Monday morning. I can't remember. She died at the weekend and I presumably was told about her death Monday morning. Mondays are my PICU day. I can't remember. But --

Q. If you can't remember, just say if you can't. But in those circumstances, if you learnt in that way, are you

likely to have been given any information about the cause of her death?
A. I can't remember.
THE CHAIRMAN: Let me just get my understanding clear. The possibility or likelihood that you would have been told about it on the Monday morning suggests to me that that would have been regarded as a very striking, significant event over the weekend.
A. Yes.
THE CHAIRMAN: And when you're being told about it, it wouldn't be as cursory as "A 9-year-old girl died at the weekend", you'd be told some level of detail about it.
A. I can recollect it was a major discussion point in the hospital at some stage. I'm not sure it was the Monday.
THE CHAIRMAN: So I understand that you won't necessarily pick up all the information on Monday morning, but if there were concerns held by people like Dr Crean, it's likely that those would have emerged from the normal toing and froing between you over the following days and weeks?
A. Well, I imagine that the nurses and everybody would have been in a state of shock over a child -- a previously very healthy child who had died.
THE CHAIRMAN: So that's inevitably going to lead to some

discussion, even though you weren't directly involved in Raychel's case at all, some discussion about how on earth this happened?
A. Yes.
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: Thank you.
Did you at that stage have the interest which we see from the paperwork that you had in the development of guidelines, a concern about the possible misuse of low-sodium fluids? We see you take that up through the paperwork in relation to MCA and so forth. Did you have that interest at that stage?
A. I don't believe I had any investigation ongoing into hyponatraemia apart from having read the Halberthal paper. I remember that being more pertinent. It was obviously pertinent at the time, but after Raychel, I think that's a time I probably would have --
Q. Obviously there had been Adam's death and the verdict and, whether you accepted it or not at that stage, you knew that the verdict was for dilutional hyponatraemia.
A. Yes.
Q. So you knew about that and you knew about the papers that had come out in relation to that. And you had attended that PIC meeting in 1999, with they'd had a whole session devoted to appropriate fluids and so

forth in relation to children.
A. Yes. That was the albumin debate, that wasn't to do with hypotonic fluids. A Cochrane review by Dr Ian Roberts had concluded that albumin, in a meta-analysis of Cochrane, a very high level of evidence, and he was interviewed by Des Bohn and others, and he claimed that his research had shown albumin caused more deaths -- six deaths in every 100 were more likely with albumin. There was no mention of hypotonic fluids at that debate and in fact it was later at that meeting in London -- and later shown that albumin had no increased risk of death compared to normal saline.
MR UBEROI: [Inaudible: no microphone] I'm not sure, but perhaps there may have been some confusion.
I anticipate my learned friend is asking about Dr Chisakuta's presentation in 1999, although I may be wrong.
MS ANYADIKE-DANES: No, I'm not asking about that.
Thank you very much.
MR UBEROI: Sorry.
MS ANYADIKE-DANES: So when you have this meeting on 26 June and you present several papers, what prompts you to have this meeting and include this item in it?
A. This was a scheduled meeting. If you look back to the previous minute --

Q. No, I don't mean the date of it. What prompts you to have this item in the meeting?
A. Raychel Ferguson's death.
THE CHAIRMAN: Okay. Sorry, I just want to get this clear. On the screen we have a note:
"Hyponatraemia. BT presented several papers which indicated the potential problem with the use of hypotonic fluids in children."
Have I got this clear then that you presented those several papers on the back of being told about Raychel's death?
A. Yes.
THE CHAIRMAN: And only on the back of being told about Raychel's death?
A. Yes. In fact, I still have them stapled together when I went through my records because only four people turned up. I had actually photocopied more papers than I needed that day. I was expecting more attendees and I still have three or four papers that were never distributed, and that's the Halberthal paper and the Arieff paper from 1998.
MS ANYADIKE-DANES: Did you discuss Raychel's death at all if that's what prompted you?
A. No. I mentioned a child had died.
Q. Why didn't you?

A. I ... I told the meeting that there had been the death of a child in Altnagelvin and there were going to be guidelines. I don't know who gave me the information about guidelines, but that's what it said in the minute.
Q. In order to have presented papers on the potential problem in the use of hypotonic fluids, did that mean that you had either been informed about that as potentially an issue in Raychel's death or you had made that connection somehow yourself?
A. I think Dr Crean and the rest of us knew that vomiting and hypotonic fluids to replace the vomiting was central to the death of Raychel.
Q. And that's what enabled you to present the issue in that way?
A. As I said earlier, when I heard about Raychel's death it made me review the papers that I would have read anyway.
Q. Yes, I understand that. But if you're putting this on the agenda, if I can say it in that way, and you've got it down to papers that relate to potential problems in the use of hypotonic fluids, I think you have just said that you believe that you would have been told that that's what was central to Raychel's death --
A. Yes.
Q. -- and that's what makes this relevant to give this particular part of the talk. Would you not at least

have been discussing that element of Raychel's death?
A. I think because of the people there -- I don't remember a long discussion about it, I remember people saying, "Well, this is going to be covered by future guidelines". It wasn't even sure then, was it goes to be a working party, was it going to be CREST guidelines or was it going to be some other working group. There was no knowledge at that time how the guidelines were going to be produced and disseminated. It was basically to say there was a whisper that there's going to be guidelines. I think that's all I was able to tell.
Q. Did you know at that stage why Raychel's case was considered appropriate for guidelines to be issued by the department?
A. I think it was a shocking death.
Q. Yes.
A. It was an unexpected death in a healthy child.
Q. I am not saying this is the case, but you could have a shocking death caused by gross negligence and that wouldn't necessarily lead to guidelines.
A. I had previous knowledge, as you can see by my CV, of the meningococcal guidelines, and they were triggered by shocking deaths of children -- healthy one minute and covered in rash, literally the next minute -- and so I had experience from 1997/1998 of the production of

a working party and guidelines following -- unfortunately, they were only developed following the tragic death of young, fit and healthy children.
Q. Sorry, I'm asking you a slightly different question, which is: when you were telling those there that there were going to be departmental guidelines, did you at that stage understand why it was that there were going to be guidelines following Raychel's death?
A. No.
Q. No, just the fact that you thought it was going to happen?
A. It was a whisper. Somebody had whispered me some knowledge to say, "We're going to take this forward".
THE CHAIRMAN: Isn't there a convergence there? We'll explore this more after the break, but there's a convergence here, isn't there, with the BMJ paper on 31 March, there are the changes which are taking place in the Royal in the use of Solution No. 18, however informal or formal those changes are, and then you have the death of Raychel in Altnagelvin?
A. Yes.
THE CHAIRMAN: So this is perfect territory for somebody saying, "Look, we're going to have to step up on this and it's time for guidelines".
A. Yes.

THE CHAIRMAN: Let's take a break now and resume at midday.
(11.50 am)
(A short break)
(12.05 pm)
MS ANYADIKE-DANES: Dr Taylor, Dr McAloon was at that Sick Child Liaison Group meeting on 26 June, and he writes a memo on 27 June to the relevant persons in his hospital. We can pull it up, witness statement 059/2, page 14. If we pull up page 15 as well, just so that you see the end of it.
Those are his colleagues. The point I want to draw your attention to is he's there when you discuss this point, but he takes from it, apart from passing on the two papers:
"I understand that the protocols in the Children's Hospital may shortly be revised with the use of fifth-normal saline being reserved for children under 10 kilograms and half-normal saline combined with 2.5 per cent dextrose being used in place for fifth-normal in the older age group."
Then he goes on, having said that this is something that they in their department will need to review:
"My suggestion is that we adopt the same protocols as the Children's Hospital."
Are you able to explain, contrary to what you've

minuted as departmental guidelines, why he thought that protocols in the Children's Hospital were going to be revised?

A. No, I have no idea why he thought that.

Q. It's a day after, and for that matter, if there were protocols in the Children's Hospital that were going to be revised, what protocols might he have been referring to?

A. Exactly. I don't know. I have never been able to -- I have never been made aware of a protocol for the use of post-operative or medical patient fluid management, either before or after. And can I also say that if I had gone to that meeting and there had been a protocol as well as bringing the papers, the Halberthal paper and the Arieff paper, I would have brought the protocol with me. And also can I say that if -- I know you're going to come to this. Later I attended the working party, Dr Crean, myself, would have been saying, "Why sit here writing a protocol when we have already got a perfectly good one in the Royal?" So I really don't understand why people think there's a protocol in the Royal because there was no protocol in the Royal.

THE CHAIRMAN: We need to be a bit careful, doctor, because we're sitting in a legal setting surrounded by lawyers, that we don't attribute formality to words which were

not written in that way.

A. Sorry.

THE CHAIRMAN: If he's referring to a protocol, he might be referring to a practice, and if you read that sentence as "I understand that the practices in the Royal may shortly be revised", would that sentence make sense?

A. I don't think there was a common practice that the Royal had. I think doctors practice an individual practice, anaesthetists gave Hartmann's for resuscitation fluids and for intraoperative fluids, and really when a patient got back to the ward or a patient on the medical wards -- we would have had really little say or little control over what paediatricians or surgeons would have prescribed to them.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Well, if we keep that first page up there and substitute for the second page, the second page of your paper with your colleagues, 043-101-224. In the highlighted bit or the bit with the arrow showing what he believes that the practice, guidelines or protocols in the Children's Hospital are going to be revised to, it accords with what is written under the IV fluid prescription part of your paper, does it not?

A. There's no date on that IV fluid prescription, but I think when I looked at my timeline of when things

happened, this was produced just prior to the first meeting of the working party and was e-mailed to Dr Carson.

Q. No, sorry, I'm asking a different question.

A. Sorry.

Q. What he's put there as what he believes the change is going to be accords with what is under that IV fluid prescription part, does it not?

A. Well, the IV fluid prescription chart wasn't written, to my knowledge, at that time.

Q. But the information accords with it. So if you've got a split between the young and the slightly older, and so where it says, "Give 0.45 per cent normal saline, 2.5 per cent glucose", is that not consistent with what he believed was going to be the change in the Children's Hospital's practice?

A. I fail to see the link between the two in terms of time, but the --

Q. On the information though.

A. I think all paediatricians see a difference between infants under one year of age and children of over one year of age. It's a normal age differential. And I think you might be highlighting a point that may not be particularly relevant to that document. I'm not sure.

THE CHAIRMAN: But surely the document on the left divides children up by weight, doesn't it? The one on the right divides them by age.

MS ANYADIKE-DANES: And weight also. Anyway ...

So you can't help us with why the day after that meeting, when Dr McAloon attended, he is talking about a change happening in relation to the Children's Hospital as opposed to departmental guidelines?

A. I don't even understand why he's including children under 10 kilos or one year of age because the context of my reporting to the Sick Child Liaison Group was the death of Raychel, who was not under 10 kilos. So I honestly don't understand why he can draw that out of the discussion, the brief discussion that I presented at the Sick Child Liaison Group. I'm just at a loss. I'm trying to help you, don't get me wrong, but I'm trying to explain how he could have drawn this conclusion that we had protocols and we were going to revise them, that we had a different prescription for over 1s than under 1s. I fail to see how he could have got so much information from what I believe is what I discussed with the group, which was the death of Raychel and that the Department of Health were going to do guidelines. It's completely strange that he gets the completely wrong end

of the stick here.
Q. Do you have a clear recollection of what was discussed at that --
A. No.
Q. -- Sick Child Liaison --
A. The minute's all I --
Q. The minute is all you have? Okay. Do you remember anything over and above that minute? I should have asked you that before, I'm sorry.
A. No.
Q. Because that minute, of course, refers to potential problems with the use of hypotonic fluids in children. In fact, the minute actually doesn't mention Raychel's name at all, but it wouldn't necessarily for confidentiality reasons. But it doesn't even say about anything that would lead you directly to believe that it's Raychel's case you're talking about, does it?
A. I'm recollecting from that minute that it was in relation to Raychel's death and the timing and other factors. I don't recall --
THE CHAIRMAN: Dr McAloon's second sentence is:
"The issue has recently been highlighted by the death of a child in the Province."
Which one might take to be Raychel unless there's evidence to the contrary.

A. I think the only way he could have got that information was from the Sick Child Liaison Group the day before.
MS ANYADIKE-DANES: What I was putting to you is that you might have had a broader discussion than just Raychel and actually discussed the issue about the potential risk to children generally, which might make it relevant as to what age you're talking about in terms of the different calculation in relation to weight. You might have had a broader discussion.
A. Since I can't remember the detail of the conversation, it's quite possible that we could have talked about a number of items, but that's -- it's not my recollection.
Q. Thank you. Then you are invited to attend on 21 August 2001, or rather to be part of the meeting. The reference for it is 007-050-099. It starts off:
"There is increasing evidence that acute hyponatraemia is emerging as a significant clinical problem in sick children receiving IV fluids."
So that's not just Raychel, that is a process of being aware that we have a problem here:
"As a result, we believe we should convene a group to consider how best practice could be brought to bear on the problem and to explore whether further advice needs to be issued ..."
And as a result of that, you are asked to attend at

a meeting on 26 September 2001. Was there any discussion with you about that meeting, about you being part of it, prior to you receiving this letter?
A. No, not that I can recall. Although I seem to have known that there was going to be departmental guidelines, but I didn't know -- I don't think I knew that I was going to be a member of that development of those guidelines. I think this is the first time I was confirmed as being a member of the working party, yes.
Q. Were you asked to do any work in connection with that meeting?
A. Well, I recently came across an e-mail trail that was buried in some of my other documents.
Q. We can pull that up, Dr Taylor. It's witness statement 330/1 at page 10. You've got only the first page of a two-page e-mail thread, as I understand it.
A. Yes.
Q. And this page picks it up, it's something to be explored with others about action not having been taken because this would be in hand at local level, but it's now going to be taken, as a result of which there is a e-mail from the CMO to Dr Carson asking if there's anybody at the Children's Hospital who could put together a short paper and that she would be happy to disseminate any such advice. The result of that is he says he's going to ask

you to do it, to consider drafting advice and guidance suitable for dissemination throughout the hospitals.
Then you have provided us with two documents, and I wonder if you can help whether either of these are in response to you providing guidance or if it's something else. We have one which starts in witness statement 330/1 at page 12. We can put alongside the first page of another one, which is slightly different, witness statement 330/1, page 14.
As you can see, there is a difference. There is more detail in the left hand one under "introduction", and you've got the baseline assessment, which we don't see in the one on the right-hand side. Did you produce either of these in relation to that request?
A. No.
Q. What were these being produced for?
A. I believe these were -- it is my writing on the right-hand side one. That is my handwriting. I believe that was notes that I took at that first meeting on 26 September, and I believe that was the very first template of what later turned out to be the guidelines.
THE CHAIRMAN: That's page 14?
A. Page 14, sir.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: Who would have produced page 14?

A. I think it's Miriam McCarthy, because on the bottom, if you read the bottom in small print, it says "McCarthy 2001".
Q. And not at the bottom of the other?
A. It looks like it says "410", which might mean 4 October.
Q. But in any event, it does have her name.
A. I don't know what it means.
Q. Do you know what the other one was produced for, was it a development?
A. I believe it -- it looks to me like a development of the guideline, but before it became a wall chart.
Q. So potentially following the meeting?
A. Definitely following the meeting.
Q. Thank you. And then the document that we've been looking at before, 043-101-223. Was this produced in response to that request by Dr Carson?
A. Yes. I believe Dr Carson's e-mail asking me to do some work was on the 27th at 14.47 pm in my Yahoo address. Then I worked on this with my colleagues, as I've stated previously.
Q. Yes.
A. And it was then e-mailed by Dr Carson to Dr Campbell on the 30th as an attachment.
Q. If we just pick that up. 026-016-031.
A. Yes.

