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2 (10.00 am)  
3 (Delay in proceedings)  
4 (10.14 am)  
5 THE CHAIRMAN: Good morning. Ms Anyadike-Danes?  
6 MS ANYADIKE-DANES: Good morning. I call Dr Taylor, please.  
7 DR ROBERT TAYLOR (called)  
8 Questions from MS ANYADIKE-DANES  
9 MS ANYADIKE-DANES: Good morning, doctor.  
10 A. Good morning.  
11 Q. You've given evidence a number of times -- I think in  
12 almost every section -- and also provided witness  
13 statements in relation to the other children's deaths.  
14 The witness statement that you provided in relation to  
15 Raychel, the reference is 330/1, and it is dated  
16 22 May 2013. Can I ask you, as I've asked you on each  
17 occasion, do you adopt that as your evidence, subject to  
18 anything that you say to the chairman today?  
19 A. Yes.  
20 Q. Thank you very much. I wonder if I might start with  
21 something that we have touched on before in your  
22 evidence, which is what did you consider the  
23 Children's Hospital's role to be in relation to other  
24 hospitals in the region? And I'm asking this  
25 in relation to 2001.

1 Q. Would you say that, along with providing the care to the  
2 region as a whole for that type of child who required  
3 it, that along with that would go providing advice  
4 in relation to treatment for children who required that  
5 kind of service?  
6 A. Yes.  
7 Q. And if one looks at it in that way, would it be fair to  
8 say that if, as a result of the work that was being done  
9 at PICU, there were concerns about practices from  
10 referring hospitals, let's put it that way, that that  
11 was something that PICU, those who work there, really  
12 ought to be communicating?  
13 A. Yes.  
14 Q. And not just in an ad hoc way, i.e. I happen to have seen  
15 this child and I'm a little bit troubled about her care,  
16 but to the extent that we, as PICU intensivists or  
17 anaesthetists, have a concern about what's happening  
18 in relation to any particular part of care in the  
19 district hospitals, then that's something that we should  
20 perhaps be drawing to people's attention in a more  
21 coordinated way?  
22 A. Can I just caveat my three yeses that I gave previously  
23 with the fact that it was my knowledge that the  
24 anaesthetists, intensivists, should share that  
25 knowledge. I don't know if there was a formal structure

1 A. To other hospitals we were a resource that could be used  
2 by professionals, by anaesthetists -- and I suppose  
3 paediatricians, but mostly anaesthetists -- to come and  
4 share some skills and some knowledge that we would have.  
5 Q. Yes. The Children's Hospital was commissioned as  
6 a regional resource by the other boards at that time?  
7 A. I don't know about the structures so well, but what  
8 I knew, what I know, is that the paediatric intensive  
9 care is a regional resource. I don't think the whole  
10 Children's Hospital is a regional resource. Some  
11 services in the Royal Belfast Hospital for Sick  
12 Children -- I could be wrong about this, I don't know.  
13 I think children's neurology is a regional service,  
14 I think children's intensive care is a regional service.  
15 I don't think the whole hospital is a regional service.  
16 Q. I don't have to deal with you in detail about that, if  
17 I just for the purposes of reference say that Dr Carson  
18 gave evidence about it, and the transcript for it is  
19 11 June 2013. It starts at about page 141 where he  
20 talks about the commissioning arrangements for the  
21 Children's Hospital.  
22 A. He'll know that better than I.  
23 Q. From your point of view, the paediatric intensive care,  
24 where you worked, that was a regional resource?  
25 A. Yes.

1 where you give PICU a sort of structure, an institution.  
2 I'm not sure if there's an institutional arrangement  
3 for ... Am I taking it too far?  
4 Q. No.  
5 A. As I understood, my yeses were that I, as a doctor  
6 working in PICU -- and I'm sure if my colleagues would  
7 see that if a concern was noticed by us, we would have  
8 a responsibility, if you like -- maybe an obligation --  
9 to share that information with colleagues.  
10 Q. And to the extent that that concern could be distilled  
11 into a guideline or a set of recommendations that might  
12 be helpful, in the way that you've produced the  
13 meningococcal guidelines, for example, that is something  
14 that you would see as a step that those in PICU could  
15 take?  
16 A. I think that's a good example because, as you know, the  
17 meningococcal guideline was developed as a lead through  
18 us and including stakeholders. You can't -- what I have  
19 found over my years was that it's not very good drawing  
20 up a guideline from the Royal and telling everybody to  
21 follow it. That's not my experience of working with  
22 people. Home ventilation would never have been  
23 developed without involving stakeholders. So any  
24 guideline or help that I was to give for paediatricians  
25 and anaesthetists working in Northern Ireland would be

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

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

10 A. That's right.

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

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

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1 A. I can't remember being concerned in PICU about the  
2 administration of fluids other than what was coming  
3 through from Arieff and then obviously the lesson of the  
4 week from Dr Halberthal and his colleagues, which was on  
5 31 March 2001. And I think that's an article that was  
6 a seminal article.

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

11 A. Yes.

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

19 A. I have read the transcripts, yes.

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

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

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

12 A. Yes.

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

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

21 Q. Well --

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

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

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1 A. Yes.

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

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

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

20 A. That's correct.

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

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1 321-073-001.  
2 You can see in that first large paragraph, about  
3 two-thirds of the way down:  
4 "We are instructed that the change of practice most  
5 likely refers to intraoperative fluids prescribed by  
6 anaesthetists and not post-operative fluids."  
7 I think Dr Crean has said that he's not sure he's  
8 entirely accurate as to his logic, but what doesn't seem  
9 to be being denied is that there was a change of  
10 practice in the use, or rather the prescribing, of  
11 Solution No. 18.  
12 And furthermore, we had a statement from Paul Loan  
13 volunteered to us. Are you aware of Paul Loan?  
14 A. Yes. He was a former colleague of mine in the  
15 Children's Hospital.  
16 Q. If we pull that up, it's quite short. If we can pull  
17 up, please, witness statement 360/1, and pull up pages 2  
18 and 3 next to each other, please. In fact, this is the  
19 entirety of his statement; page 1 is just the cover  
20 sheet for it.  
21 So he had heard the evidence in relation to the  
22 changes in the use of Solution No. 18 and he volunteered  
23 this statement, where he tries to explain his  
24 experience. We can pick it up firstly in the first  
25 substantive paragraph where he says that he returned to