Q. Is that document what's being referred to here -- and you can see at the bottom "dilutional hyponatraemia".
A. I'm almost 100 per cent certain that that is the same document.
Q. Then just so that we get correct the documentation, there's another bit of documentation that goes ahead of the meeting. If I can pull up 007-051-100. This is an e-mail from you to Paul Darragh, 18 September.
A. Yes.
Q. And you can see from the attachments there's that "dilutional hyponatraemia"; would I be right in thinking that that's that background piece that we've just been looking at? Sorry, that's got "PowerPoint presentation" on it.
A. PowerPoint, PPT. The other one was "recommendations.doc" and I think that is the same document.
Q. That second one there, the recommendations, is that the document we were just looking at?
A. I'm almost certain, but there could be some doubt.
Q. In addition to you providing those to Dr Carson, Dr Carson's sending them off to the CMO, you also send them to Paul Darragh ahead of the meeting, in addition to which you send him a PowerPoint presentation; is that right?

A. Yes.
Q. And just so we're clear about the one, is it 007-051-101? That's what goes along with that background piece.
A. I'm pretty certain, yes.
Q. Thank you very much. So then when you get your letter of invitation, did you know who else was going to be part of the working group?
A. Um ...
Q. Sorry, before you went to the meeting, did you know who else was going to be part of the working group?
A. I don't believe I would have known who else was on the meeting, no.
Q. Did you discuss with Dr Carson what your role was going to be?
A. It is probable. It's likely that he would have given me some purpose, some reason. Certainly in the e-mail he says ... Sorry, perhaps you can help me.
Q. In the e-mail you're simply asked to:
"Consider drafting advice and guidance suitable for dissemination throughout the HPSS."
And the letter tells you that you're going to try and achieve a broad measure of agreement on how to proceed in the light of the problems that have been identified. So did you have any clearer idea of what

actually was the problem that these guidelines were going to be designed to address or was it your view that that was all going to be discussed when you got to the meeting?
A. I think I'd formed a view that the advice, the guidance that we were going to do, was related to the literature, based on the references, Arieff and Halberthal.
Q. Yes.
A. This was evidence -- this was the best evidence we had that children could develop hyponatraemia, certainly in the post-operative period, and that's the advice that -- the subsequent guidance would have been developed taking into account the best research evidence to date. All guidelines are developed with the best evidence to date because they have to be trusted and believed.
Q. Did you know that Dr Crean was also being invited to attend?
A. I can't remember if he told me he was also invited. I can't remember. It's possible. It's likely. We were colleagues.
Q. Well, if you were going to a meeting which was inviting you to formulate guidance which was coming out of increasing evidence that hyponatraemia was emerging as a significant clinical problem, how much of an attempt

did you make before you went to identify the incidence of hyponatraemia?

A. Well, I think I've given evidence on that before. I asked my secretary to do a PICU database search. I think the date on the top of those pages is the 3rd and the 2 August 2001, so a few days --

Q. I beg your pardon, we are going to come to that in a minute. So one of the things that you did was to ask your secretary to do a PICU search.

A. Yes, and that was shortly following this e-mail from Dr Carson.

Q. Did you think to discuss it amongst your colleagues? Dr Crean was very experienced, did you ask him what his experience was?

A. Yes, I'm certainly sure that I discussed it not only amongst my hospital colleagues but also colleagues in other hospitals.

Q. And if you do that, would it not have come to your attention, certainly from Dr Crean, that there was a child called Lucy?

A. I don't believe that came to my attention during that time.

Q. So you were discussing with your colleagues, including Dr Crean, their experience of the incidence of hyponatraemia, Lucy's died the previous year and he

doesn't mention that?

A. I can't remember her name being mentioned.

THE CHAIRMAN: Whether he mentioned a name, did he mention a death in 2000? Here's the two most -- even if you set aside Adam and even if you set aside Claire, there's two deaths in 15 months, which are directly hyponatraemia-related. And I'm being given to understand over the last couple of weeks at that no point during anything to do with the working party was Lucy mentioned, and I don't understand how that could possibly have been the case. I don't understand, if you're in the working party with your colleague in the Royal, Dr Crean, how that could possibly have been case, nor do I understand, since there was somebody on the working party from the Erne, how that was the case. Can you help me with that?

A. I can't help looking back now.

THE CHAIRMAN: Not a name, I'm not necessarily looking for Lucy's name, but the idea that there wasn't even a reference to a girl who had been treated in the Erne and who had then been referred to the Royal, the idea that there was no reference to her leaves me bewildered. Can you help?

A. I can understand your bewilderment and it seems strange. My previous work on the meningococcal working party,

when that group met it took forward evidence-based advice on the best treatment for antibiotic treatment and recognition and it didn't dwell or discuss the deaths of children who had died of meningococcal disease, so it was my experience that the working parties were very focused on developing evidence-based guidelines and didn't dwell -- possibly also because there was no pathologist or neurologist on the working parties, they were not constituted to investigate individual deaths, they appeared to be -- and you'd have to ask somebody from the department.

THE CHAIRMAN: You're not investigating deaths, you're not investigating other deaths, you're drawing up guidelines to change practice so as to avoid deaths like those which have occurred. And the idea that the working party doesn't mention the deaths which have occurred is what troubles me.

A. Yes.

THE CHAIRMAN: Or do you have something against which to test the guidelines? Yes, you do, you've got at least two very recent deaths in Northern Ireland. But if I understand the evidence that's coming correctly, it's that nobody on the working party thought, "Let's see how those stand up and how those guidelines would have applied better in Raychel's case or in the case of

a girl from the Erne". I also understand that nobody from Daisy Hill, nobody from any of the other hospitals said, "How extensive is the problem? How big is the issue?"

MS GOLLOP: Sir, I hesitate to interrupt, but my recollection of Dr Jenkins' evidence was that his understanding was that they would formulate guidelines and those would then be e-mailed out to, amongst others, some of the clinicians involved and they would go back, those clinicians, and look at the clinical records, test out, do the stress testing, as it were, of the guidelines against those records, so that process would happen. But it would sort of happen on a delegated and disseminated basis like that because of the resource implications for getting everybody into the same room on multiple occasions from different hospitals. That's my recollection of what he said.

THE CHAIRMAN: Ms Gollop, I'll check Dr Jenkins' evidence, but I think he had trouble on exactly the same point that Dr Taylor is unable to assist me on about how the working party possibly met as a group without discussion about the incidence of recent deaths.

But even if I make the jump of setting aside Adam and Claire, the fact of two very recent deaths -- and Raychel's death was recognised as problematic, to put it

lightly, in Altnagelvin and, in the Royal, Lucy's death was recognised in the Royal as being problematic. I'm not quite sure what description to put on the Erne's analysis of it.

MR QUINN: Mr Chairman, if I could also make a point for the transcript here. Is it not also bewildering from the families' point of view that neither Adam's death nor Claire's death was linked to hyponatraemia by Dr Taylor? Because he said in his evidence, in his inquiry evidence, that he wasn't aware of Claire's death until much later.

THE CHAIRMAN: Well, I'm going on the gentlest possible line here, Mr Quinn, about the two very, very recent deaths in 2000 and 2001 for a working party that has its first meeting in September 2001, but I take your point.

MS ANYADIKE-DANES: I'm coming to that in a little while in the way that I deal with what's in your PowerPoint presentation in relation to the incidence of hyponatraemia. So if we pull that up now, 007-051-103. I just want to be clear about some of these elements of your evidence about this before we actually get into the underlying data for it.

Firstly, I think you've confirmed that this goes off to Paul Darragh and it's to be part of what will assist him in the forthcoming meeting on 26 September. That's

correct?

A. Well, I developed this off my own bat. It wasn't in Dr Crean's --

Q. Sorry, that's why you send it to him. That's what you said in your e-mail.

A. I sent it to him as a teaching aid --

MR UBEROI: I wonder if the witness could be allowed to finish his answers, please. It would be appreciated.

THE CHAIRMAN: That's fair.

MS ANYADIKE-DANES: It is fair.

But what you say in your e-mail is:

"Here are some draft documents for your consideration in advance of the meeting on 26 September."

A. Yes.

Q. Thank you. Had you prepared it independently of having that meeting because you wanted to conduct an audit of PICU deaths in relation to hyponatraemia or generally? Do you understand my point? So quite apart from responding to what Dr Carson has asked you to do, were you also carrying out an audit of PICU deaths which you could then draw on?

A. No.

Q. Sorry?

A. No.

Q. You weren't carrying out an audit of PICU deaths?

A. No.

Q. Were you carrying out an audit of PICU deaths at any stage?

A. Yes. I did an audit on PICU deaths on patients in 1994, which we've already shown, and that was in relation to a paper from, I believe, Sheffield, talking about how children died in intensive care. And I wanted to benchmark our experience against their experience.

Q. So between then and now, then being 1994, you hadn't carried out an audit of PICU deaths?

A. Correct. I looked at children who died of meningococcal disease prior to the meningococcal guidelines.

Q. It's shortly after this meeting that we're going to come to, that you're asked to and you do fill in a yellow card in relation to Raychel's death and you write to the Medicines Control Agency on 23 October 2001.

A. Yes.

Q. The reference for that, which we don't need to pull up, is 094-165-773. In that letter you say:

"I am also conducting an audit of all infants and children admitted to PICU with hyponatraemia. My initial results indicate at least two other deaths attributable to the use of Solution No. 18."

When you said "audit" there, does that mean that is

something that you hadn't already started as at the time of the meeting?

A. I think I was referring to this computer-based database audit.

Q. You were referring to this audit?

A. Yes, I believe so.

Q. If you're referring to this, what are the two other deaths? You've only got two on there.

A. Yes, and there's a reason for that which I've already explained. The secretary was unable to find any data for 1996, and the data she showed me -- it's on the chart for 1995 -- was for a child who died with hypokalaemia, which a low potassium, so there were no hyponatraemia incidents reported by her to me for 1995 and 1996. However, I knew of Adam and there was a death that we've already informed the inquiry about in 1997 of a child who died with hyponatraemia, but not due to hyponatraemia, as I later found out.

Q. But you did know about Adam, of course.

A. I did know about Adam. I don't know who those two deaths were in the letter. They're not referenced. I'm assuming that those would have been the other two deaths that came up. So I had one death that came up on the PICU database and the other death that I was aware of, which was Adam Strain.

Q. Right.
A. But it didn't come up on the database, therefore it didn't appear on this bar chart.
Q. Yes, but you're providing a bar chart of the incidence of hyponatraemia. One source of your information from that is whatever is on the PICU database. Another source of information is your direct knowledge. So since you're going to provide this to Paul Darragh, who's going to chair that first meeting, and one of the things you're presuming that people want to talk about is, as the chairman said, how big is the problem? So you are providing something to show, at least from the Children's Hospital's perspective, the incidence of hyponatraemia. Why don't you put Adam's death in 1995 in because you know about it?
A. I don't know -- the only evidence I took for this bar chart was the secretary's interrogation of the PICU database.
Q. Yes, but you know that Adam died, implicating hyponatraemia. So why don't you add hyponatraemia to this chart?
A. I don't know. I can't explain. I didn't do it.
Q. Because it's quite glaring, that hole in the middle of the chart where Adam's death would be and, for that matter, Claire's death would be.

A. And my explanation is that I only used the data that was interrogated by the secretary.
Q. But you knew that the --
MR UBEROI: If I rise for clarity as well. I appreciate the line of questioning that's being explored, but I think folding in the separate issue of Claire takes the question into a rather different sphere because there isn't the same level of evidence or understanding, as I understand the evidence, of direct knowledge, which was the phrase which my learned friend used shortly before. So I appreciate the line of questioning so far as Adam Strain goes, but I think, in fairness to the witness, it's not right to simply fold in the name of Claire at the same time.
MS ANYADIKE-DANES: I laid the ground for Claire, but let's stick with Adam. You also knew that the PICU evidence or the PICU database wasn't always complete --
A. That's right.
Q. -- because it was only as good as the inputting of the clinicians to a degree.
A. That's right.
Q. So if you knew that and you are trying to provide some information to be of assistance at a quite important meeting, one that's going to develop regional guidelines, why don't you add to it information that

you have?
A. I can't explain.
Q. As soon as you saw it, you would know it's inaccurate.
THE CHAIRMAN: I think you've got the point, Ms Anyadike-Danes. He said he can't explain.
A. I think I would have made it clear that this was data that was interrogated from a database and could not be relied on. I never expected this to be accepted as the complete -- and I'm convinced that I would have told Dr Darragh or others that this was not 100 per cent foolproof data.
THE CHAIRMAN: Did you add "For instance, I personally know of a death in 1995"? Because there's no point in telling Dr Darragh and others that this isn't foolproof if you don't then go on to say, "There was definitely one more death in 1995".
A. 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.
THE CHAIRMAN: Dr Chisakuta wasn't.
A. Well, I can't explain that.
THE CHAIRMAN: Dr Chisakuta, in fact, just to make this

point now, wasn't aware from his work in the Children's Hospital of the note which was put before the coroner, which included the statement that the paediatric anaesthetists working in the Children's Hospital would be trained in the area of hyponatraemia. He comes along a few years later, he doesn't know about Adam, and he doesn't know about the note. So the undertaking which was given to the coroner wasn't honoured.
A. Well, I believe there were lessons learned from Adam. One of the biggest things that happened shortly after Adam's death, before the inquest, was a new reliable blood gas analyser had been bought for PICU and we still use a blood -- a blood gas analyser gives rapid and accurate sodium, potassium levels both for theatre and intensive care, and any anaesthetist and paediatrician working in the hospital now has access to a very rapid testing system for measuring sodiums very quickly and repeatedly. And that was a big lesson that we learnt from Adam and it was implemented very rapidly and it has changed practice and almost made the rest of the recommendations obsolete because it's such a good piece of equipment, and we use special blood gas syringes that have dry heparin in them so that none of the dilutional effect of heparin can make a difference to the sodium.

So I do believe there was an improvement ...
THE CHAIRMAN: Dr Chisakuta didn't know about Adam, but more to the point, in the context of the working party, do I understand that your explanation for not improving this bar chart by adding Adam to it is because Adam's death and the 1996 inquest had been well reported, you worked on the assumption that the other members of the working party would know about Adam's death without it being referred to in the bar chart or without it ever being mentioned during the course of the working party?
A. Yes. Can I also say, this bar chart and the PowerPoint was never tabled and never taken forward by Dr Darragh.
MS ANYADIKE-DANES: We'll come to that in a minute.
MR HUNTER: Sir, can I just make one point on behalf of the family? They are at a complete loss to understand -- if one accepts Dr Taylor's evidence that he had trouble getting his head around the death of Adam and the mechanism of Adam's death, here he was, presented with a golden opportunity, sitting with his colleagues, discussing the whole issue of hyponatraemia, and he didn't even raise it as an issue.
THE CHAIRMAN: Okay. Ms Anyadike-Danes?
MS ANYADIKE-DANES: The difficulty, Dr Taylor, is that the very assumption that you made, the clinicians in Altnagelvin actually didn't know about Adam's death.

That was the whole point. That's actually how this started in relation to the role of the Children's Hospital. They were saying, "You should have told us about a death like Adam. It might have affected how we did things".
A. And my perception was that all the clinicians in Northern Ireland would have read about Adam in the case, and that's my perception. I was aware that I was working with colleagues who would have been -- who would have known about Adam even without my explicit mentioning of Adam. That's my perception and remains my perception.
Q. You will appreciate that was 1996 and this is 2001.
A. I understand.
Q. Then the other hole in that is Claire. Claire's case isn't there either. You have given evidence to say that actually you didn't have much involvement in Claire's treatment itself while she was in paediatric intensive care, although you accept that you were on duty and you did treat her for a period of time. You were on duty from 8.30 to 5 o'clock on that Wednesday, 23 October, during which time you did treat her. In your witness statement, you said that you read and reviewed Claire's medical notes and that you were aware, after reading the medical notes and following the handover, that Claire

was receiving Solution No. 18 fluids and you were aware that she had low sodium levels and that her sodium level had fallen from 132 to 121 within a space of about 23 hours in that case. That was your evidence: you were aware of that.
A. Yes.
Q. And in fact, if you had looked at her documents, and if her case note discharge summary, which I think Dr Crean gave evidence the other day to say would be on file, which is 090-009-011, you would see that under "other diagnosis", it says, "hyponatraemia". So whilst you weren't as intimately involved with Claire's case as you were with Adam, if you were doing what you said you were doing in your evidence then that was a case that should have come to your attention.
MR UBEROI: I'm not sure that's fair, if I may say. To use the statement "while you weren't as intimately as involved as you were in Adam" is rather the understatement of the century. Dr Taylor was involved, as I have said before, in a very specific stage in the care of Claire Roberts, no doubt doing as good a job as he could, accepted he would have looked back through the records in administering the clinical tasks which he did, but to suggest that five years on he would be recognising or remembering a term such as that which has

been put to him is not fair, in my submission.
MS ANYADIKE-DANES: What you're trying to do, Dr Taylor, is you're trying to engage in a bit of research as to what the incidence is, and you accepted from me that as part of that you'd be talking to your other colleagues to see what their experiences were.
MR UBEROI: That's an entirely different point. If the question is "Did no clinician raise Claire Roberts with Dr Taylor in 2001?", that's completely separate.
MS ANYADIKE-DANES: It is. Dr Taylor, if you'll allow me, what I'm trying to put to you is that there was information there for you to have in relation to Claire's case being one that could and should have been included on your bar chart; would you accept that?
A. 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.

Q. I appreciate that.

A. I believe that was my recollection.

THE CHAIRMAN: Let's move on, Ms Anyadike-Danes, we need to keep going.

MS ANYADIKE-DANES: Can you see, doctor, from the families' point of view, that if you provide a graph like that without the caveats that you have now provided to the chairman that, from the families' point of view, that

might look as if you were excluding from that chart the two rather contentious deaths in which the Children's Hospital had been involved?

A. I accept that.

Q. Thank you. Was there any discussion about the possibility that Dr Darragh might present at the working party meeting the two documents that you had given him as perhaps rather helpful summaries of the situation? Had you that in mind, that they might find their way to the meeting?

A. My recollection was that my PowerPoint was not taken forward and I remember -- so that document was not used.

Q. No, I asked you a different question. Did you think that he might or were you prepared for those documents to be provided to the meeting?

A. Yes.

Q. Thank you. We had a document up just earlier, 026-016-031.

THE CHAIRMAN: I'm sorry, I'm not quite sure what that means. Does that mean that having done the work, gone out of your way to do the work, taking on this extra risk, that you expected Dr Darragh to share that work with the working party?

A. Yes.

THE CHAIRMAN: Because if there's a message coming through

from the chief medical officer's office for somebody to do a background paper, which you have done, and you have done a PowerPoint presentation, that's to put people in the picture as to what the issues are and you might then expect that that information be shared with the members of the working party who are coming, who don't all have the advantage of working in the Children's Hospital and might not be as familiar as you are with the problems.

A. I think I've said before I recollect coming away from that meeting very disappointed that no one had said to me "That's a good start with your incidence and with what you've shown. You've told us the data is incomplete". For the meningococcal I wasn't able to get all the data I needed from the PICU database and I had to undertake a chart review with my secretary and I fully expected to be told "Go back and get some more reliable figures, including deaths, on this chart and we might use it". But I remember coming away quite disappointed -- as you said, I'd done quite a bit of work and no one said to me "Well done" or "But we can't use it because it's incomplete, go and finish it". That never happened and it was a source of great disappointment to me and I was never invited back to the drafting of the document either. So I came away from

that party quite upbeat that I was going to have an impact on the guidelines and perhaps the impact I had wasn't quite as good as I'd anticipated.

MS ANYADIKE-DANES: Does that mean that the figures were presented? I'm just looking at the transcript that's coming up. You referred to coming away from the meeting disappointed.

A. I presented a narrative.

Q. But you referred to figures.

A. I didn't present the presentation. I didn't use the PowerPoint. There was nothing there to use. There was no PowerPoint projector in my recollection.

Q. Let me just take you to what I am talking about. You say:

"I fully expected to be told 'Go back and get some more reliable figures, including deaths on this chart we might use'."

A. Well, this is what I anticipated Dr Darragh saying to me. I believe I told him this was PICU database, pure data, raw data, that I couldn't rely on it, and I fully expected someone to say to me "Go and get something reliable before we use it".

Q. Okay.

A. And that didn't happen. And I remember coming away from the meeting quite disappointed with the work, albeit

poor, incomplete, missing data -- I knew that and I believe I informed at least Dr Darragh, if not others, not to rely on the data.

Q. Who else did you show it to?

A. I don't believe it was tabled at the meeting.

Q. No, no, sorry, it was a different question. Who else did you show the chart to?

A. It wasn't tabled or shown at the meeting to anybody in my recollection.

Q. Well, what I think you have just said is that you believe you told Dr Darragh and others not to rely on it, so who were the others?

A. No, when I sent it to Dr Darragh, I believe ... I can't remember the words, but I don't believe I gave them the impression that this was accurate data.

MR UBEROI: If I might add for clarity, what the witness said he was anticipating that would be an exchange which would occur, not that it did in fact occur.

A. It did not occur and I was disappointed that it different occur.

THE CHAIRMAN: Can I just get this clear in my own mind? The bar char was not put before the meeting; is that right?

A. Correct.

THE CHAIRMAN: The PowerPoint presentation was not put

before the meeting.

A. Correct.

THE CHAIRMAN: And the background paper which you had been asked to write?

A. I don't believe it was put to the meeting. I believe the paper you showed me earlier with my notations on it was what was produced for the meeting, which is actually a template. I think it's from --

THE CHAIRMAN: You're guessing it's Miriam McCarthy.

A. I think it's Miriam McCarthy and I believe it's an abbreviation of my other documents that I sent to Dr Darragh. I don't think either of my papers were actually tabled, but I do understand that the minutes show that I gave a narrative that the incidence in Northern Ireland was reflective of the papers that were in the literature, such as the lesson of the week. In other words, there was a real need for Northern Ireland to progress to produce guidelines urgently because we were experiencing an incidence of hyponatraemia not unlike that which is experienced in the literature. I believe that is what that refers to.

MS ANYADIKE-DANES: In relation to this e-mail here, Dr Carson has clearly spoken to you or has got your views from someone -- maybe I should ask you. Did you speak to him to give him the information that he's now

passing on to the CMO?

A. I clearly spoke to him. I don't recall the conversation and I don't have a record of it.

Q. And at the stage of 30 July, where would he be getting or where would you be getting it to give it to him, the information that the Children's Hospital would have approximately one referral from within the hospital per month?

A. I think this e-mail is a follow-up e-mail from the one that I gave you earlier on the 27th.

Q. Yes.

A. So on the 27th at 14.47, Dr Carson e-mails me to say would I do some work.

Q. Yes.

A. And then he contacts me on or before 11.52 on 30 July 2001, and I clearly -- I don't deny, I clearly give him information. Whether that is all my information, I don't know.

Q. No, sorry, my question to you is --

MR UBEROI: If I might add to an answer that a witness has just given, just perhaps to make this point now before -- I completely understand my learned friend is about to embark on one or two questions on this document. The extract quoted is not clearly put in the mouth of Dr Taylor. The early sentences read equally as if they

could be a compendium of Dr Carson's knowledge accrued from other individuals. I of course accept that one sentence begins "Bob Taylor thinks", and in using that terminology it would be my position that that rather makes that sentence attributable to Dr Taylor in a way that other sentences aren't.

MS ANYADIKE-DANES: I haven't asked a question like that. I said --

THE CHAIRMAN: Sorry, Ms Anyadike-Danes, Mr Uberoi was anticipating a line of questioning. He wasn't saying you'd asked a question, he was anticipating a line of questioning.

MS ANYADIKE-DANES: Sorry, I thought he was going back to something I had asked. What I'd asked was:

"At the stage of 30 July, where would he [that's Dr Carson] be getting that information?"

Or where would you be getting it from to give to him? I don't know where that would have come from. And the information that I'm talking about is the anaesthetists in the Children's Hospital would have approximately one referral from within the hospital per month. Where in your view would Dr Carson be getting that kind of information from?

A. Well, he's getting it from the anaesthetists in the RBHSC, which is myself and Dr Crean and Dr McKaigue and,

at that time, Dr Loan and Dr Chisakuta.
Q. I know it's put approximately, but in order to get that order of magnitude, where would you go back to to get a view of what the level of referral from within the hospital was? What would be the source of your information?
A. I don't know what the source of information is. That may well just be a compendium of views that we would have given him. I don't know where he gets that information.
Q. And is that information being given him as if that is significant? Is it significant that there was approximately one referral from within the hospital per month?
A. It depends, of course, how you define hyponatraemia. Sodium frequently ... Even today, I wouldn't say frequently, but there would be still cases of children with sodiums less than 135. If a sodium is less than 135, the laboratory highlight that with an asterisk and say, "This is hyponatraemia". And then there's a clear audit path line through the labs about the number of hyponatraemic, in other words children with sodiums of less than 134. Now, it could be -- or less than 135. In other words, 134 or below.
Now, it could well be an anaesthetist giving an

incidence of a child coming for surgery who the junior doctor phones me up and says, "You've got a patient tomorrow on your list and their sodium's 134. What do you want me to do about it?" So it may well be this refers to a not uncommon situation where children are referred to anaesthetists.
Q. If the context of that is the problem of dilutional hyponatraemia, which we're now going to try and address by agreed regional guidelines, that kind of hyponatraemia, is that what you would have regarded as relevant or significant to pass on to Dr Carson?
A. No, I don't accept that there was one case of dilutional hyponatraemia referred to the anaesthetists every month, although my bar chart, inaccurate as it is and not to be relied upon, does show an incidence going up to about seven --
Q. Yes, I'm going to ask about that --
A. -- per year of PICU admissions, but that does not mean that they were the only patients that anaesthetists were seeing. That data, inaccurate as it is, and with all the caveats that I've given you, would refer to only the patients in the six beds in PICU, not the 80 beds in the rest of the hospital. So I think -- I don't know the answer to that.
Q. Where my question started is: where would you get the

information to be giving him? What's the source of your information?
A. I'm not sure I've given him that information. I think the labs would be the best place to give the information about the number of children who had low sodiums, but I don't know where you'd get the information if he is referring only to children who had developed iatrogenic or dilutional hyponatraemia. That's information that I was not in a position to give him.
Q. And in your bar chart you actually have the incidence of the admitted and not leading to death. They are on the rise after 1995 by comparison with the figures before 1995.
A. You see, that's why I went about in my poor manner -- I accept that it wasn't accurate, but I tried to get some data that could be useful to inform the working party, and I accept all the criticism you've given me that there's data missing and that it's not complete, but it's the only data that I could quickly access in the summer holidays with the benefit of my secretary, who was very good at getting data out of the computer. But it was incomplete data and it wasn't always recorded accurately in the coding.
Q. Yes. That incidence of hyponatraemia, Dr Taylor, did you consider that to be of concern, that level of

incidence?
A. In children that didn't die?
Q. Well, the information that you have recorded --
A. Yes.
Q. -- on your bar chart, did you consider that to be of concern?
A. Yes, we were getting -- I think in 2000 there were seven cases, it peaked at seven cases, which was double what it was in --
Q. Yes.
A. -- an average of the years before. It goes up and down like the stock market, but there's obviously a trend towards an increasing incidence of hyponatraemia, and that was concerning, and I think what I was trying to do --
Q. Sorry, I've understood --
A. -- was tell the working party to get a move on and let's get guidelines to stop this rising any further.
Q. If you hadn't been asked to do some background work in relation to the meeting which was triggered by Raychel's death as you've described it. At what stage, if at all, would anybody have looked at those deaths and seen the pattern or the level of incidence that you considered to be concerning?
A. I don't think anybody would have looked at that.

Q. So that could have just gone on until something --
THE CHAIRMAN: Well, we don't know. We don't know if anybody else would have done it if Dr Taylor hadn't done it.
A. You can speculate to say it would have gone on.
THE CHAIRMAN: You can speculate --
MS ANYADIKE-DANES: Is that kind of information routinely audited?
A. No.
Q. So there is no systematic way -- or is there? Is there a systematic way in which those non-fatal incidents of dilutional hyponatraemia would have come to anybody's attention to do anything about?
A. I don't think so back then.
Q. Is there now?
A. Yes, there is a system in place now with trigger points to alert doctors to -- if you use a solution with a sodium of less than 130, it's an automatic adverse incident form. If the lab phones up a result that's less than 130 -- I can't go through each of the data, but it's in a wall chart in every clinical area where children are admitted and you cannot get out of it. In other words, if you give a dilute fluid for maintenance or a dilute fluid for replacement or a sodium is below a certain level, it's an automatic trigger for an

adverse report.
Q. Yes. We've heard one of the outcomes of the RQIA in 2008 was that Antrim had actually developed a trigger. Is that the sort of thing you're talking about?
A. Well, it's throughout Northern Ireland, not just Antrim. It is regional.
Q. Which was ultimately taken up --
A. I believe it's the same thing. I'm not exactly sure.
Q. Thank you.
A. And I think the lab also have a proactive adverse incident reporting. If the lab gets a low result, it has to report to its directorate control.
Q. Can I just ask you about your five to six deaths? Well, you are reported as having said that you thought there were five to six deaths over a 10-year period of children with seizures. And I think in your evidence, in your witness statement in this case, you said that that doesn't appear plausible. What you actually say is:
"Five to six deaths over 10 years does not appear plausible to me."
The reference for it is 330/1, page 4. Why did you think that wasn't plausible?
A. Well, I've thought a lot about this statement, obviously, in advance of this. The only deaths I was

aware of at that date was Adam and Raychel. Those are the only two deaths I recall that I was aware of. So I don't know where -- it's attributed to me -- Dr Carson is able to write that there were five to six deaths. He doesn't say they were in Northern Ireland, so my feeling is that perhaps that's deaths that I had accumulated by speaking to doctors outside Northern Ireland, and I was in contact, as was Dr Crean, as was Dr Loan.
For instance, Dr Loan came back with the experience of a death of a child when he was in Toronto, and that was within 10 years, so that would have been maybe tallied as one of the extra deaths due to dilutional hyponatraemia.
Q. My question was a little different, Dr Taylor. Why did you think it wasn't plausible to have five to six deaths over 10 years? That's what I meant.
A. Because I don't think it was based on data ...
THE CHAIRMAN: I think that's what he was answering.
MS ANYADIKE-DANES: No, I think he was answering where you might have got the figure of five to six deaths.
THE CHAIRMAN: No, that's not what I understood.
A. My answer earlier was in the Northern Ireland context.
MS ANYADIKE-DANES: Yes, that's what I meant.
A. I didn't think five to six deaths was plausible in Northern Ireland because I would have known about them.

Q. That's what I was getting at. Because if there had been that many deaths, you would have known about it?
A. I would have expected one of the people I'd been talking to, if not me, one of the people in the Children's Hospital would have known about it. We obviously were talking about deaths after Raychel.
Q. Yes.
A. We must have been.
Q. One of the people you might have been talking to was Dr Crean?
A. Yes.
Q. In fact, he'd be a logical person for you to talk to. If you'd been talking to Dr Crean then Lucy's death would have been added to that and you'd have at least had Adam, Lucy and Raychel in a period of six years?
A. I don't remember being aware of Lucy's death being due to hyponatraemia at that stage. I honestly was not aware of Lucy's death being reported as a hyponatraemia death. I now know the role that hyponatraemia played in her death. I've read the papers now and I believe the sodium of 127 was, if you like, a red herring and that people were not attributing her death at that time to dilutional hyponatraemia. For some reason, Lucy's death did not trigger the same concern in my memory that Adam did and that Raychel did. That's the honest, truthful

answer that I can remember from that time, but I've read so much stuff I can't be sure.