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1 aware of who Mr McNulty is and was?  
2 A. Yes, he's a friend of mine.  
3 Q. Yes, and he was appointed the resuscitation training  
4 officer and he was a vigorous proponent of the APLS  
5 style of fluid management and he says that his approach,  
6 which was in line with his own views, may have been more  
7 effective than his own in changing practice. And  
8 then -- and this is what I particularly want to draw  
9 your attention to in terms of something concrete about  
10 the change in practice -- there came a point where:  
11 "Mr McNulty wanted to rationalise and standardise  
12 the contents of the resuscitation trolleys in the  
13 Children's Hospital."  
14 Dr Loan suggests that:  
15 "... the accidental use of hyponatraemic fluids  
16 during resuscitation would be counterproductive and  
17 dangerous and that they should be removed from the  
18 trolleys."  
19 And he thinks that Mr McNulty accepted that  
20 argument. So that's one certain thing, according to  
21 Dr Loan, that happened. They got removed from the  
22 resuscitation trolleys.  
23 Then he goes on to say:  
24 "Following this, I heard that the removal of  
25 hyponatraemic fluids had been extended to the entire

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1 Belfast having been in Toronto, the same unit you were  
2 in; is that correct?  
3 A. Yes.  
4 Q. He returned in January 1997. And then if we go, so that  
5 you've benchmarked when he's coming back, and he has the  
6 information about the different attitude to the use of  
7 prescribing Solution No. 18 than had been common when  
8 he was in Northern Ireland and was still prevalent  
9 amongst the paediatricians when he returned.  
10 Then if you see the middle paragraph:  
11 "I found it difficult to challenge ..."  
12 The third sentence there says:  
13 "However, soon after my return to Belfast I became  
14 educational supervisor in anaesthesia for the  
15 Children's Hospital. I consistently taught my approach  
16 to fluid balance in children to these groups, which  
17 included the risks in relation to Solution No. 18."  
18 And then he goes on in the penultimate paragraph to  
19 say:  
20 "It is possible that my efforts to teach what  
21 I believed to be a rational approach to IV fluids in  
22 children may have resulted in some of the reduction  
23 in the use of Solution No. 18."  
24 Then he goes on, in the latter part of that  
25 paragraph, to talk about Mr Trevor McNulty. You're

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1 emergency medicine department in the Children's Hospital  
2 for similar reasons."  
3 Were you aware of that?  
4 A. Yes. Again, like him, I'm not aware of the date. It's  
5 possible it followed the introduction of the Department  
6 of Health guidelines wall chart. I'm unaware of the date  
7 that changed. But yes, I was aware it was taken off the  
8 resuscitation trolleys.  
9 Q. If it were to follow the introduction of the Department  
10 of Health guidelines in March 2002, you wouldn't be  
11 restricting that to simply the entire emergency medicine  
12 department because those guidelines were to take effect  
13 wherever children were going to be treated. And I would  
14 have thought that if that's what he meant, his statement  
15 would read rather differently. So if I can put it to  
16 you this way: you were aware that that change happened;  
17 is that a change in line with what you had said earlier,  
18 that you think ought to have been communicated to other  
19 hospitals?  
20 A. Um ... Well, yes.  
21 Q. Yes?  
22 A. It would have made good sense to communicate that to  
23 other hospitals.  
24 Q. Thank you. And if anybody had drawn up any guidelines  
25 or protocols in order to assist the doctors in those

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1 units about that, that's something that should go along  
2 too? That would be the logic of it, wouldn't it?  
3 A. Yes. Can I just illuminate the resuscitation carts?  
4 There's, I think, two bags of fluid on a resuscitation  
5 cart and it's not used unless in the event of a cardiac  
6 arrest. So this is not ward prescribing of normal  
7 saline; this is to be used in the rare, the relatively  
8 rare, event that a child would arrest on a ward. So  
9 there's about ten areas, maybe 12 -- I'm not sure of the  
10 exact number, don't quote me -- resuscitation carts  
11 in the Children's Hospital, so that would account for  
12 maybe 20 bags of Solution No 18 being removed.  
13 The emergency department mainly looks after children  
14 who come in with bumps and scrapes and sore tummies, not  
15 every child that attends the emergency department of the  
16 Royal Belfast Hospital for Sick Children would have  
17 fluids erected or prescribed. Most children go home  
18 after a period of treatment.  
19 Q. Dr Taylor, that's not actually the force of my comment  
20 to you. Why I'm really asking, although that's helpful  
21 to know that --  
22 A. I thought you were looking for why the -- I had read  
23 this to being why the numbers tailed off so dramatically  
24 and that doesn't, to me, tally in with why this practice  
25 would have dropped the numbers so dramatically.

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1 done that to other hospitals?  
2 A. The APLS course was run from the Children's Hospital.  
3 Q. So you believe that the Children's Hospital had made  
4 that decision?  
5 THE CHAIRMAN: I'm not sure you can follow that because the  
6 doctor made the point at the start of his evidence by  
7 saying that the communications don't necessarily and  
8 probably don't best come from the Children's Hospital.  
9 And I think the point you were making was it wasn't  
10 effective practice just for the Royal to send out "we're  
11 changing things and this is why we're changing things",  
12 that you would -- that works better if you engage with  
13 other hospitals in that process.  
14 A. Yes.  
15 MS ANYADIKE-DANES: I'm sorry, Mr Chairman. Perhaps I can  
16 frame it another way.  
17 So far as you're aware was the fact that the  
18 Children's Hospital had effected that change and the  
19 reasons behind it communicated to the other district  
20 hospitals?  
21 A. In terms of phoning other consultants in other  
22 hospitals, I don't believe that happened.  
23 Q. Thank you. Are you able to offer any explanation for  
24 the information that was given to Dr Nesbitt, which is  
25 that the Children's Hospital had changed, in round

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

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

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

3 A. I think it was directly related to APLS.

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

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

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

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

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1 Dr Carson, just as it happened.

2 A. Yes.

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

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

25 A. Right.

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

9 A. I haven't read this paper before.

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

11 A. Looking at it, it does seem strange that the RBHSC on  
12 21 June 2001, which is the date -- it says the RBHSC has  
13 changed its guidelines. I wasn't aware that we had  
14 guidelines to change. I wasn't aware -- I've been  
15 working in the Royal since 1991 -- that we had  
16 guidelines for giving fluids and that we changed them.  
17 Maybe I'm in the dark on that.