Q. This e-mail was copied to you.

A. Um ... Can I just see it again?

Q. 026-016-031. Cc --

A. Yes, I'm on the cc, thank you.

Q. If there was a potential misunderstanding for how the information that you are being recorded as having been provided, don't you think you might correct that and say, "Hang on second, you've got that out of context. We're talking about five to six deaths internationally", or something like that, whatever the points are that you think are misleading or not accurate. Did you not think you might correct your medical director on that?

A. I don't know.

MR UBEROI: If I might add, I'm not sure it's been established that there's anything to correct, necessarily.

THE CHAIRMAN: If Dr Taylor understood the reference to five or six deaths to be internationally, that e-mail does not need to be corrected.

MR UBEROI: That'd be my point, sir. I'd also add that was Dr Carson's best recollection of how he interpreted that figure when he drafted it in his e-mail.

MS ANYADIKE-DANES: Also, I think Dr Taylor's evidence was

he wasn't sure about where the figure of one referral from within the hospital -- and I think your view was that didn't necessarily accord with the sort of case that would be part of this kind of concern.

THE CHAIRMAN: Okay, I've got the point.

MS ANYADIKE-DANES: Thank you.

THE CHAIRMAN: Let's break for lunch. We'll resume at 2 o'clock, doctor. Thank you.

(1.12 pm)

(The Short Adjournment)

(2.00 pm)

MS ANYADIKE-DANES: Could we please pull up a statement that you made in relation to Claire's death, which is witness statement 157/2, page 3? If you see in the answer to (e):

"Did you seek information from colleagues as to hyponatraemia cases in the RBHSC within the preceding 10 years to assist in the work of the Northern Ireland working group?"

You say to that:

"Yes, I did discuss the hyponatraemia deaths with other colleagues."

Which is what you have told the chairman today:

"I cannot recall what information was discussed. At this time in 2001 we were aware of Lucy and Raychel's

deaths."

You have given evidence about Raychel. Who is the "we", and how were you aware of Lucy's death?

A. Yes, I can see what I've answered. I'm just trying to work out the context, if you don't mind. I don't know how that's -- in the context, Lucy obviously died in the PICU, and, as I said earlier, I think there was concern or confusion that because her sodium was 127 ... I don't know if I know this information now, after 2001.

Q. I'm only asking you how you answered the question. You have answered the question:

"At this time in 2001, we were aware of Lucy and Raychel's deaths."

If you leave Raychel's aside, what do you mean by that in relation to Lucy?

A. I understand, but what I'm trying to feel and remember is when this was written. Presumably, in 2010.

Q. When your statement was produced? I can tell you that. Your statement was produced 21 September 2012.

A. 2012. So it's information -- I'm obviously saying in 2001 I was aware of it, but it was written in 2012, so what I'm now struggling to understand is is it really information that I knew in 2001 or is it information I knew in 2012 that I think I remembered in 2001. My other evidence was -- and it's consistent with my

feeling -- that I did not know that Lucy's death was due to dilutional hyponatraemia at that time and wasn't included in the audit.

Q. Or it could be quite simply that you did, either you knew that directly or somebody told you. And A person who could have told that was Dr Crean because you and Dr Crean were on that working party, you were colleagues together, it's a rather small specialism, paediatric anaesthesia, at consultant level. It is quite possible that you discussed it and that is how you knew.

A. It's possible, but it's not my memory in the context of the other questions that were put. So I don't know if it's memory that I have post the events of the inquiry or it is genuinely evidence that I had at the time. I'm sorry.

THE CHAIRMAN: Can I ask you this: if Raychel's death was a shocking death in 2001 and you come into work on the Monday and you're told about it and people are in a state of disbelief, at the risk of comparing the deaths of two children, Lucy's would be equally shocking, wouldn't it? Lucy didn't even have an operation. Lucy went into the Erne Hospital with some sort of bug or whatever and was to be rehydrated and died in a very, very short timescale. If Raychel's death was shocking in 2001, Lucy's death, by definition,

must have been at least equally shocking in 2000; right?
A. That's what I'm failing to comprehend, why it didn't have the same impact.
THE CHAIRMAN: And you had no contact or input at all into Raychel's case. Right? You had limited input into Lucy's.
A. No, I didn't know about Lucy's death.
THE CHAIRMAN: Okay. So you had no --
A. Her management, sorry.
THE CHAIRMAN: -- input into Lucy's management, no input into Raychel's management. Two shocking deaths a year apart. You pick up on Raychel's death through the responses and sadness in PICU.
A. Yes.
THE CHAIRMAN: It seems to me then that you would pick up, on the same basis, on Lucy's death in 2000.
A. Well, I can understand how it seems like that.
THE CHAIRMAN: Okay. If that's the case, and you didn't think it was hyponatraemia, then somebody would have said to you "Lucy died of gastroenteritis". Dr Crean has told us that if Lucy was ever discussed at an audit meeting and gastroenteritis was put up, people would have been hopping up and down in disbelief at the idea that a girl from Fermanagh in 2000 died of gastroenteritis.

If that's the picture for 2000 and the picture for 2001, I am once again lost as to why you didn't know about or didn't have concerns about Lucy's death, not because of your personal involvement in it but because of what goes on within the children's unit, adding in the fact that I'm continually told children's deaths are very, very rare. Can you help me?
A. I struggle to understand that. Looking back now it seems incredible that Lucy's death did not have the same impact as Raychel's and I have no explanation for that, sir.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: Then just while we're on the deaths, very briefly, if I can ask you about Claire Roberts. I've already been there with you before, but bear with me. You had some input into Claire's care.
A. Yes.
Q. You have already said that. You have already said that you read her notes, you have already said that you were aware that her sodium levels had fallen from 132 to 121, and that's within 23 hours, and that is potentially an issue.
A. Yes.
Q. That would register with you, as a paediatric anaesthetist, the significance of that. And you were

also aware that she was receiving low-sodium fluids. So that much you knew.
On her case note discharge summary, which is a PICU document, it has "Other diagnosis: hyponatraemia". So the question I'm putting to you is: why, from that information, were you not able to see that there was a fluid management problem with Claire? Not necessarily to diagnose her, but to recognise it as a fluid management problem.
A. I don't understand why I didn't register it as a hyponatraemia case. It must go back to what was the prevailing thinking at that time, which was the paediatricians were of the view and had convinced us of the view that on the wards No. 18 was the standard solution and there was an element of safety about it. But that's speculation, I don't know. I can't remember why her death didn't register as being --
Q. But they hadn't convinced you about the potential risks and the double whammy. That's actually the point of professional difference you had with them and you have summarised that very nicely in your background piece, which sets out some of the elements which would have allowed to you be concerned about Claire's fluid management. So what I'm asking you is: even if you didn't feel you were in the position and it wasn't your

role at that time to actually make a diagnosis of her, when you are now thinking about issues, of concerns we might have about the use of low sodium fluids, that was a case which you would have seen and people didn't really understand why Claire died either. She's another child who dies, and if children's deaths register particularly because they don't happen very often, she's another one that people might have been rather shocked about. They don't know why she died.
A. I can only agree with you. I can't explain why I didn't register ...
Q. So in addition to the Adam that you know of and the Raychel that you're told about, there's Lucy, which should have registered as a rather shocking death, you've conceded that, there's also Claire, which you had some involvement in, which should also have registered as a rather shocking death.
A. That's true, but the Arieff lead editorial was 1998 and the Halberthal paper was 2001, and those both happened after certainly Claire's death.
Q. Yes.
A. And obviously, one of them before and one of them after Lucy's death. So what I think was happening -- it's speculation, and I really don't know. I understand what you're getting at. I don't know why those deaths didn't

have the same impact as Raychel, and I think it's very, very unfortunate and tragic that they didn't.

Q. Yes. Then if I might pull up this letter that you write to the coroner on 1 November 2001. So obviously, this is after that first meeting you attended, and we'll come to the minute of that meeting of September, but before the guidelines are actually issued. Okay? The reference for it is 012-071b-409.

Can you see where it says in the middle of the page: "As you will remember, I also had a child's death related to this type of fluid."

And then you go on to talk about writing to the MCA, the Medicines Control Agency. So it would appear, as at 1 November 2001, if you hadn't done it before, that you had associated Solution No. 18 with Adam's death unless there's some other child you might be talking about. Is this Adam?

A. I think this is Adam because I've started the sentence "as you will remember", so it's obviously a case that has been through the coroner's system.

Q. Exactly. So at that time you have managed to associate Adam's death with this type of fluid; is that right?

A. That would appear to be so.

Q. You also knew, because you'd been told, that Raychel's death was associated with Solution No. 18. That's part

of the trigger of getting the meetings going.

A. Yes.

Q. So did you ever make a link between Adam and Raychel in terms of surgical cases where Solution No. 18 had played a role?

A. Um ... I don't really understand what --

Q. Did you make a link between Adam and Raychel, two paediatric deaths, surgical cases, if I use that expression, where Solution No. 18 had been implicated in the death? Did you make a link between those two?

A. I can't remember.

MR UBEROI: If I might assist, in fairness, he's making the link in the very text that's on the screen. It's a yellow card with regard to Raychel Ferguson and he has put the text which has already been put to him.

THE CHAIRMAN: Yes, I think Ms Anyadike-Danes is accepting that that's the link which was made in 2001 and what she's asking is: at what point prior to that, between June and November 2001 --

MR UBEROI: I'm sorry, I thought the question was "Did you make a link?" rather than "When did you make the link?"

A. I don't remember.

MS ANYADIKE-DANES: Because if you had made a link earlier, then that's all the more reason to have mentioned that case during the course of the September meeting.

Dr Nesbitt's evidence is that he discussed Raychel's case because that was so raw with him at that meeting.

A. I think even after -- up until recently, we -- myself and my colleagues -- did see Adam's death as being different. Raychel did die post-operatively, Adam had polyuria. There were similarities, they were both children and they received Solution No. 18. Adam received Solution No. 18 as a bolus in a unique situation of polyuria and I've accepted that. I don't believe Raychel received a bolus. I think the pathogenesis, the disease process, that led to Raychel's death was more akin to the papers that were coming out from lesson of the week and Arieff. I still obviously was having a problem accepting that Adam had died by that mechanism.

So in some ways, I agree with you, I had established a link by 1 November 2001, but I still think perhaps there was some differences between the two cases that we had already learnt our lesson from the coroner's inquest about Adam's death in terms of changing the blood gas analyser, giving better sodiums in the theatre and improving our management of major surgery intraoperatively. I think what Raychel's death was highlighting was the fact that that was a child who had gone through surgery and survived anaesthesia and was

now in a post-operative position, was now going through the ADH double whammy response.

I don't think I associated the double whammy response with the death of Adam at this stage. So there's some similarities but there's also some differences that I think I still get confused about.

Q. Whatever the differences between them, what you have identified here is a common feature, which is in both those deaths Solution No. 18 was implicated.

A. Two deaths.

Q. And the simple point that I was putting to you is that if you had appreciated that by the beginning of November 2001, had you appreciated that by September 2001?

A. I don't know. I can't remember the date I started appreciating that.

Q. Sorry, giving a date probably doesn't help. Had you appreciated, before you went to the meeting, that Solution No. 18 was implicated in Adam's death?

A. I don't know. I think when I spoke to Dr Carson, I would have known about Adam's death and Raychel's death amongst those five to six deaths that he has picked up from our conversation.

Q. Yes.

A. I am certainly sure that Adam's death and Raychel's

death would have been among those two. They were the only two deaths in Northern Ireland that I was aware of at that time.

Q. Thank you very much. If we then go to the actual minute of the meeting. It's 007-048-094. The chairman has the clinicians who are from the hospitals who are involved in this investigation in terms of children who have died. There's yourself, of course. Dr Lowry, Dr Nesbitt, Dr Marshal and Dr Crean are all in that category. Leaving aside the introduction, when you are recorded as informing the meeting about the background and incidence of cases seen in the Children's Hospital and patients who are particularly at risk of hyponatraemia, what are you drawing on in terms of conveying the incidence of cases? You don't have your PowerPoint presentation, imperfect as it was, so what are you drawing on to convey that?

A. Well, I can't remember. I speculate that I was trying to draw on some of the basic research in terms of the bar chart that we'd gathered, that they seemed to be increasing over 10 years and that was in keeping with the number of case reports or papers coming through. So I think, as I said earlier, what I was trying to do was make sure that any information I gave to this working party was to say, "This is a real problem in

Northern Ireland as well as globally --

Q. Yes.

A. -- and we need to get on with the guidelines". I think that was the point.

Q. I understand that's the tenor of it, but if you're actually talking about the incidence of cases, the implication, the most natural thing in the world is, apart from referring to papers and articles and so forth, the most natural thing in the world is to talk about actual cases in which you have been involved. As I put to Dr Crean when he was giving his evidence, most of the clinicians, when asked to deal with an area that I've explored with them, have different examples from their actual experience because that's the most natural thing to do. So if you are being recorded here as giving the incidence of cases seen in the Children's Hospital, even if you don't identify by name -- and I can quite understand that -- are you not seeking to convey actual cases of which you either have direct knowledge yourself or of which people have told you about?

A. I honestly don't see it that way. I see it in terms that this is a growing problem, there's more than one or two deaths, this is down to a rising number of cases which could, some people have said, be classified as

near misses. They did end up in PICU, they did end up with what we think is dilutional hyponatraemia. We know that one of them certainly highlighted as a death in 1997 probably wasn't hyponatraemia, although he was a coroner's case, the coroner would have -- he was referred to the coroner, certainly, at that time. So although he came up on the bar chart as a death with hyponatraemia as another diagnosis -- I'm trying to be very careful about not identifying the patient. We know from the bar chart, in a redacted way, that it was a death, it was a coroner's case, it was a tragic death of a child. Hyponatraemia was present at some stage during his intensive care admission.

I don't think what I was trying to convey was my knowledge of his death or Raychel's death or Adam's death. I believe what I was trying to convey was that we were having a trend in general terms, spiky as it is, but a trend over a 10-year period, confirmed by my very rapid contacting other colleagues in English and Canadian hospitals, which was coming back to say that, yes, we're now hearing about cases coming through, seriously ill children coming through. These weren't just children with a low, you know, slightly low sodium, these were children who were coming to intensive care and that that was what I was talking about by incidents,

not why should we discuss one case and go through the minutiae, if you like, of that patient's management, which would have distracted perhaps.

When I sit on this committee, time is limited and my knowledge of sitting on working parties is there's a real need to progress the guidelines, and if you hold them back by -- if there's an argument that develops and somebody says, "That is not true, that patient didn't die of that cause", or, "That patient did die", it distracts the team and, as I said, the composition of the team was directed towards developing a guideline, not to go over a death that might have already been subject to a coroner's inquest.

Q. Did Dr Nesbitt discuss Raychel's death?

A. I believe he brought Raychel's death up. I know that because a volunteer was asked to yellow card Raychel's death.

Q. Yes. So he did discuss Raychel's death?

A. He must have discussed it.

Q. Yes, and if he was bringing that death as part of the significance of this thing, a child has died, this is real, we need to do something about it, did that not prompt anybody else to say, "Well, actually, we've had a child die as well"?

A. Apparently not.

Q. And it didn't prompt you to say, "Well, actually, I know of at least two", or whatever might have been the number you'd have known at that time?
A. I might have said, it's not recorded. I have no recollection of saying that.
Q. Okay. Then if we can just go to 001-080-273. Sorry, that may be an incorrect reference. I beg your pardon. No, it is a correct reference. (Pause)
It may not be up on the system, I apologise for that. I can read out what it says because it's very short. It's an e-mail thread and it really is coming between Trevor Birney from UTV and Marie Dunne, the communications manager, I take it. This particular part of the thread --
THE CHAIRMAN: At Altnagelvin.
MS ANYADIKE-DANES: Yes, at Altnagelvin. This particular part of the thread is 27 September 2004. Some information has been sought from Dr Nesbitt, which has been provided. Then there is a supplemental point and it's this:
"Others involved in the CMO's working group say they studied the Lucy Crawford case as part of their work."
And the question goes on:
"Was Dr Nesbitt never informed of her death?"
But that's not the point I wish to raise with you.

So this is suggesting that Lucy's case was actually studied as part of the work of the CMO's group. Were you aware of that?
A. I have no recollection of Lucy's case.
THE CHAIRMAN: Just to get it clear, this is Mr Birney saying to Marie Dunne on an e-mail:
"Others who were involved in the CMO's working group say they studied Lucy's case as part of their work."
MS ANYADIKE-DANES: Yes, that's correct.
Do you have any knowledge of that?
A. I have no knowledge of that.
Q. So far as you're concerned, was there any study going on on Lucy or any other particular child's death in relation to the working group's work?
A. I can't remember any other death being discussed. What I suggest might have happened then is people might have said, if that had happened, "Why are we just yellow carding Raychel's death? Why do we not have to yellow card Lucy's death?" So I don't remember it being discussed and I can't remember being asked to yellow card -- which was actually the first form of adverse incident recording in the UK. For many decades the yellow card system worked as an adverse incident report.
MR UBEROI: If I may be of assistance here, of course, what we know is there was the initial meeting of the working

group on the 26th, but then there was a subgroup, which moved on afterwards, which Dr Taylor wasn't a part of, and I wonder whether that distinction might be relevant. I simply wish to place it before you --
THE CHAIRMAN: It may also be journalistic bluff.
MR UBEROI: Absolutely, sir.
MS ANYADIKE-DANES: I refrain from putting the first question, because if he wasn't there, he's unlikely to be able to help us on what was discussed.
Then you had said before that you weren't aware of any guidelines at all. Can we have back up the minutes? 007-048-094. This is recording your contribution to the discussion, and then you say:
"Fluid replacement in children is complex and while guidelines are in place for acute management, chronic management is not as well covered."
What did you mean by "guidelines for acute management"?
A. I think that's the APLS guidelines for resuscitation fluids that I was referring to. It could only have been that because there were no -- and I have to say again that Dr Crean and myself, we have been to many committees and Dr Crean has certain -- one of the phrases I've learnt from Dr Crean, as my senior colleague over the years, is, "Bob, don't re-invent the

wheel". And when we go to a meeting, we're busy people, and Dr Crean is very quick to say, "Let's not re-invent the wheel here. Let's pick the guidelines that the Royal have and slot them in here and make them department guidelines". That didn't happen because I am certain we did not have written guidelines for the management of post-operative or medical fluid in the Royal Belfast Hospital for Sick Children prior to the working party's guidelines. I'm very convinced of that.
THE CHAIRMAN: Okay, thank you very much. That fits.
A. But there were APLS guidelines, which every doctor in Northern Ireland had access to, every paediatric doctor.
MS ANYADIKE-DANES: Yes. Ultimately, the guidelines didn't require the actual mention of Solution No. 18 by name.
A. Well, I wasn't part of --
Q. You have seen --
A. The wall chart?
Q. Yes. You have seen the product.
A. The wall chart didn't mention the ban of No. 18, that's correct.
Q. And that was something with which you had a concern about; would that be fair?
A. I think that was well-known.
Q. In fact, when you write to the coroner, 064-004-033, on 23 February 2003, so this is after they've come out, and

you're providing feedback from your notification of Raychel's death to the MCA. You say that:

"Several members of the committee were not happy that Solution No. 18 should be banned. Others, like myself, were adamant that this fluid should be named and shamed so that clinicians would only use it if there was a clinical indication."

Like, for example, the cases that were always specialist cases. But the expression used is "named and shamed". I beg your pardon, I think it's actually on the next page.

A. Yes, I read that.

Q. Yes. Can you see it? It's point number 1, the last three lines of point 1:

"Several members ... Others like myself were adamant this fluid should be named and shamed."

And that's a view that you had really from the outset when there was an issue as to whether the choice of fluid should be included in the guideline or not; is that correct?

A. Yes. I believe so.

Q. Yes. And the others who shared that view, amongst that group, one of them was Dr Nesbitt; isn't that right?

A. From what I've read in his transcript, that's correct.

Q. Yes. In fact, just to outline the point or underscore

the point, can we pull up next to each other 095-010-046bo and, alongside that, 007-003-005.

So this is the Altnagelvin group. So Dr Fulton there, medical director, is writing to his chief executive. They've got the intravenous fluid draft guidelines at this stage, this is 14 November 2001:

"I have told Dr Nesbitt that I think the 'Choice of fluids' section is totally inadequate considering the gravity of our local experience. As Geoff says, it's a fudge and fails to address the use of No. 18 Solution."

Then if we go over the page you can see an e-mail from Dr Nesbitt himself to Miriam McCarthy. He is speaking of his disappointment of the plan to drop the reference to Solution No. 18:

"What evidence do you need exactly? We had a child who died and for that reason I feel strongly that No. 18 Solution is an inappropriate fluid to use."

So they appear to be supportive of your position that Solution No. 18 needed to be named and shamed on the guidelines in some way; is that correct?

A. Or I was supportive of their position.

Q. Or you were supportive of theirs.

A. Yes, that's correct.

Q. Why I'm putting this to you is when they are making this case for how Solution No. 18 should be treated, they specifically refer to the death they've had. That, as far as they're concerned, makes it very important that appropriate reference to Solution No. 18 is given. But you also, by this time, have linked Solution No. 18 with Adam's death. Is there any reason why, when you were communicating with either the Medicines Control Agency or anyone else, for that matter, that you weren't also saying, "It's not just a matter of an incidence of difficulties with Solution No. 18. I personally know of a child's death in which that fluid was implicated", in the same way that Dr Nesbitt does?

A. I can't recall.

MR UBEROI: Sir, is I understand it's an important question, but strictly for accuracy, we've seen the correspondence earlier where he does mention it to the coroner, Mr Leckey.

MS ANYADIKE-DANES: You can't think of why you wouldn't have done that?

A. No.

Q. During the discussions in terms of what should be the detail, if I can put it that way, on the guidelines, this is Altnagelvin's position about that. You have your own view about that and I'm only asking you why, in

order to strengthen your view, you too aren't making the case to the other members of the working party that you have a direct knowledge of a child who died with Solution No. 18 being implicated?

A. I can't explain.

THE CHAIRMAN: To be fair to the doctor, that might at least in part depend on the number of meetings he's at to press that issue.

MS ANYADIKE-DANES: Yes. Then if I come to that slightly out of order, but I can come to it. You, I think, said that although you attended that first meeting, you weren't involved in the design group or those who were establishing the smaller group to take away and actually draft the guidelines; that's correct, isn't it?

A. That's correct, yes.

Q. That decision was made at the meeting of 26 September itself. It's on the second page of the note, we don't need to pull it up. It simply says:

"It was decided that a small group should undertake the drafting of guidelines and audit protocol."

Do you know whether it was decided then who should be in that small group?

A. No.

Q. You know it's not going to be you.

A. Yes.

Q. Did you know at that stage it wasn't going to be you?
A. I've no idea. I can't remember.
Q. And what Ms Gollop said --
A. It wasn't my decision.
Q. I understand that.
A. I would liked to have possibly.
Q. The counsel for Dr Jenkins said that her understanding is that the drafting of the guidelines was then taken back by the members who were in the working group and they would discuss that amongst their colleagues.
A. Yes.
Q. And in fact in the papers you can see the e-mail traffic of various elements of it going back and forth, and you're involved in that, you have contributions to make as well.
A. Yes.
Q. So in that e-mail traffic, would it not have been possible for you to have made the case forcefully, more forcefully, for a reference to Solution No. 18 by reference to cases that you knew about or, for that matter, Dr Crean knew about?
A. I can't remember.
Q. Okay.
A. I thought I was being forceful. My experience of committees are if you're too extreme and too forceful,

you tend to get sidelined, and maybe that's why I wasn't offered ... I didn't refuse -- I don't think I was offered the chance. I wouldn't have turned it down, I don't think.
Q. Yes. Then just because I'm asked to do this, and it might help, although I think we've had the point, 007-048-095. This is the second page of the note. If you see at point 3:
"A general discussion then followed on the management of children in hospital."
In that general discussion, was there any discussion about actual cases? Not by name, I mean, but actual cases.
A. I can't remember. I think if other cases apart from Raychel had been discussed there would have a demand to yellow card more than Raychel. It's just circumstantial evidence, I don't remember. There was just general discussion involved, but it does say the issues were highlighted, so I presume that is what the discussion was about.
Q. Just to clarify something that your counsel, Mr Uberoi, said when I was putting questions to Dr Crean, he suggested -- the first page which talks about:
"... calculation of replacement fluid can be calculated in a number of ways, either on an hourly

basis, daily basis, and he [which is you] proposed a number of recommendations to prevent the occurrence of hyponatraemia."
Did those recommendations derive from that original background piece that you had provided, which got itself attached to Dr Carson's e-mail to the CMO?
A. I assume so because that's the only paper that I've been able to find that relates to any recommendations.
Q. Yes. And who else, just also for clarity, did you send that background paper to?
A. Well, I don't remember. But I know it ended up with Dr Asghar in the Erne Hospital. I think on the 10th.
Q. Yes, that's what is written on the top of it.
A. 10 August.
Q. Did you intend to circulate it amongst your colleagues for discussion?
A. I don't recall. It hasn't, I don't think, come up in anybody else's files, so I don't think I disseminated it. I don't think I went off on my own and pretended to be the chief medical officer if that's -- you know, I wasn't trying to subvert the work of the party.
Q. And for completion, there's a second meeting of the working group. We can pull up a very, very cryptic note of it at 007-038-072. It takes place, as, you can see, on 10 October 2001; did you attend a second meeting?

A. No, I didn't attend any further meetings after 26 September.
Q. So is your involvement confined to that first meeting on 26 September and the e-mail traffic when you're commenting on various parts of the draft that will ultimately be the guidelines?
A. I believe that's correct.
Q. Thank you. You are, though, subsequently invited to take part in another exercise. You get a letter from Miriam McCarthy, and the reference for it, we don't need to pull it up, is 007-955-123. You receive a letter on 12 August 2004, which is further to an earlier letter of 5 July. Maybe it would help you to see it. Sorry, I don't mean to keep you in the dark. 007-055-123. She says she has received helpful comments on the current guidance and suggestions regarding amendments. If I just pause there. Do you know what she meant by that?
A. I think it turns up again in another paper to say that they wanted to update the guidelines around 2004.
Q. Yes.
A. But I felt that was by e-mail, but I can't be sure. I don't remember attending another meeting. Maybe I was unavailable, I can't remember.
Q. Just to help you, Dr McAloon had conducted a review of compliance with the guidelines.

A. That's correct, the regional review.
Q. Yes. And the upshot of his review was that were some deficiencies in compliance --
A. I believe that's correct.
Q. -- and that there was an issue as to whether the guidance should be revised. Ultimately, it wasn't quite revised in that way, but that's what appears to have been discussed.
A. I remember reading that.
Q. Does that help you a little bit, jog your memory?
A. That I attended another meeting?
Q. No, no, no, that that was happening at that stage.
A. It doesn't jog my memory, but I've read the papers.
Q. And then you get this invitation, you along with Dr Crean and Dr McAloon and Dr Jenkins and other senior clinicians, to attend a short meeting to discuss proposed amendments. Did you attend a short meeting to discuss proposed --
A. I have no recollection. I feel that there was no meeting or I didn't attend the meeting, but it's -- I could be wrong.
Q. Did you attend any other meetings in relation to the guidance, whether for revision purposes or anything in relation to the guidance?
A. At the Department of Health?

Q. Yes.
A. No. There was an SAC meeting, but that wasn't -- I think at the SAC meeting I attended, paediatric SAC, the CMO welcomed or thanked the members of the working party for producing the guidance, something like that. But I was at no further working party or spin-offs from the working party on the prevention of hyponatraemia guidelines, to my knowledge.
Q. Did you ever become a member of a group called the Northern Ireland Paediatric Fluid Therapy Group?
A. No. I don't think so. Are you going to tell me I did?
Q. And you know that ultimately what --
A. I was stepping back from management at this time in my career.
Q. Okay.
A. After the death of my daughter, I was taking a more backward seat from management.
Q. I understand. And then, just finally, doctor, Alert No. 22 ultimately was issued --
A. Yes.
Q. -- in 2006, in fact, I think it was. Did you see the draft that was circulated for comment? Did that come your way? Sorry, I think that happened in 2006.
A. You see, I can't remember if I did, but I remember other people have said that I was going round, putting --

Q. Sorry?
A. -- wall charts up in the different parts of the hospital and I think, looking back now, that jogged my memory that I was putting up draft wall charts that I'd printed out as a draft in A&E and the wards. I think Dr Steen made a reference that Dr Taylor was ... So I liked the guidelines and I thought they were important and I think I was sticking a draft up on as many -- trying to preach and get that draft going in advance of the final ... So I think I was given a draft and I printed it off.
Q. To a certain extent, did that draft including the more robust terms you might have wanted to happen in the earlier guidance?
A. No, I don't think the draft ever included a prescription or sort of a ... I think it's been shown in e-mails I would have liked a sample template prescription that would guide doctors. It was -- I think Geoff Nesbitt used the word "woolly" or "fudgy" or "fudge".
Q. Sorry, I meant the draft Alert No. 22 that was circulated.
A. I can't remember.
Q. You can't remember if you commented on that?
A. I just remember, in general terms, being a keen person on guidelines and would have placed it in different parts of the hospital.

Q. And they have been --
MR UBEROI: Just to be clear, in case there is some confusion, I do think there's been a misunderstanding that's crept into the question and answer there, where as I understand it, the doctor's referring to the guidelines whereas my learned friend is referring to the separate matter of Alert No. 22 perhaps.
MS ANYADIKE-DANES: I am asking about that.
Just to be clear about it, Dr Taylor, before Alert No. 22 is published in 2007 --
A. Sorry, is this the draft wall chart? No? Can I see the --
Q. This is pathway that emerges with Alert No. 22. You saw the Alert No. 22?
A. I've just temporarily forgotten it with all the questions I've been asked, sorry.
MR UBEROI: It might be a starting point for the question to ask whether Dr Taylor had any specific personal knowledge of that matter.
THE CHAIRMAN: Well, Alert No. 22 is 303-026-350.
A. My answers might have been referring to the draft wall chart, sorry. Sorry, this is the NPSA.
MS ANYADIKE-DANES: You saw this?
A. This is different. My answers before might have been wrong.

Q. Sorry?
A. I thought you were referring to the draft Northern Ireland working party guidelines in 2000. I think they came out in March, but I think we got a draft before that. That's what I was referring to, I was going around sticking it up. Yes, this is later, this is 2007, from the NPSA throughout the whole of the UK.
Q. And before that went out, it went round for comment and what I was asking you is whether you had seen it and had commented on it, or whether the first you saw of it was the published Alert No. 22 in 2007. That's what I was asking.
A. I can't remember.
Q. Okay. And then what is actually published finally emanating from the department is 303-059-817.
A. Yes.
Q. You see that there, September 2007. And that is revised and there's one amended in February 2010, 303-068-818?
A. And that's got the trigger list on it, if I'm correct.
Q. There we are. In that development, did you or your colleagues at the Children's Hospital play any role in that, make any contribution to that?
A. Well, I didn't. I don't remember making a formal contribution to that.