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

22 A. Yes.

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

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

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

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

15 A. Yes.

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

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

21 THE CHAIRMAN: Right.

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

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

4 A. Yes.

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

6 A. Yes.

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

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

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

23 And then you can see:

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

21

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

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

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

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

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1 guidelines should be issued to all units."

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

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

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

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

22

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

12 THE CHAIRMAN: And not measuring electrolytes?

13 A. That's correct.

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

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

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

24

1 see the bit that you are referring to? It is  
2 036a-056-142.  
3 A. But how that would have led to a drop in the use, the  
4 dispensing of Solution No. 18 to our hospital I fail to  
5 completely comprehend because the paediatricians did not  
6 welcome a change in their practice as easily as we did.  
7 Q. If we look to the marginal note of that, that's I think  
8 the bit that you also cited verbatim:  
9 "Do not infuse a hypotonic solution if the plasma  
10 sodium concentration is less than 138."  
11 That was obviously a banner headline and the logic  
12 of the thing is something that you say that, at least  
13 in the Children's Hospital, the anaesthetists were  
14 already of that view.  
15 A. Yes.  
16 Q. And if you like, this helped them -- I'm interpreting  
17 now from what you said -- in putting forward their  
18 argument because now this was another thing that they  
19 could use to support their view; would that be right?  
20 A. Well, I'm speculating. I can't remember, obviously,  
21 what I thought 12 years ago, but it had a big impact  
22 and, of course, after the unfortunate death of Raychel,  
23 this was really very important.  
24 Q. Yes, but if we just don't quite get there yet. This  
25 came out, I think, in March.

25

1 Q. But in any event, where, I think, the chairman --  
2 A. -- or to ban it.  
3 Q. -- was putting to you that it wasn't just as simple as  
4 the fluids used during the operation or even in  
5 preparation for the operation, the document that I had  
6 up just before that, which was the minutes from the  
7 meeting of the directors of public health, explicitly  
8 referred to certain fluids that are used incorrectly  
9 post-operatively. So they've identified that. And this  
10 is something that doesn't appear to be being recorded as  
11 if it's news; it seems to be being recorded in much the  
12 same way as you've got the evidence before saying,  
13 "We're aware of near misses".  
14 So from your point of view, did you have any  
15 knowledge or any awareness that it was used  
16 inappropriately post-operatively at that time? From  
17 time to time; I don't mean necessarily routinely.  
18 A. Well, you see, when we finish an anaesthetic we go to  
19 see the patient post-operatively and we wouldn't -- we  
20 obviously see how the patient's doing, but we  
21 wouldn't -- if a patient's on the fluids for maybe 24 or  
22 48 hours, that would be beyond our prescription of that  
23 post-operative --  
24 Q. It would if it happened in your hospital, but if you're  
25 seeing a child who had had a procedure in a district

27

1 A. 31 March, I think.  
2 Q. Yes. This comes out in March 2001 and because it's the  
3 lesson of the week, so you're going to see it pretty  
4 quickly, I would imagine. What's the immediate response  
5 or reaction to it to what one should do about it?  
6 A. Well, I can't remember. I certainly recall we discussed  
7 it. I recall that this was in line with our practice.  
8 Q. From the point of view of the anaesthetists, this wasn't  
9 really news. It might be news to set a target level  
10 which helps if you want to devise some guidelines, but  
11 the logic of it was not news to you and your colleagues  
12 in the Children's Hospital at that time. So if it's  
13 going to have an impact, where it needs to have an  
14 impact, is it not, with the paediatricians?  
15 A. Yes.  
16 Q. So when you see this, you and your colleagues see this  
17 at the Children's Hospital, what do you do with it or  
18 how does it help the professional difference that you're  
19 having with your paediatric colleagues?  
20 A. I can't remember.  
21 Q. Did it get used like that to try and effect change?  
22 A. I can't remember. What I do know is that even in 2002,  
23 when we'd moved on, and even after the case of Raychel  
24 was well-known, there was still a reluctance to stop  
25 using No. 18 --

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1 hospital being referred, then you might be seeing them  
2 in paediatric intensive care trying to address an error  
3 or poor practice that had happened in another hospital,  
4 because that's exactly what happened in relation to  
5 Raychel.  
6 A. Yes. I don't recall there being such a post-operative  
7 case transferred to us, who had mismanaged fluids.  
8 I don't recall such an event.  
9 Q. Even without dealing with a case directly yourself, were  
10 you aware that that was happening?  
11 A. I can't remember. It certainly didn't trigger a memory  
12 when I think back.  
13 MR UBEROI: Sir, before we go on, I'm not suggesting it  
14 needs to be put to Dr Taylor, but perhaps for the  
15 record, to remind you of the Halberthal article and the  
16 evidence you heard, I think from Dr Jenkins, but how  
17 those articles were disseminated around the medical  
18 profession, and obviously, so there's no  
19 misunderstanding about it, it doesn't simply come into  
20 the Royal and rest there with the responsibility for  
21 dissemination; it goes to all clinicians through the  
22 Province.  
23 THE CHAIRMAN: Yes, and one of the inevitable problems,  
24 in the same way as lawyers might know the New Law  
25 Journal or whatever it is, some get it, some don't, some

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

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

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1 And then, we'll come to it in more detail, but  
2 trying to establish what might have been known and what  
3 you might have known. You at some point prepare  
4 a document headed "Hyponatraemia in children". We can  
5 pull that up, 043-101-223 and 224. This document has  
6 the benefit of providing some explanation for the  
7 problem, which one can see in the first four paragraphs.  
8 Then it's got some recommendations, and there are some  
9 ready reckoners here in a way. And then there is an IV  
10 fluid prescription to assist.  
11 So now the problem, as you state it, or describe it,  
12 is not one that was appreciated for the first time just  
13 prior to Raychel's death. For a start, you have  
14 dilutional hyponatraemia being documented in otherwise  
15 healthy children. Part of your reference, as you can  
16 see it on the second page, is Arieff's work. 1998 is  
17 the one that you've given there, but if you looked at  
18 1998, you'd be taken to 1992.  
19 A. Yes.  
20 Q. So that's been around for quite some time, that  
21 proposition. Then you go on to talk about what happens  
22 in the body in relation to the isotonic fluids being  
23 metabolised and so forth to become hypotonic and the  
24 effect of that on fluid shifts and so on. And then you  
25 refer to the antidiuretic hormone and that response and