Q. I understand.
A. I don't know about my colleagues. I can't answer for them.
Q. I understand that.
I have one final question I'm asked to put to you. Given what you now know about the actual cause and have been able to accept about the actual cause of Adam's death in 1995, is that something that you feel -- not you personally, necessarily, but the trust should have accepted responsibility for to Adam's mother?
A. It's difficult for me to answer for the trust. You asked me to answer for the trust or -- to understand ...
MR UBEROI: If I may say, it's a very general question.
MS ANYADIKE-DANES: Do you think Adam's mother should have received an acknowledgment of responsibility, liability, for Adam's death?
A. I haven't thought of it.
THE CHAIRMAN: Doctor, the reason you're being asked is this: one of the real aggravating features for the families is that not only do they lose their children but then they find that -- and I know that this is not necessarily the case -- but on the evidence of this inquiry they find it exceptionally difficult to have someone from the hospital say to them "I'm very sorry, your child should not have died. Our care brought about

your child's death and for that we apologise". There was a written apology provided a few weeks ago to Mr and Mrs Ferguson, which came very, very late, many years afterwards, but was welcomed by them.
When Adam's mother sued the trust, she secured a confidential settlement of her claim. Entirely confidential. But as I understand it, there was no open acceptance on the part of the trust or apology for bringing about Adam's death. Mr and Mrs Roberts did not go down the line of litigation, they took a different line -- it's not better, it's not worse, it's just different. They didn't go down that line and they've had to wait for a long time until this inquiry started to hear people express regret. And perhaps one of the lessons from this inquiry is to remind doctors that sometimes the most humane thing they can do is simply to say to the families, "We are sorry, we made mistakes and we apologise for that".
A. I understand.
THE CHAIRMAN: I think the question that Ms Anyadike-Danes has been asked to put to you on behalf of Adam's mother, in effect, is to say: isn't that something which could and should have been done many years ago? It won't bring back Adam, but it will help ease her pain and her anger and her frustration about Adam's death.

A. Yes.
THE CHAIRMAN: Thank you.
MR McALINDEN: Mr Chairman, just in relation to that issue, I know that there's going to be further stages in this inquiry, and one will include the panel discussion where the present chief executive and the medical director and the director of nursing and, I think, the clinical director of the Children's Hospital will be appearing before you. I have consulted with the board of the Belfast Trust. I don't wish to pre-empt what will be said, but I think it's important that the families be made aware that at the outset of any panel discussion it is the intention of the chief executive to apologise to the families for the shortcomings in the management of the Belfast Trust, both in relation to the clinical management of the patients concerned and in relation to any shortcomings in governance which have been uncovered by this inquiry and, finally, in relation to the conduct of the litigation in relation to the case of Strain and in relation to any other case where the way in which the case has been managed has added to the distress of the families. I think, Mr Chairman, it's important that the families are aware that this development will not be in response to what you've said, but has already been decided upon as the appropriate response to the evidence

that has been given during this inquiry.

THE CHAIRMAN: Thank you, Mr McAlinden. I hope that that adds to whatever else the families are getting from the inquiry. Thank you.

Mr Coyle, any questions? Mr McAlinden, Mr Lavery, Mr Uberoi?

MR UBEROI: No, thank you, sir.

THE CHAIRMAN: Mr Quinn?

MR QUINN: I have one, sir.

Dr Taylor, I just want to go back on your knowledge of Claire Roberts again --

MR UBEROI: Sorry, as a starting point, I would be grateful if these questions could be put through the chairman, as is the style.

THE CHAIRMAN: It goes through me, Mr Quinn. Without any disrespect to Mr and Mrs Roberts, I want to make sure we're not covering any issues which have not already been covered both before and after lunch.

MR UBEROI: I would be grateful for that as well, sir.

MR QUINN: I won't ask any questions, sir.

THE CHAIRMAN: Let me explain this so that Mr and Mrs Roberts understand. I understand that during the morning and over lunch, Ms Anyadike-Danes had raised with her, on behalf of the family, some issues which were then raised by her in her questioning of Dr Taylor.

Those issues having been raised and some of the answers having been probed, I'm not going to allow, because we haven't allowed it with any other witnesses, going back over the same ground again. Okay?

Doctor, thank you very much for coming back. You're now free to leave. Thank you.

(The witness withdrew)

We'll take a break, ladies and gentlemen, for a few minutes and then we'll hear from Ms Doherty.

(3.00 pm)

(A short break)

(3.30 pm)

MRS KAY DOHERTY (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good afternoon. Mrs Doherty, you have made a statement for the inquiry, for reference purposes it's 326/1, and it's dated 20 June 2013. Do you wish to have that as your evidence together with anything that you say today?

A. Yes.

Q. Thank you. You are Raychel's maternal aunt; is that right?

A. Yes.

Q. And just in terms of what you do, you're a cook with the Western Education Library Board for St Patrick's Primary

School; is that correct?

A. Yes.

Q. And that used to be Raychel's old school?

A. Yes.

Q. Were you there when she was there?

A. Yes.

Q. I want to take you back to the early hours of the morning of Saturday 10 June. This is when you're first contacted after Raychel's collapse. How do you know that something untoward has happened to Raychel?

A. Well, my sister, Marie, rang me, about quarter past four or so in the morning, around that time, to say that something had happened to Raychel and she was very sick. And is there any way that I could come over. So I left immediately, which takes about 10 minutes to get there.

THE CHAIRMAN: Sorry, was that to your sister's home or Altnagelvin?

A. Altnagelvin Hospital.

THE CHAIRMAN: Thank you.

A. When I arrived there, I found Marie sitting on the floor in the corridor, crying, and I asked her what had happened and she said that she just knew that there was a seizure or something. And I asked her did she see Raychel, and she said no. And I asked her then, "Where is she?", and she said, "She's in that room there". So

I opened the door and went in to find a bed with a lot of people standing around it, not doing anything or saying anything, but just standing. There was a gap where I looked through and I seen Raychel lying, she was -- with a tube down her throat and wires and her eyes were slightly open. That's all I can say. It was awful.

Q. Did anybody say anything to you when you approached?

A. No. Nobody said anything at all. Nobody even moved. People were just standing there. And I just walked out.

Q. And what happened then?

A. Marie asked me, "Is she all right? What's happening?", and I just ... I had to sort of take a couple of minutes to think. When I seen Raychel, I'm not a medical person, but I knew that Raychel was dead. So when I came out of that room, and I looked at my sister and thought, "This is not good". So I told her that I'd seen her and she had tubes in, whatever, and then I just sort of thought, "Right, this is not good". I had to sort of talk to myself and think what I'd do or what I'd say. I didn't want to tell her that I thought that Raychel was dead because how would I know that? But that's the looks -- that was what the look to me was like.

So then it was around that time then -- I think it

was Dr McCord maybe -- that somebody came out and spoke and said about getting a brain scan done, but that they couldn't move her, said she was very ill at the minute. This might be a wee bit mixed up because I am not sure of the full context at that particular minute. And then they came back and said, no, it was okay, they were getting her down now for a brain scan. So that's what happened.

Q. And at that stage or thereafter, when there was going to be any talk with the doctors as to what had happened and how it had happened, who was the person putting the questions or interpreting what they were saying?

A. Do you mean me or my sister?

Q. Yes.

A. It was more or less me that was asking questions or Ray, but mostly ... Just about what was going to happen or what --

Q. Why was that?

A. We really didn't see anybody that much to ask what was happening until we were told from Dr McCord about the scan, the brain scan.

Q. Yes. Were you there when -- Mr Ferguson has given his evidence earlier this year, on 26 March, and at that time he didn't know who the doctor was or whether it was a doctor or a nurse, but he said:

"A man with dark hair and a dark beard came and sat beside us and started to explain that she was going to go to the Royal for an operation, and I asked [that's Mr Ferguson] him how long it would be until we knew she if was going to be brain damaged and he said two to three weeks and I asked how long it would be until we knew if everything was going to be okay, and he said two to three weeks."

Were you there for that discussion?

A. Yes. Yes, that happened later on that morning, when Raychel was actually moved into the intensive care unit and there was a side room where we were sitting. And that -- I don't know if he was a doctor or a nurse, just a man with a beard.

Q. And before that, were you there when information was given to Mrs Ferguson that Raychel was very seriously ill, there was a lot of pressure inside her head and they would operate to reduce the pressure?

A. The only information we were given was a trickle of blood to the brain.

Q. That's what you remember?

A. And then the next piece of information was the brain is clear. That's the only information that we were given.

Q. Well, do you remember anybody saying anything about the brain swelling or low sodium? Do you remember anything

like that?

A. Once, after we were told the brain was clear, we were told that her sodium was very low, but we didn't know what sodium was.

Q. Did anybody explain to you what that meant or how it was relevant at all to what had happened to Raychel?

A. No.

Q. Can I just ask you -- I hope you won't consider it offensive -- how well do you remember all of this?

A. Very well.

Q. Other than what I have just read out there as to how it might be two to three weeks before they would know the outcome of whatever they were going to do at the Royal, did anybody else talk to you about why, more specifically, Raychel was going to be transferred to the Royal or what they hoped would happen there?

A. The only information that we got was from that man with the beard, and I honestly felt at that time -- and still, looking back now, he was the only person that gave us a clear indication of the stage Raychel was now and what we had ahead of us, by going to the Royal for an operation and hopefully two to three weeks in ...

Q. Even though they might be discussing the possibility of an operation, did anybody tell you how serious the situation was?

A. Never. Only by my own thought, but after speaking with this man with the beard, I thought, "Well, that's a bit of positive news".

Q. Raychel then is transferred to the Children's Hospital and she gets there at around about midday or thereabouts. Do you go to the Children's Hospital as well?

A. Yes, I do, yes.

Q. And you're going with your sister, are you?

A. My father and mother drove Marie, myself and Ray up there.

Q. When you come out of that room where you first saw Raychel and everybody is still, as you described them, just looking, apparently. Thereafter, what did you gain, if anything, from the demeanour of the doctors? What was their mood? How did they interact with you?

A. We didn't really -- we didn't have any contact, really, with anybody.

Q. Then when you get to the Children's Hospital, what happens there so far as you can remember it? If you can keep separate whatever you know that you've heard your sister say, but so far as you can remember, what happens when you get to the Children's Hospital?

A. Well, whenever we got there, as we were approaching the door, the ambulance was there, but Raychel had already

been taken in. And Mr Nesbitt was -- as I now know who it was -- was getting into the back of the ambulance, and he just said to me as we were passing, "She's in the best place". So we went on in. I think we went upstairs and we were there -- we went to go in through the double doors, but I think it was maybe a nurse said that "We will call you, it will take us maybe up to 40, 45 minutes to get Raychel set up and settled, but we'll call you as soon as we're ready". But it only took about, maybe, 35 to 40 minutes we were waiting, and there was, I take it, a doctor came out, and he just said that Raychel is very ill, this is very serious and I am not giving you any false pretence, this is not looking good, but until the neurologist comes in -- the neurologist will come in and speak to you, but I don't want to give you false pretence. He says he should be here shortly and that was it.

Q. So you had that information. Dr Nesbitt has given evidence as to what he told Mr and Mrs Ferguson. Were you there at any time when Dr Nesbitt was having a conversation with your sister and brother-in-law?

A. No.

Q. So you can't comment on what he said to them?

A. No.

Q. Thank you. So now, after he said that the neurosurgeon,

once they've had an opportunity to examine Raychel and consider her, they would be able to give you their assessment of the situation, what happens then?

A. Then we were called in and we were taken into a side room and it was myself, Marie, Ray and Ray's brother, and it was Dr Crean and Dr Hanrahan and they just said that -- they had to just tell us in a straight way that they had done -- I think he called it, the neurologist, a brainstem test -- I'm not sure I'm right in the words I'm using -- but they were negative. And it basically meant that Raychel was brain-dead, that they would have to repeat the test again in 24 hours because it's the law, but that they could assure us that there would be no change in 24 hours as to what they had just done today.

Q. Did they, either of them, explain how they thought Raychel had got to that state?

A. Well, all that I can remember at that time -- it was horrific in that room.

Q. Of course.

A. And I really -- I can't remember any conversation with those two men because I was holding Marie behind the door, trying to restrain her. It was just -- it was chaotic in there.

Q. Did you stay until the second brainstem test or were you

there for the results of that?

A. No, I stayed the whole time.

Q. At any stage thereafter, did anybody come to explain to you how they thought Raychel had got into that state?

A. I honestly have no ... of talking to anybody.

Q. I understand.

A. I can't ...

Q. After Raychel's death, you contact Stanley Millar at the Western Health and Social Services Council on 23 August that year. So just a little bit after.

A. Yes.

Q. Do you remember doing that?

A. I remember ringing him, yes.

Q. We can pull up his memo of it to help you. It's 014-001-001. That's his memo. Firstly, why did you contact Mr Millar?

A. I still don't know how or why. I think I may have spoken, but this is not 100 per cent accurate, with Helen Quigley. I believe she was a councillor and she gave me -- she told me about Stanley Millar and who he was and I believe that's why I contacted him.

Q. Okay. By the time you are contacting him, has it been decided between you and your sister that you're the person who will be carrying out this type of investigation or this type of contact?

A. Yes. My sister was not, you know -- she just was not up. She wasn't in a fit state to be talking. This was with her permission that I would have done this.

Q. And at the time you're doing it, do you have any information or any idea as to how Raychel came to die?

A. I did hear the word hyponatraemia mentioned in Belfast. I don't know how or why. The only recollection that I have of the word -- when we were all in the Royal and between the two brain tests being taken, it was my oldest brother then went to the Internet and got information from there about the word hyponatraemia. But that's -- we had never heard of it before, we didn't know what it was. And we were just reading notes from that. That's the only information that we had.

Q. You say that you don't remember, so it may be that you were told some of these things --

A. Yes.

Q. -- or at least that your sister and brother-in-law were told them. But so far as you are concerned when you are making this contact with Stanley Millar, what information do you have to be able to give him as to what has happened?

A. I just can't remember exactly what I told him. Obviously I would have told him the way that she died. We didn't know what she died of. I really don't have

a clear mind of having that --

Q. That's all right. It is perfectly understandable. Can you see all these points that he's noted from that telephone conversation?

A. Yes.

Q. Do you think these points are matters that you might have raised or matters that he might have found out independently once he knows the name of the child?

A. Well, I have no doubt that I would have pointed ...

Q. So if I can give you an example of that. For example, would you have been able to tell him that the morning after her operation she was in good form? Would you have been in a position tell him that?

A. Yes. And the reason I would have done that -- my sister worked at that time in one of our outlying centres so she rang me that morning at ten to, five to eight to say she wouldn't be coming to work. Raychel had been through the operation and she says, she's up and she's in good form, but she says, I'm not coming to work today because I'm going over to hospital. So everything I would have had -- that information.

Q. I understand. Then you see:

"After lunch, she vomited [and then in brackets] blood in vomit and complained of sore head."

Even if you leave aside the timing, would you have

known either directly or from your sister or brother-in-law that Raychel had been vomiting with some blood in her vomit and that she had complained of a sore head?

A. Well, on the Friday that Raychel took sick my sister rang me -- it was around, I think, maybe ... It was after school time, half four, or whatever, and we were on the phone and she told me about Raychel complaining first of all about this pain. And while we were on the phone, we were saying, "We'll give her a pillow and a wee blanket, sometimes that's all that happens, that's all she needs". But then later on then, she contacted -- I just need to get this right. This was on the Thursday that this happened. So she left me a message saying -- just to say she'd taken Raychel because she didn't get any better. And then later that night, then, just to say that Raychel was kept in, we'll speak in the morning. Then she rang on the Friday morning to say that everything was over, she had her appendix out, and on that day I said to her, "Well, after work, my husband and I had something to do in Larne, and we were going to Larne, but keep me posted and I'll talk to you when I come home". So we were home around half eight that night, quarter to nine, and just as we got in the door she rang and she said, "I'm home,

but I have to go back to hospital, Raychel has been so sick all day", and she described the vomiting, non-stop vomiting. And she explained that Ray had been on the phone and she said, "He's really cracking up because Raychel is crying with pains in her head and there's nobody taking them on".