30

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

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1 Q. You wouldn't have understood that before 1998?  
2 THE CHAIRMAN: No, at least.  
3 A. I can't remember. Quite possibly, yes.  
4 MS ANYADIKE-DANES: Sorry, the reason I'm pressing you about  
5 that is -- when you gave your police interview in  
6 2006 ... Can we pull up 093-038-286 and 287 alongside  
7 each other?  
8 There was an issue in relation to Adam's case about  
9 isotonic/hypotonic, if I can put it that way, and you're  
10 being asked about that by the interviewing officer.  
11 In relation to Solution No. 18, right at the top of 286,  
12 you said to him that you chose one-fifth normal saline  
13 because it's isotonic. You say "yes", and then he puts  
14 to you that that is a technical point and that:  
15 "The minute it's infused, its effect is hypotonic."  
16 Your answer:  
17 "It can become hypotonic, but not in every patient.  
18 It depends on their metabolic condition."  
19 And you go on to say:  
20 "How quickly they burn glucose, basically."  
21 Then, over the page, you're being asked to consider  
22 Adam in contradistinction to Lucy and Raychel. Lucy and  
23 Raychel were awake and active, Adam was anaesthetised.  
24 And you say:  
25 "Apart from the brain, which contains some activity,

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1 MR UBEROI: If I may add, I'm not sure where this takes us.  
2 THE CHAIRMAN: We're not going to go back over taking  
3 Dr Taylor through previous police statements,  
4 Ms Anyadike-Danes.  
5 MS ANYADIKE-DANES: We're certainly not going to do that.  
6 THE CHAIRMAN: Then why are we there?  
7 MS ANYADIKE-DANES: The only reason I asked that is that  
8 I went to check what was being said and I couldn't see  
9 that he had moved away from this point and I simply want  
10 to clarify whether, in 2001, he and his colleagues  
11 regarded the situation as being as straightforward as he  
12 had portrayed it in that document. That's the only  
13 point I'm putting to him.  
14 THE CHAIRMAN: Which document?  
15 MS ANYADIKE-DANES: The document at 043-101-223, which is  
16 his background piece, where he refers to the double  
17 whammy.  
18 So as far as you were concerned, Dr Taylor, was it  
19 as straightforward as that? We can pull it up, sorry.  
20 043-101-223 and it was alongside 224.  
21 A. I hesitate to go back over Adam, but as you remember  
22 I was concerned that Adam had polyuria, ADH wasn't, as  
23 I understood it then, a factor in the development of  
24 dilutional hyponatraemia with Adam.  
25 Q. Yes.

35

1 the rest of the body is at rest and the glucose  
2 metabolism is much reduced, so its ability to remain  
3 isotonic is enhanced."  
4 And you conclude with:  
5 "It shouldn't become hypotonic to the same degree.  
6 That's another reason why the isotonic dilutional  
7 hyponatraemia theory doesn't hold for Adam's case."  
8 So when you're giving your evidence to the police in  
9 2006, you seem to be having a sort of a caveat or  
10 a caution for that very straightforward example that  
11 you've given and why it ends up as a double whammy  
12 effect, that there are some children, those who are  
13 being anaesthetised, where it might not have that  
14 effect. Did you mean a qualification like that in that  
15 background piece that you provided in 2001? Should it  
16 be read with that kind of qualification?  
17 A. I can't explain.  
18 Q. Sorry?  
19 A. I can't explain this.  
20 THE CHAIRMAN: I thought that rather a long time ago,  
21 Dr Taylor had accepted that a number of the things he  
22 said prior to coming to the inquiry in last spring,  
23 spring 2012, were the things that he couldn't stand over  
24 and which he regretted having said.  
25 MS ANYADIKE-DANES: Yes, Mr Chairman.

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Q. What we have there -- if we can pull up 321-074-002 and  
13 003 alongside each other. So the minutes for Raychel's  
14 meeting are in much the same format as the minutes for  
15 the one in relation to Lucy where it simply says the  
16 number of cases that are presented and discussed without  
17 identifying them. And then, if you look at the  
18 spreadsheet, you see that she is identified there.

19 A. Yes.

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

22 A. Yes.

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

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

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

4 A. Yes.

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

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

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

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1 there's evidence in the website to say that I stepped  
2 down on the 9th -- at a directorate meeting on  
3 9 January 2003 and handed over to Mr Alan Bailey,  
4 consultant paediatric surgeon. So I don't remember it  
5 being discussed and those aren't my minutes.

6 Q. I beg your pardon. I thought our records were it was  
7 2003 to 2006.

8 A. I then became --

9 Q. If I may just finish --

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

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

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

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

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

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1 I was referring to. You were a member of the clinical  
2 audit committee between 1997 and 2006 and you were  
3 a chairman of it from 2003 to 2006.  
4 A. That's right.  
5 Q. And the reference for that, not that we need to pull it  
6 up, is 306-019-012. I apologise, that's exactly it.  
7 As chairman, though, or even as a member for that  
8 matter, what does that involve in terms of knowing which  
9 deaths are being audited?  
10 A. Um ... I think I submitted documents in my previous  
11 evidence to show trust activity, audit activity, so the  
12 chairman of the audit committee wouldn't take  
13 a micromanagement of each directorate, so I would have  
14 held monthly meetings, chaired monthly meetings if I was  
15 available and not working or away. I would have chaired  
16 a meeting where the audit facilitators, the audit  
17 facilitators for paediatric surgery, gynaecology,  
18 neonatology -- all the different directorates would have  
19 their own facilitators. So I would have got them all  
20 together with my audit support team and discussed --  
21 ensured that they were submitting minutes, that they  
22 were having meetings. The Eastern Board had actually  
23 funded quite a lot of funding so that clinics were  
24 cancelled, operating lists were cancelled to ensure  
25 consultants and junior doctors and nurses were available

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1 don't mean anything more substantial than that?  
2 A. I wanted to make sure they weren't drinking coffee and  
3 having a chat. I wanted to ensure that they were  
4 performing the function to which the trust and the board  
5 had funded.  
6 Q. I appreciate that.  
7 A. It was an oversight to make --  
8 Q. It's a slightly different question. What I meant by the  
9 minutes is -- under the format that I just showed you  
10 for both Lucy and Raychel ... in fact, we'll just pull  
11 up Raychel's for example, 321-074-002, and we can pull  
12 up alongside it Lucy's, 319-023-004.  
13 Is that what constituted a minute for your purposes  
14 in satisfying yourself that there was a minute of the  
15 meeting or were you intending that there should be some  
16 more detail around the heading "mortality"?  
17 A. I think that was regarded as being a minute of the  
18 meeting and that was satisfactory.  
19 Q. Thank you.  
20 A. And there were other directorates who weren't submitting  
21 any minutes and they were the ones I was more interested  
22 in trying to get --  
23 THE CHAIRMAN: This is rather out of sequence, but the  
24 minuting of these meetings has substantially changed?  
25 A. Yes. I had the ... I chaired the August paediatric --

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1 to attend audit meetings.  
2 Q. How would you know --  
3 A. And that was a very, very heavy -- and we had to police,  
4 in a way, we had to make sure that everybody who could  
5 attend was actually pulling their weight and performing  
6 audit.  
7 Q. Yes. How would you know if a child's death had not been  
8 submitted to audit?  
9 A. The PICU secretary had a very systematic approach of  
10 bringing the death of every child in the  
11 Children's Hospital to the mortality meeting in  
12 paediatrics.  
13 Q. I appreciate that and you've told the chairman that  
14 also, but if it turns out that Lucy's death wasn't  
15 submitted to audit, according to the PICU secretary's  
16 records it was, so that would be a death that slipped  
17 through the cracks, if I can put it that way, and how  
18 would you know that or anybody performing that oversight  
19 function?  
20 A. It wasn't policed to that degree.  
21 Q. So you might not know?  
22 A. I might not -- I probably would not have known.  
23 Q. And when you say that you were also trying to ensure  
24 that they produce minutes, by minutes do you mean the  
25 sort of thing that I pulled up for you just now? You

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1 because my colleague had been up all night and she asked  
2 me to stand in for her, so I chaired and wrote a minute  
3 of the four mortality cases and learning points. And  
4 that was submitted to the PICU secretary, who is a new  
5 PICU secretary because Maureen retired.  
6 THE CHAIRMAN: I'm sorry, I don't mean it -- I'm not  
7 comparing 2000 to 2003; I'm thinking beyond that.  
8 There's now much more minuting of these meetings;  
9 is that right?  
10 A. Yes. Just to add to that, she e-mails every single  
11 consultant in the Children's Hospital, whether they  
12 attend that mortality meeting or not, and asks them for  
13 comments or learning points or do they remember the  
14 case. So things have changed through the trust and  
15 through the medical directors, very substantially, and  
16 this obviously is not an adequate record of the cases.  
17 I accept that.  
18 MS ANYADIKE-DANES: When you were giving evidence  
19 in relation to Lucy, the chairman was asking you about  
20 what came out of Lucy's case. This was in relation to  
21 the audit and any review that there should have been.  
22 He asked you directly whether you could help him  
23 understand why nothing of substance emerged from  
24 a discussion of Lucy's case and ultimately he put to  
25 you -- you were discussing whether there should have

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

15 You said that:

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

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

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1 for example, if the treatment had had that effect but,  
2 once again, had not occurred in the Children's Hospital?  
3 A. I don't think I or the people at the coalface decide  
4 whether it's an SAI or an adverse incident. We log an  
5 adverse incident. So if I feel this is an adverse  
6 incident, this is a potential harm or harm that could  
7 have happened to one of my patients, I'm obliged to  
8 complete an IRL form or an adverse incident form. That  
9 goes to an oversight committee in the  
10 Children's Hospital; Dr Keaney, a colleague of mine  
11 chairs that. There's a pharmacist on it and a senior  
12 nurse on it, Paula Forrest. They review all the adverse  
13 incident reports that week or that day or quicker if it  
14 comes to their attention. They report to the clinical  
15 director, I believe -- I'm not exactly au fait with  
16 this -- and then a decision is made if this is an SAI.  
17 Q. Yes.  
18 A. So I don't decide it's an SAI. Obviously if a child  
19 dies, my understanding is it's an automatic SAI.  
20 Q. That's not quite so much the point that I'm getting at.  
21 The point is that you log treatment -- a patient of  
22 yours who has come to harm --  
23 A. Or potentially.  
24 Q. -- or potentially has come to harm in relation to  
25 treatment that has happened outside your hospital.

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1 nonetheless you completed a serious adverse incident  
2 report?

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

6 Q. An adverse incident report.

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

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

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

2 A. Yes. Now. We do that now.

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

6 A. It did.

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

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

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

16 A. Yes. And probably an SAI.

17 Q. Thank you.

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

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

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

8 THE CHAIRMAN: Okay.

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

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

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

24 THE CHAIRMAN: Okay.

25 A. I hope that's helpful.

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

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

6 THE CHAIRMAN: I understand.

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

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

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

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

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

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

23 A. Okay.

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

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

7 THE CHAIRMAN: Thank you.

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

14 THE CHAIRMAN: Thank you.

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

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

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

21 THE CHAIRMAN: Thank you.

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

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1 within it, an adverse incident report, which would then  
2 go on and, in your view, would have made its way into  
3 a serious adverse incident report. In 2001, would it  
4 have been the practice to alert Altnagelvin to the fact  
5 that such a form had been completed?  
6 A. I wasn't part of the governance structure, so I don't  
7 know.  
8 Q. In your view?  
9 A. And also I don't think the term "SAI" was used in 2001.  
10 "Adverse incident" was used, was used from May 2000. It  
11 was introduced in May 2000. I know that now from what  
12 I've read.  
13 Q. Then let's stick with adverse incident because for the  
14 purposes I'm asking you, it amounts to the same thing,  
15 which is something that's happened that has brought harm  
16 to a child.  
17 A. Yes.  
18 Q. So you're logging it for that reason to enable it to  
19 attract investigation with a view to seeing what went  
20 wrong, how it went wrong and what can be done to try and  
21 reduce the incidence of that happening again. That's  
22 the whole purpose of it, isn't it?  
23 A. That's correct.  
24 Q. If that's how, in your view, Raychel's death would have  
25 been regarded in 2001, is that something that, in your