At that time, I said to her, "Well, go over and tell them that you want to know why -- why Raychel is so sick. If it was a simple operation, she'll be okay". My words to her were, "Sure when I spoke to you at ten to eight this morning, you told me she was okay", and she said, "But she was okay at ten to 8 this morning, she was fine, she was able to walk down the corridor with Ray", but she said, "By the time I got there then, by the time it came to lunchtime, she was just getting sicker and sicker".

I still think -- at times I think to myself now maybe I should have went over, maybe if I had went over, would things have been different? Because they'd had a long day of Raychel being sick and I always ask myself that question. Maybe if I'd been there, maybe if I'd have said "Is there nobody else that can tell us or answer us as to why Raychel is so sick?"

Q. Can you remember what you did as a result of your conversation, what information Stanley Millar gave you,

and what was done as a result of it?

A. I have absolutely no idea as to what ...

Q. If you look there at the bottom, he has there the advice he gave you, and two parts of that --

THE CHAIRMAN: Just before you get there, Ms Anyadike-Danes. Do you see, Mrs Doherty, all the arrows, point after point, down that page?

A. Yes.

THE CHAIRMAN: And the line below that says:

"Note: sodium level checks in Altnagelvin. Six-hourly in RBHSC."

Can you remember, is that information that you gave to Stanley Millar?

A. No, that wouldn't mean anything to me.

THE CHAIRMAN: Okay, thank you. And then Ms Anyadike-Danes was then going to ask you about the bottom four bullet points, which are Stanley Millar's advice:

"To go to solicitor with an allegation of negligence."

And that would mean that it wasn't a National Health Service complaint. Do you remember him advising you like that?

A. Now that I see that --

THE CHAIRMAN: If you don't remember, don't start trying to guess, but does it ring a bell?

A. It does ring a bell, but word by word, I couldn't -- don't know what exactly we said.
MS ANYADIKE-DANES: Do you see there are two ticked items?
A. Yes.
Q. One is to send a draft letter to ask for the post-mortem report. Just at that stage, did you know that there was going to be a post-mortem?
A. Not -- I wouldn't have. I don't think so.
Q. So that arrow just before the note that the chairman took you to:
"A coroner's post-mortem was held and brain retained."
Is that something you would have been telling Mr Millar or is it something he might have found out for himself?
A. I could have told him because I would have known that a stem of the brain was kept back.
Q. You did know that?
A. I did know that, yes.
Q. Just so that we're clear -- I should have asked you this before: these interactions with what was happening about her vomiting and the sore head and the nurse advising it was routine, all those are matters that your sister or your brother-in-law told you, is that right, because you actually weren't there that day?

A. No, I wasn't.
Q. Thank you very much. Then those two items that are ticked at the bottom of the page, do you have any recollection as to whether the reason they're ticked is because there had been some sort of agreement that that's what would happen, that would be the action, or do you just not know why they're ticked?
A. I don't know.
Q. Thank you. Just to be clear on it, leaving aside whether you knew how often sodium checks were done at the Children's Hospital, did you have any knowledge about there being an issue about whether or not sodium checks had been done of Raychel before she died? Were you aware of that?
A. No, no.
Q. Then if I can now take you to the meeting of 3 September. When did you first know that there was going to be a meeting between your sister, and whomever she might take for support, and the trust?
A. I couldn't give you an exact date. It's something that was talked -- that she wanted to find out.
Q. Yes. Was it something that you understood your sister to want, to want now to meet with the people at Altnagelvin?
A. Yes, yes. She told me she wanted to find out what

happened.
Q. Are you aware of the fact that there had been an offer of a meeting before, quite shortly after Raychel died? Were you aware of that?
A. No, no.
Q. But in any event, your recollection is a time came when your sister did want to meet with the people at Altnagelvin to find out what had happened?
A. Yes.
Q. And she asked you to come with her?
A. Yes.
Q. Did you know who else was going to go in a sort of supportive role?
A. Yes, it was myself and my oldest brother.
Q. That's Mr McMullen; is that right?
A. Yes. And a friend, Rosaleen Callaghan, and the councillor, Helen Quigley, said she would come along.
Q. This is the same one that you think might have told you about Stanley Millar?
A. Yes.
Q. The GP was there. Did you know that was going to happen?
A. I didn't know that the GP -- I don't think I knew the GP was going to be there, but she was there at the meeting.
Q. Yes. That's Dr Ashenhurst.

A. Yes, that's right.
Q. And did you know who you were going to meet?
A. No, we just knew we were going to the hospital, but we had no idea.
Q. At that stage, did you know the names of the main people who had been involved in Raychel's care?
A. Well, I knew that there was Dr McCord because I had -- we had spoken to him.
Q. Yes. Did you know what he was? Did you know he was a consultant paediatrician?
A. Yes. The reason I did is because one of my own children had been under him at one stage, so that's how I knew who he was.
Q. So you knew who he was. Did you know who Dr Nesbitt was?
A. No. Only that I had met him at the ambulance door.
Q. Yes, but you didn't know what his specialty was?
A. No.
Q. And did you know if he would be there?
A. No, I had no idea he would be there.
Q. Did you know, or in fact did your sister know, whether Raychel had a consultant under whose care she was?
A. I can't answer that. I don't know.
Q. Let me help you in a slightly different way. Had you ever heard the name Mr Gilliland?

A. I had heard the name, yes.
Q. And had you heard that name before you went to the meeting?
A. No, not that I recall, no.
Q. In fact, did your sister want any of the nurses there? Did you know if they would be there? Did you know if she wanted them to be there?
A. We didn't have a clue who would be there.
Q. When you and the others who were going to support Mrs Ferguson went to Altnagelvin, can you help us with what happened as you arrived there?
THE CHAIRMAN: Just before we get there, had you, as a family, worked out a list of questions that you were going to ask or ...
A. The only one thing that we had discussed was we wanted to know why Raychel had died.
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: Just following on from that, had you decided whether any one of you would be the person to put the questions or whether you would just all put questions that you were concerned with?
A. Well, me and Marie would have talked and Marie didn't feel that she was being fit to ask a lot of questions, so it was me that would ask the questions. But my brother was there too if he felt he needed to ask any.

Q. So then when you arrive, who meets you?
A. Well, what I know now is Mr Nesbitt -- I remember him at the door along with Mrs Burnside. We just went into a room, then another people followed in. And I now know them people to be Nurse Noble, Sister Millar, Mr Nesbitt, Stella Burnside, Dr McCord, I think -- and I think Dr McCord as well.
Q. Yes, you're right about that. Those people, certainly the nurses, are people that your sister would recognise from when she was there.
A. Yes, well, the only one that I recognised and she recognised, because I had met that morning, was Nurse Noble. My sister didn't know who Sister Millar was at that meeting.
Q. I'll just pull up the minute or the note of the meeting. If we start with the first two pages, 022-084-215 and 216. If you can see it right at the beginning, Mrs Burnside's introducing the members of staff to all of you. Did you know, out of any of those members of staff, the person who was responsible for Raychel's care? Was that ever told to you? Did you know it?
A. No.
Q. Was Mr Gilliland's name mentioned at all during this meeting?
A. Not to my knowledge, no.

Q. Then you see there right at the bottom there's a Mrs Doherty, who's a patient's advocate. She's going to take the notes. Were you told what her role was?
A. No. We had asked about taking notes, that the family friend, Rosaleen Callaghan, would take notes, and we were told, there's no need, there's someone here who will take notes. But the person wasn't named to us.
Q. And did you hear the position patient's advocate, so far as you can remember?
A. I didn't hear that until I came to this inquiry.
Q. And before the meeting actually got started, was there any prior discussion with you, as a group, as to how all this would work, what form the meeting would take?
A. No.
Q. Or to ask you what sorts of things did you want to have dealt with at the meeting?
A. No.
Q. And if that didn't happen when you actually attended the meeting, do you know if anybody ever got in touch with Mrs Ferguson to ask her those questions, who would she like to have, what sort of thing did she want to know?
A. No, never. If that had happened, she would have told me.
Q. Thank you. I think you've said that one of the things that you would like to convey was the atmosphere during

the course of that meeting. Can you help us with that?
A. Well, I didn't feel that the atmosphere was very good. I felt that with Sister Millar and Nurse Noble, they both sat at the door as I would describe maybe as laid out, with their arms folded, just with this real negative or negativity, if you see, approach from ...
Q. One thing I should have asked you when I was asking about the patient's advocate: when Dr Nesbitt provided a witness statement for the inquiry, the reference for it is 235/1, page 5, he refers to speaking frankly and openly and honestly to those present, but then -- and this is the part I wanted to ask you -- he says that:
"No official notes were kept of this meeting but the patient's advocate representing the Ferguson family did keep a record."
Did anybody tell you that there was anybody there representing you as a family?
A. No, definitely not.
Q. Then can I ask you about what -- I'm not going to go through all of this note because, apart from anything else, I think your sister has said it's broadly accurate as to what happened; would you accept that?
A. Yes.
Q. What did you particularly want to know that you don't feel you actually got an answer to?

A. The answer we wanted was how and why Raychel died, but we didn't get that answer. We were told that Raychel died of a rare thing, and during that time Nurse Noble and Sister Millar and, I could safely say, everyone else in the room of the medical profession agreed with them that it was a very rare thing and at no stage was there ever any concern about Raychel. They had absolutely no concerns.
Q. This is the nursing team?
A. This is Sister Millar and Nurse Noble, who sat with their arms folded, shaking their heads, saying that there was absolutely no concern about Raychel.
Q. And this was in relation to the vomiting; is that correct?
A. Yes, yes.
THE CHAIRMAN: Was it in relation to everything?
A. Yes. They had absolutely no concerns that day.
MS ANYADIKE-DANES: The impression that you were getting was at no stage during that day did the nurses caring for Raychel have any concerns about her condition?
A. No, and they were very definite.
Q. Then did you want to know, if they didn't have any concerns about her, how was it that she came to die?
A. That's what we wanted to find out. And Marie had said that to the nurses. She said that she kept telling them

she was sick and they kept saying it was normal, but they said that it was normal, but I feel that I did say, "Well, If it was normal, why is she not here today?", and again, it was a rare thing.
Q. When Mr Nesbitt was carrying on giving his evidence in his witness statement, he says that he met with you and your sister. The reference is 035/2, page 22:
"It was clearly stated that the cause of Raychel's death was brain swelling [which is cerebral oedema] and that this had followed the low sodium in her blood."
So in his view you wanted to know the cause of Raychel's death and, in his view, they were telling you.
A. No, I disagree with him totally. At no stage did he tell me or my sister that Raychel had a swollen brain.
Q. Well, it's quite a technical thing and the whole meeting is emotional. Is it possible that he did tell you that and just didn't pick up on it?
A. I can only speak for myself, but I know I would have picked up -- that's the reason that I was there, to find out as to why Raychel died.
MR LAVERY: If I can just interject for a moment. It is technical and it is emotional, but it's also recorded in the minutes, Mr Chairman, and I think Mrs Doherty has accepted that the minutes are an accurate reflection of what happened at the meeting.

THE CHAIRMAN: Yes, I think she's not challenging the minutes in any sense. I'm just looking at her statement, Mr Lavery, and she was asked if she agreed the minutes and she said, effectively, that she couldn't remember. So in terms she was saying that she didn't challenge, but of course part of the problem of challenging the record of the meeting is it was shared around within the hospital and not given to the family. She said in page 6 of her witness statement:
"I have not seen these minutes, therefore I do not know if they are accurate."
A. That's right.
THE CHAIRMAN: "I was not sent a copy of the minute".
I accept your point and I accept it without doubting for a moment her recollection and her honesty that there may be things that were said at that meeting which didn't register or she doesn't remember. But if somebody had taken the trouble to say, working away from hyponatraemia and whatever low sodium means and so on, if somebody had said that Raychel had a swollen brain, that might be the sort of thing that a layperson might remember.
You don't remember it and you don't think it was said.
A. I am just speaking honestly --

THE CHAIRMAN: I understand.
A. -- that at no stage did anybody tell me that Raychel died of a swollen brain.
MR LAVERY: That is recorded in the minute at page 022-084-223 at the top of that page, Mrs Burnside said:
"So the result is a swelling in the brain."
And then Dr Nesbitt says:
"The treatment is exactly the same regardless of what the cause is. Result is swelling of the brain. Even with treatment, the swelling cannot be reduced. The main thing is to get her to a centre where the experts are and who can operate if necessary."
THE CHAIRMAN: Mr Lavery, when I try to work out as best I can what happened at the meeting, I will place some reliance on this note, obviously, but I'll also have to take account of what Mrs Doherty says and what the family remember.
MR LAVERY: Of course. Thank you, Mr Chairman.
MS ANYADIKE-DANES: Is this a fair way of putting it: if they were saying those sorts of things, however they said them, neither you nor your sister understood why they thought Raychel had died? Is that the upshot of it?
A. Yes, that's right.

Q. Whatever it was that they said, it didn't penetrate to you so that you can understand why Raychel had died?
A. That's right.
Q. And that's what you wanted out of that meeting?
A. Yes.
Q. Did anybody ask you whether you had understood the medical discussion that was going on or the reasons that were being given to you?
A. No, but I didn't really feel that there was such a big discussion going on.
Q. The point that you make about the unusual response, Mrs Doherty. Dr Nesbitt does go on to refer to that. He says:

"We explained that the treatment that Raychel had received had been the same as countless other children and they had received exactly the same type of fluid. We said that in Raychel's case she might have had an unusual response in that she retained free fluid, causing her brain to swell."

Then he goes on to say -- sorry, I should tell you where I'm reading from. I'm reading from later on in witness statement 035/2, at page 22. Then he goes on to say:

"The family did ask about the vomiting and the headache and the nursing staff who were there had said

that the vomiting had not worried them unduly and it was a common thing after surgery. I explained that headache is also a common finding in children post-operatively."

Although that's in more technical language, is that the sort of exchange that was happening?
A. I would agree with that, yes.
Q. Did anybody explain to you how any of that fitted with what you and your sister understood about the trickle of blood in the brain and the possibility of surgery at the Children's Hospital?
A. No.
Q. Did anybody mention the blood on the brain?
A. I don't recall it being mentioned at that meeting.
Q. Dr Nesbitt goes on to say that he said:

"We would have to review procedures to ensure that blood tests were done pre and post-operatively, and that it might be needed to be more frequently than this."

Was there any mention of the fact that it might have helped if Raychel's blood had been tested more frequently? Was there any of that discussed so far as you can recall?
A. Not that I can recall.
Q. And even if it was discussed, did you understand the significance of that, why that might be important?
A. Not really, no.

THE CHAIRMAN: Just remind me, is that point by Dr Nesbitt from his evidence or from the notes?
MS ANYADIKE-DANES: That's from his witness statement, Mr Chairman.
THE CHAIRMAN: Is it in the notes? Do the notes record anybody saying that they would review the frequency of blood tests?
MS ANYADIKE-DANES: I don't think so, but I'll have a quick scan through.
THE CHAIRMAN: Okay. We don't need to delay now.
MS ANYADIKE-DANES: He says the bit about the fluids, Mr Chairman, that's on 022-084-223. That's where he says about the fluids are standard across the country and:

"We may have to change these if children are getting too much sodium. There has to be a middle ground. Nothing we were doing was unusual."

One of the concerns that you had and your sister had was that, given what was told to you about Raychel when you were at Altnagelvin and what you discovered shortly after arriving at the Children's Hospital, your concern was that effectively you travelled with false hope. You thought that something could be done, might be done, and that you might just be two or three weeks away from finding out whether Raychel would be brain damaged or

not. Did you still feel at that meeting that you had travelled in false hope or your sister had?
A. Yes, I did.
Q. Did you convey that to them or did you say that?
A. I would say I probably did, because it was always something that was there, but I can't just be 100 per cent.
THE CHAIRMAN: Your view, from the moment you saw Raychel, when you went into that room, was that she wasn't going to survive?
A. Yes.
THE CHAIRMAN: And when you got down to Belfast and you were told there by the doctors what you have just told me, did that confirm to you that your initial impression was right?
A. Yes. Most definitely. And that was my first -- why did Altnagelvin put us through this and send us the whole way here and it only took 40 minutes to be told that the hopes weren't good and possibly an hour to be told that it definitely wasn't good, there was no going back.
MS ANYADIKE-DANES: I'm going to put to you Dr McCord's view when he gave evidence as to that meeting to see the extent to which that accords with what you thought was happening.

Just before that, Mr Chairman, you'd asked whether

there was any mention of the sodium checks. It happens at 022-084-221. You, Mrs Doherty, refer to it as what happened when she went into the Children's Hospital that Raychel then had her blood checked regularly, so there seems to be some discussion about that. And Dr Nesbitt says:

"That is something we might have to do, check bloods six-hourly."

But in all of that, did you understand why that might be important and how that might have helped Raychel if they'd actually done that?

A. No.

Q. Then if I put to you what Dr McCord was saying. It may be more helpful, so that you can see it for yourself on the screen, the transcript of 10 September 2013, page 182, starting from line 25. There you see that he refers to himself as being rather unhappy with how things had gone. Over the page, you see he wasn't sure what the meeting had set out to do, there was no agenda, no plan, no prior thought as to who was going to speak. Then he goes on a little bit further down talking about who was there:

"There was no surgeon. It would have been nice to have had a radiologist there."

I am presuming that's because there was an issue of

the brain scan and what could be seen there. Then a little bit further down he says:

"But at the end of it, as it progressed, it really slipped away into a question and answer session. And at the end of it, there was no structure to it, no order, no sense that we'd achieved anything at the end of that that was going to help."

Does that seem a fairly accurate description of how you thought the meeting progressed?

A. Well, I was here when Dr McCord gave his evidence and I've actually read the transcript for Dr Nesbitt where he has mentioned as well about the family firing questions. Why did they think we were there? What other reason? The only reason we were at that meeting was to find out what had happened to Raychel. Why wouldn't we ask questions? That's the only way I can answer that.

Q. There was, it would appear from the note, quite a bit of discussion as to Raychel's treatment, even if you didn't fully understand the implications of all of that or didn't even agree with some bits that you did understand. Did you think that Raychel's medical notes might be there?

A. I don't know if I actually thought about her medical notes.

Q. Dr McCord, when he's trying to explain what happens, refers to an innate sensitivity in relation to Raychel, which is, I suppose, one way of saying it was a very rare thing. Did you know what that meant in relation to Raychel?

A. No, just a rare thing.

Q. Did you know what it might have been about Raychel to have produced that, what was the rare thing? Did you know?

A. No.

Q. Were you aware of what was going to happen that would be different? Did they make an effort to explain to you what changes they were going to make?

A. Do you mean at this meeting?

Q. Yes, what changes they would make at Altnagelvin to try and make sure that no other child suffered what had happened to Raychel. Did they explain to you what that would be?

A. I can't say that I understood anything about change because my feeling was that this was all, in their eyes, at that time, that Raychel was fine that day, there was no need for concern, there was nothing wrong. What did they need to change if everything was right?

THE CHAIRMAN: Can I ask you it this way? You now know, I think partly from the inquest and perhaps more from

the inquiry, that in fact there was a critical incident review, that a whole lot of issues were identified, changes were made in Altnagelvin, and then that led to the working party, which was set up and which had already been decided by 3 September 2001 would be set up. Would it have helped you and your sister and the family to know that as a result of the way things had gone wrong with Raychel that these changes were being made and that things would be different in the future? Would that have helped at all?

A. Well, I think on that meeting, on 3 September, if they had said openly and told us exactly from the minute that Raychel left Altnagelvin that they had a meeting and they had discovered problems and they had found things weren't done right, that simple care was not given to Raychel, Mr Chairman, I don't think we'd all be sitting here today if they had been open and honest with us in that meeting.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: I know that one of the things you wanted to comment on were the views that the inquiry's expert, Professor Swainson, had recorded in his report. His report starts at 226-002-001, but I would like to take you to two parts of his report that specifically deal with the family. The first is, if these could be pulled

up alongside each other, 226-002-006. The second is 226-002-008.

If we go to the first one, which is the latter part of paragraph 16, you'll see it at the top of the left-hand side, he's expressing the view that:

"It is clear that the doctors and nurses present at that meeting suspected the use of Solution No. 18 after an operation and failure to check on electrolytes while on intravenous fluids, and these were discussed openly with the family in September."

Do you think you did have an open discussion with them or they had an open discussion with you about that?

A. No, they most definitely did not.

Q. Then let's go to some of the things that he thinks are deficiencies in the way that meeting was conducted. He said:

"Failings in the accurate recording of fluids administered and to measure urine and vomit output properly that were important factors do not appear to have been discussed."

If I pause there, is that right? In your view, were those things discussed?

A. No, at the meeting, no.

Q. He regards them as important. Even if any of those things had been discussed, did anybody tell you: these

sort of things are really important and, sorry, we should have done that, we should have measured her urine or whatever; was any of that said?

A. No, because no one at that meeting had any concern that Raychel was sick.

Q. Then he goes on to say:

"Nor was there any recognition that the worsening of Raychel's condition during the evening of 8 June was due to factors other than normal post-operative recovery."

And that seems to accord with what you're saying.

A. Yes, that's right.

Q. Did anybody at any stage say that mistakes had been made in Raychel's care?

A. No.

Q. The expression "mistake" was never used?

A. No.

Q. Then if we look to the other side, which is paragraph 26. He talks about how matters might have been handled. If we start with the notes taken. He's saying:

"The notes suggest that the matters discussed were determined by the questions asked by the family."

Then he goes on:

"There was no attempt by the chief executive, nurses or doctors to create an environment of openness that

encourages parties to resolve disputes, reduce delays and reduce the requirements for litigation, nor one that encourages staff to offer apologies and/or explanation as soon as an adverse outcome is discovered."

And those things in quotations are coming from guidance. Is that your understanding that you didn't feel you were in an environment of openness where anybody would concede to you that errors, mistakes, had been made?

A. Most definitely.

Q. When the meeting concluded, so far as you are concerned, what was going to happen then? Not just you, but so far as you and your family were concerned, what was going to happen then?

A. Well, then when we came out of the meeting, we just looked at one another and thought, "What a waste of time".

Q. Did you think that at the time?

A. Yes.

Q. Was that just you or did your other family members think that?

A. No, the family members felt the same.

Q. You're a group that includes not just family members, but a family friend, a GP. Was there any discussion amongst you about what you had just experienced there?

A. No, just that we came out and -- I came out with my sister and we both just looked at one another. I think my brother was talking to someone behind and we just felt it was a total waste of time.

THE CHAIRMAN: I should know this, but would you just confirm for me, the Helen Quigley who was with you at the meeting, she's a councillor in the sense that she was a member of the city council, was that right? Was she also involved in Altnagelvin?

A. I honestly don't know.

THE CHAIRMAN: There was a reference yesterday to a lady called Quigley who was on the trust board.

A. Well, she possibly could have been, yes.

THE CHAIRMAN: Okay. If we can double-check that.

When you came out and you thought it was a waste of time, did you talk after you came out of the meeting with Dr Ashenhurst?

A. I can't say that I definitely remember a conversation with her. I don't.

THE CHAIRMAN: Okay.

A. I could safely say I probably did make my view clear to Mrs Quigley, maybe, as we walked away, that it was a waste of time.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: I think, Mr Chairman, that Mrs Quigley

might be a member of the Western Health and Social Services Council.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: The family friend, Ms Callaghan, she had asked if Raychel's medical notes could be made available.
A. Yes.
Q. Was she asking that because that was something that you -- not you personally, but the family -- now wanted to see in the light of what was being said during that meeting?
A. I'm honestly not sure why that was asked.
Q. But in any event, they were going to be produced and they were going to be provided to the GP?
A. I would say yes.
THE CHAIRMAN: Did you or your sister or the family then have any follow-up with Dr Ashenhurst after this that you can remember?
A. No. Not as regards Raychel, no.
THE CHAIRMAN: Okay, thank you.
MS ANYADIKE-DANES: And then can I ask you, just finally, two questions, really. What did you do then? So having had, for your purposes, a very unsatisfactory meeting, which you rather thought had been a waste of time, you're going to get the medical notes and records. So

far as you're aware, what were going to be the family's next steps?
A. Marie's attitude was then: where do I go next? What do I do? Because I'm not accepting what we've been told in there. We haven't been told anything. If Raychel was okay and there was no concerns, Raychel would be here today.
Q. That attitude that you and your sister, and maybe also your family members felt, do you think that you conveyed to the Altnagelvin personnel there that you really were dissatisfied with the outcome of that meeting? Would there have been any doubt about that?
A. I don't really understand.
Q. Sorry, I beg your pardon.
THE CHAIRMAN: It's okay. Mrs Burnside said yesterday she knew at the end of the meeting it hadn't gone well.
MS ANYADIKE-DANES: Thank you very much. And certainly Dr McCord thinks it didn't go very well and if Mrs Burnside, the chief executive, thought it hadn't gone very well, did anybody tell you what you could do then, that you could make a complaint if you wanted to? Did anybody give you that kind of information?
A. I don't remember. I don't ... Unless maybe if I spoke to Stanley. Obviously Stanley Millar says something here.

Q. Sorry, it's my fault, I didn't ask it properly. When you were at the meeting, and at the end of the meeting when it became clear to the Altnagelvin personnel that this is not a meeting that had gone well and, as far as you're concerned, you didn't have your questions answered so it was very unsatisfactory, did anybody at that meeting tell you, if you wish to make a complaint, this is the procedure or this is where you can go? Did anyone give you that sort of information?
A. Not to my knowledge.
MR LAVERY: Mr Chairman, at page 022-084-221, that's again Mrs Anne Doherty's minute of the meeting, and on the third paragraph from the bottom it's recorded:
"Mrs Burnside said to the family that they would have more questions. It would be a long time until the inquest and we would do all we could to help them."
I think in answer to the previous question, she had indicated that perhaps she doesn't remember and I think you've alluded to that too, Mr Chairman, that Mrs Doherty doesn't remember everything that was said.
THE CHAIRMAN: That's right, but I think the problem about that is Mrs Burnside told us yesterday, Mr Lavery, that she then waited and the hospital didn't make any contact with the family because she took the view that Mrs Ferguson wasn't really in much of state for the

hospital to make contact and then it all seems to have just slid away. So there was no further contact by the hospital, and the patient's advocate never actually fulfilled the patient's advocate's role because the patient's advocate, who had been brought in that day for the meeting, never took up anything.
MR LAVERY: What Mrs Burnside is saying at that meeting -- if you go to page 9, Mrs Burnside says in the fourth paragraph from the bottom:
"She would leave the offer with the family. The door is open."
So she was in one sense leaving it perhaps to the family to come back. If they had any further questions, she was indicating to them that the door was always open.
MS ANYADIKE-DANES: Yes.
THE CHAIRMAN: Well, I'll take a view on that.
MS ANYADIKE-DANES: Thank you, Mr Chairman. I appreciate that. My point was more particularly about whether they were directed to the complaints procedure, which of course is something that the patient's advocate can do. But you're not aware of anybody telling you you could make a complaint?
THE CHAIRMAN: Ms Anyadike-Danes, that didn't happen, and the patient's advocate wasn't actually there that day as

a patient's advocate in any meaningful sense whatsoever.
MS ANYADIKE-DANES: Exactly, thank you.
Finally, from your point of view, and I'm sure that you've thought about it and discussed it with your sister and brother-in-law, how do you think that meeting could have been done better? What would have had to have happened for it to have helped you and your sister?
A. Well, at the stage we're at today, and everything that we know, if the truth had been told on that day, at that meeting -- because as everyone knows, at that meeting, everybody there from the medical profession knew exactly what happened to Raychel, what care she didn't get, and what she should have got. And if that had been given to us at that night, it would have made a big difference. And it --
THE CHAIRMAN: So if they'd said, "Look, we're really taken aback by what happened to Raychel, we realise that we made some mistakes and we've made changes, we've improved what's going on in the hospital and we've also contacted the Department of Health to try to make sure this doesn't happen to anybody else", that would all have made it just a bit easier for the family?
A. Yes, instead of my sister being made to feel that she was imagining that Raychel was sick.
THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: Thank you very much. I don't have any further questions.
THE CHAIRMAN: Any questions from the floor before I come to Mr Quinn? No questions?
Mrs Doherty, thank you very much for coming. I know it hasn't been easy. Unless there's anything more that you haven't had a chance to say, you're welcome to sit back.
A. Well, there is something I would like to say.
THE CHAIRMAN: Okay.
MR LAVERY: Mr Chairman, just before Mrs Doherty says what she's going to say -- and I don't know what she is going to say -- and I appreciate you have given this opportunity to every witness who has given evidence previously, but I am conscious of the fact that Mrs Ferguson, as you will recall back in March when she gave evidence, also said a few words, which turned out to be more than a few words and she made some serious allegations, much of which were unsubstantiated by the evidence which you had heard, Mr Chairman, in the previous weeks. I'm a little concerned about what Mrs Doherty is going to say and we don't have any advance notice of what she is going to say. It looks to me, Mr Chairman, as if she has written something out and it looks to me, from here, as if it goes to a number of

pages, and I just wonder, Mr Chairman -- I did raise this issue with Mr Quinn before Mrs Doherty gave her evidence and he assured me she would just be answering questions. I don't know what she's going to say and I don't want to stop her from saying anything. I'm conscious of the fact that she is a family member, she is Raychel's aunt, but I do have some concerns about precisely what it is she is going to say and perhaps if we had some notice of what she was going to say, that might ease it somewhat.
THE CHAIRMAN: I'm not going to prevent Mrs Doherty from saying anything, but can there be some discussion between you before she says anything? If I rise for a few moments? Just allow me a few moments, okay?
(4.37 pm)
(A short break)
(4.39 pm)
THE CHAIRMAN: I understand the road is clear for you to say whatever it is.
A. Okay. Mr O'Hara, this is just reflecting on the last 12 years and what the management and staff of Altnagelvin have put our family through. We take no comfort in assurances given that changes have been implemented, especially as we read continually in the media about hospital failings. Will we ever see the day

that the culture of secrecy and behind-the-door meetings will stop and families will be told the truth and not treated in the most disgraceful and humiliating way that our family have been?
Mr Chairman, whatever findings come from this inquiry, we hope they will be a fitting tribute to Raychel and also to her mum and dad, who have both devoted their life to fulfil the last promise they made to their only daughter, Raychel. And that's justice. And on behalf of our whole family, I would like to take this opportunity to thank Des Doherty because we feel, only for him and the help and the belief that he had in my sister, that she might not be here today. So from all of us, Des, we would like to thank you. Thank you.
(The witness withdrew)
THE CHAIRMAN: Thank you very much. That brings today to an end. We have Professor Swainson tomorrow morning. We're going to sit a little bit later, 10.30, and get through the professor's evidence tomorrow. Until then, thank you very much.
(4.40 pm)
(The hearing adjourned until 10.30 am the following day)

I N D E X