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1 children and that work was to take place on agreed  
2 guidelines from the Department of Health on this  
3 subject."  
4 Do I understand it that you believe you would have  
5 been alerted to that from the medical directors'  
6 meeting, and that's how you knew at that stage that  
7 there was going to be any question about guidelines for  
8 the use of hypotonic fluids?  
9 MR UBEROI: Can I rise for clarity? I'm not sure the  
10 introduction of the phrase "the medical directors'  
11 meeting" doesn't unnecessarily confuse the issue.  
12 Perhaps if the witness could be asked does he recall how  
13 he first became aware of the upcoming working party,  
14 that might be a fairer way of dealing with it, otherwise  
15 we're dragging in a meeting at which he wasn't present.  
16 MS ANYADIKE-DANES: I beg your pardon. I thought he'd  
17 already said that in relation to that meeting when I was  
18 asking him about it.  
19 How did you first become aware that the department  
20 was proposing to have work carried out to reach agreed  
21 guidelines on the use of hypotonic fluids?  
22 A. I can't remember. The two people that might have told  
23 me, if I can speculate, would have been Dr Carson, who  
24 I knew in the Royal and was director of anaesthetics, or  
25 a medical director, previous director of anaesthetics,

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1 view, would or should have been communicated to  
2 Altnagelvin?  
3 A. Yes.  
4 Q. Thank you. Then if we just move on now to the Sick  
5 Child Liaison Group which you referred to before. I'm  
6 going to the meeting of 26 June 2001 because what I'm  
7 trying to explore with you again is that question of who  
8 knew what about the reasons why one was having that  
9 meeting and what the position was in relation to deaths  
10 or near misses in the region prior to that meeting.  
11 Okay?  
12 A. Mm-hm.  
13 Q. The minute of the meeting of 26 June is 093-035-110o.  
14 If one just looks quickly at those who were attending,  
15 with the exception of Dr McAloon from Antrim, they're  
16 entirely Children's Hospital representatives; that's  
17 right, isn't it?  
18 A. Dr McAloon's from Antrim, yes.  
19 Q. Because on the other side, from Craigavon, Ulster,  
20 Altnagelvin and the department, they are all apologies,  
21 so they don't attend that. Dr McAloon from the Antrim  
22 is there. Under "chairman's business", under  
23 "hyponatraemia", it said that:  
24 "[You] presented several papers, which indicated the  
25 potential problems with the use of hypotonic fluids in

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1 or maybe when Miriam McCarthy had sent her apologies,  
2 she had given me information. I don't know, but that's  
3 the two obvious people that could have told me, possibly  
4 told me.  
5 Q. And if it was going to be Dr Carson, it might be,  
6 because we've seen the letter of 21 June 2001 when  
7 Dr Kelly is writing, referring to the meeting of medical  
8 directors, which talks about the near misses and the  
9 change in practice at the Children's Hospital -- it  
10 might be that meeting that he came away from and gave  
11 you information.  
12 A. I can't remember.  
13 MR UBEROI: I'm not sure that line of questioning is  
14 particularly fair to this witness. He can't speculate  
15 as to what's in Dr Carson's mind. He's given his best  
16 recollection of who notified him of the upcoming work.  
17 I do suggest it confuses matters unnecessarily.  
18 MS ANYADIKE-DANES: So you can't remember how you first got  
19 to hear. How did you first learn that Raychel had died?  
20 A. I came to work on Monday morning. I can't remember.  
21 She died at the weekend and I presumably was told about  
22 her death Monday morning. Mondays are my PICU day.  
23 I can't remember. But --  
24 Q. If you can't remember, just say if you can't. But in  
25 those circumstances, if you learnt in that way, are you

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

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

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

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

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

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1 a working party and guidelines following --  
2 unfortunately, they were only developed following the  
3 tragic death of young, fit and healthy children.  
4 Q. Sorry, I'm asking you a slightly different question,  
5 which is: when you were telling those there that there  
6 were going to be departmental guidelines, did you at  
7 that stage understand why it was that there were going  
8 to be guidelines following Raychel's death?  
9 A. No.  
10 Q. No, just the fact that you thought it was going to  
11 happen?  
12 A. It was a whisper. Somebody had whispered me some  
13 knowledge to say, "We're going to take this forward".  
14 THE CHAIRMAN: Isn't there a convergence there? We'll  
15 explore this more after the break, but there's  
16 a convergence here, isn't there, with the BMJ paper on  
17 31 March, there are the changes which are taking place  
18 in the Royal in the use of Solution No. 18, however  
19 informal or formal those changes are, and then you have  
20 the death of Raychel in Altnagelvin?  
21 A. Yes.  
22 THE CHAIRMAN: So this is perfect territory for somebody  
23 saying, "Look, we're going to have to step up on this  
24 and it's time for guidelines".  
25 A. Yes.

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

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1 THE CHAIRMAN: Let's take a break now and resume at midday.  
2 (11.50 am)  
3 (A short break)  
4 (12.05 pm)  
5 MS ANYADIKE-DANES: Dr Taylor, Dr McAloon was at that Sick  
6 Child Liaison Group meeting on 26 June, and he writes  
7 a memo on 27 June to the relevant persons in his  
8 hospital. We can pull it up, witness statement 059/2,  
9 page 14. If we pull up page 15 as well, just so that  
10 you see the end of it.  
11 Those are his colleagues. The point I want to draw  
12 your attention to is he's there when you discuss this  
13 point, but he takes from it, apart from passing on the  
14 two papers:  
15 "I understand that the protocols in the  
16 Children's Hospital may shortly be revised with the use  
17 of fifth-normal saline being reserved for children under  
18 10 kilograms and half-normal saline combined with  
19 2.5 per cent dextrose being used in place for  
20 fifth-normal in the older age group."  
21 Then he goes on, having said that this is something  
22 that they in their department will need to review:  
23 "My suggestion is that we adopt the same protocols  
24 as the Children's Hospital."  
25 Are you able to explain, contrary to what you've

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1       minuted as departmental guidelines, why he thought that  
2       protocols in the Children's Hospital were going to be  
3       revised?  
4       A. No, I have no idea why he thought that.  
5       Q. It's a day after, and for that matter, if there were  
6       protocols in the Children's Hospital that were going to  
7       be revised, what protocols might he have been referring  
8       to?  
9       A. Exactly. I don't know. I have never been able to --  
10       I have never been made aware of a protocol for the use  
11       of post-operative or medical patient fluid management,  
12       either before or after. And can I also say that if  
13       I had gone to that meeting and there had been a protocol  
14       as well as bringing the papers, the Halberthal paper and  
15       the Arieff paper, I would have brought the protocol with  
16       me. And also can I say that if -- I know you're going  
17       to come to this. Later I attended the working party,  
18       Dr Crean, myself, would have been saying, "Why sit here  
19       writing a protocol when we have already got a perfectly  
20       good one in the Royal?" So I really don't understand  
21       why people think there's a protocol in the Royal because  
22       there was no protocol in the Royal.  
23       THE CHAIRMAN: We need to be a bit careful, doctor, because  
24       we're sitting in a legal setting surrounded by lawyers,  
25       that we don't attribute formality to words which were

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1       happened, this was produced just prior to the first  
2       meeting of the working party and was e-mailed to  
3       Dr Carson.  
4       Q. No, sorry, I'm asking a different question.  
5       A. Sorry.  
6       Q. What he's put there as what he believes the change is  
7       going to be accords with what is under that IV fluid  
8       prescription part, does it not?  
9       A. Well, the IV fluid prescription chart wasn't written, to  
10       my knowledge, at that time.  
11       Q. But the information accords with it. So if you've got  
12       a split between the young and the slightly older, and so  
13       where it says, "Give 0.45 per cent normal saline, 2.5  
14       per cent glucose", is that not consistent with what he  
15       believed was going to be the change in the  
16       Children's Hospital's practice?  
17       A. I fail to see the link between the two in terms of time,  
18       but the --  
19       Q. On the information though.  
20       A. I think all paediatricians see a difference between  
21       infants under one year of age and children of over one  
22       year of age. It's a normal age differential. And  
23       I think you might be highlighting a point that may not  
24       be particularly relevant to that document. I'm not  
25       sure.

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1       not written in that way.  
2       A. Sorry.  
3       THE CHAIRMAN: If he's referring to a protocol, he might be  
4       referring to a practice, and if you read that sentence  
5       as "I understand that the practices in the Royal may  
6       shortly be revised", would that sentence make sense?  
7       A. I don't think there was a common practice that the Royal  
8       had. I think doctors practice an individual practice,  
9       anaesthetists gave Hartmann's for resuscitation fluids  
10       and for intraoperative fluids, and really when a patient  
11       got back to the ward or a patient on the medical  
12       wards -- we would have had really little say or little  
13       control over what paediatricians or surgeons would have  
14       prescribed to them.  
15       THE CHAIRMAN: Thank you.  
16       MS ANYADIKE-DANES: Well, if we keep that first page up  
17       there and substitute for the second page, the second  
18       page of your paper with your colleagues, 043-101-224.  
19       In the highlighted bit or the bit with the arrow showing  
20       what he believes that the practice, guidelines or  
21       protocols in the Children's Hospital are going to be  
22       revised to, it accords with what is written under the  
23       IV fluid prescription part of your paper, does it not?  
24       A. There's no date on that IV fluid prescription, but  
25       I think when I looked at my timeline of when things

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1       THE CHAIRMAN: But surely the document on the left divides  
2       children up by weight, doesn't it? The one on the right  
3       divides them by age.  
4       MS ANYADIKE-DANES: And weight also. Anyway ...  
5       So you can't help us with why the day after that  
6       meeting, when Dr McAloon attended, he is talking about  
7       a change happening in relation to the  
8       Children's Hospital as opposed to departmental  
9       guidelines?  
10       A. I don't even understand why he's including children  
11       under 10 kilos or one year of age because the context of  
12       my reporting to the Sick Child Liaison Group was the  
13       death of Raychel, who was not under 10 kilos. So  
14       I honestly don't understand why he can draw that out of  
15       the discussion, the brief discussion that I presented at  
16       the Sick Child Liaison Group. I'm just at a loss. I'm  
17       trying to help you, don't get me wrong, but I'm trying  
18       to explain how he could have drawn this conclusion that  
19       we had protocols and we were going to revise them, that  
20       we had a different prescription for over 1s than under  
21       1s. I fail to see how he could have got so much  
22       information from what I believe is what I discussed with  
23       the group, which was the death of Raychel and that the  
24       Department of Health were going to do guidelines. It's  
25       completely strange that he gets the completely wrong end

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

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1 a meeting on 26 September 2001. Was there any  
2 discussion with you about that meeting, about you being  
3 part of it, prior to you receiving this letter?  
4 A. No, not that I can recall. Although I seem to have  
5 known that there was going to be departmental  
6 guidelines, but I didn't know -- I don't think I knew  
7 that I was going to be a member of that development of  
8 those guidelines. I think this is the first time I was  
9 confirmed as being a member of the working party, yes.  
10 Q. Were you asked to do any work in connection with that  
11 meeting?  
12 A. Well, I recently came across an e-mail trail that was  
13 buried in some of my other documents.  
14 Q. We can pull that up, Dr Taylor. It's witness statement  
15 330/1 at page 10. You've got only the first page of  
16 a two-page e-mail thread, as I understand it.  
17 A. Yes.  
18 Q. And this page picks it up, it's something to be explored  
19 with others about action not having been taken because  
20 this would be in hand at local level, but it's now going  
21 to be taken, as a result of which there is a e-mail from  
22 the CMO to Dr Carson asking if there's anybody at the  
23 Children's Hospital who could put together a short paper  
24 and that she would be happy to disseminate any such  
25 advice. The result of that is he says he's going to ask

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1 A. I think the only way he could have got that information  
2 was from the Sick Child Liaison Group the day before.  
3 MS ANYADIKE-DANES: What I was putting to you is that you  
4 might have had a broader discussion than just Raychel  
5 and actually discussed the issue about the potential  
6 risk to children generally, which might make it relevant  
7 as to what age you're talking about in terms of the  
8 different calculation in relation to weight. You might  
9 have had a broader discussion.  
10 A. Since I can't remember the detail of the conversation,  
11 it's quite possible that we could have talked about a  
12 number of items, but that's -- it's not my recollection.  
13 Q. Thank you. Then you are invited to attend on  
14 21 August 2001, or rather to be part of the meeting.  
15 The reference for it is 007-050-099. It starts off:  
16 "There is increasing evidence that acute  
17 hyponatraemia is emerging as a significant clinical  
18 problem in sick children receiving IV fluids."  
19 So that's not just Raychel, that is a process of  
20 being aware that we have a problem here:  
21 "As a result, we believe we should convene a group  
22 to consider how best practice could be brought to bear  
23 on the problem and to explore whether further advice  
24 needs to be issued ..."  
25 And as a result of that, you are asked to attend at

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1 you to do it, to consider drafting advice and guidance  
2 suitable for dissemination throughout the hospitals.  
3 Then you have provided us with two documents, and  
4 I wonder if you can help whether either of these are in  
5 response to you providing guidance or if it's something  
6 else. We have one which starts in witness statement  
7 330/1 at page 12. We can put alongside the first page  
8 of another one, which is slightly different, witness  
9 statement 330/1, page 14.  
10 As you can see, there is a difference. There is  
11 more detail in the left hand one under "introduction",  
12 and you've got the baseline assessment, which we don't  
13 see in the one on the right-hand side. Did you produce  
14 either of these in relation to that request?  
15 A. No.  
16 Q. What were these being produced for?  
17 A. I believe these were -- it is my writing on the  
18 right-hand side one. That is my handwriting. I believe  
19 that was notes that I took at that first meeting on  
20 26 September, and I believe that was the very first  
21 template of what later turned out to be the guidelines.  
22 THE CHAIRMAN: That's page 14?  
23 A. Page 14, sir.  
24 THE CHAIRMAN: Thank you.  
25 MS ANYADIKE-DANES: Who would have produced page 14?

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1 A. I think it's Miriam McCarthy, because on the bottom, if  
2 you read the bottom in small print, it says "McCarthy  
3 2001".  
4 Q. And not at the bottom of the other?  
5 A. It looks like it says "410", which might mean 4 October.  
6 Q. But in any event, it does have her name.  
7 A. I don't know what it means.  
8 Q. Do you know what the other one was produced for, was it  
9 a development?  
10 A. I believe it -- it looks to me like a development of the  
11 guideline, but before it became a wall chart.  
12 Q. So potentially following the meeting?  
13 A. Definitely following the meeting.  
14 Q. Thank you. And then the document that we've been  
15 looking at before, 043-101-223. Was this produced in  
16 response to that request by Dr Carson?  
17 A. Yes. I believe Dr Carson's e-mail asking me to do some  
18 work was on the 27th at 14.47 pm in my Yahoo address.  
19 Then I worked on this with my colleagues, as I've stated  
20 previously.  
21 Q. Yes.  
22 A. And it was then e-mailed by Dr Carson to Dr Campbell on  
23 the 30th as an attachment.  
24 Q. If we just pick that up. 026-016-031.  
25 A. Yes.

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1 A. Yes.  
2 Q. And just so we're clear about the one, is it  
3 007-051-101? That's what goes along with that  
4 background piece.  
5 A. I'm pretty certain, yes.  
6 Q. Thank you very much. So then when you get your letter  
7 of invitation, did you know who else was going to be  
8 part of the working group?  
9 A. Um ...  
10 Q. Sorry, before you went to the meeting, did you know who  
11 else was going to be part of the working group?  
12 A. I don't believe I would have known who else was on the  
13 meeting, no.  
14 Q. Did you discuss with Dr Carson what your role was going  
15 to be?  
16 A. It is probable. It's likely that he would have given me  
17 some purpose, some reason. Certainly in the e-mail he  
18 says ... Sorry, perhaps you can help me.  
19 Q. In the e-mail you're simply asked to:  
20 "Consider drafting advice and guidance suitable for  
21 dissemination throughout the HPSS."  
22 And the letter tells you that you're going to try  
23 and achieve a broad measure of agreement on how to  
24 proceed in the light of the problems that have been  
25 identified. So did you have any clearer idea of what

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

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

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1 did you make before you went to identify the incidence  
2 of hyponatraemia?  
3 A. Well, I think I've given evidence on that before.  
4 I asked my secretary to do a PICU database search.  
5 I think the date on the top of those pages is the 3rd  
6 and the 2 August 2001, so a few days --  
7 Q. I beg your pardon, we are going to come to that in a  
8 minute. So one of the things that you did was to ask  
9 your secretary to do a PICU search.  
10 A. Yes, and that was shortly following this e-mail from  
11 Dr Carson.  
12 Q. Did you think to discuss it amongst your colleagues?  
13 Dr Crean was very experienced, did you ask him what his  
14 experience was?  
15 A. Yes, I'm certainly sure that I discussed it not only  
16 amongst my hospital colleagues but also colleagues in  
17 other hospitals.  
18 Q. And if you do that, would it not have come to your  
19 attention, certainly from Dr Crean, that there was  
20 a child called Lucy?  
21 A. I don't believe that came to my attention during that  
22 time.  
23 Q. So you were discussing with your colleagues, including  
24 Dr Crean, their experience of the incidence of  
25 hyponatraemia, Lucy's died the previous year and he

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1 when that group met it took forward evidence-based  
2 advice on the best treatment for antibiotic treatment  
3 and recognition and it didn't dwell or discuss the  
4 deaths of children who had died of meningococcal  
5 disease, so it was my experience that the working  
6 parties were very focused on developing evidence-based  
7 guidelines and didn't dwell -- possibly also because  
8 there was no pathologist or neurologist on the working  
9 parties, they were not constituted to investigate  
10 individual deaths, they appeared to be -- and you'd have  
11 to ask somebody from the department.  
12 THE CHAIRMAN: You're not investigating deaths, you're not  
13 investigating other deaths, you're drawing up guidelines  
14 to change practice so as to avoid deaths like those  
15 which have occurred. And the idea that the working  
16 party doesn't mention the deaths which have occurred is  
17 what troubles me.  
18 A. Yes.  
19 THE CHAIRMAN: Or do you have something against which to  
20 test the guidelines? Yes, you do, you've got at least  
21 two very recent deaths in Northern Ireland. But if  
22 I understand the evidence that's coming correctly, it's  
23 that nobody on the working party thought, "Let's see how  
24 those stand up and how those guidelines would have  
25 applied better in Raychel's case or in the case of

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1 doesn't mention that?  
2 A. I can't remember her name being mentioned.  
3 THE CHAIRMAN: Whether he mentioned a name, did he mention  
4 a death in 2000? Here's the two most -- even if you set  
5 aside Adam and even if you set aside Claire, there's two  
6 deaths in 15 months, which are directly  
7 hyponatraemia-related. And I'm being given to  
8 understand over the last couple of weeks at that no  
9 point during anything to do with the working party was  
10 Lucy mentioned, and I don't understand how that could  
11 possibly have been the case. I don't understand, if  
12 you're in the working party with your colleague in the  
13 Royal, Dr Crean, how that could possibly have been case,  
14 nor do I understand, since there was somebody on the  
15 working party from the Erne, how that was the case.  
16 Can you help me with that?  
17 A. I can't help looking back now.  
18 THE CHAIRMAN: Not a name, I'm not necessarily looking for  
19 Lucy's name, but the idea that there wasn't even  
20 a reference to a girl who had been treated in the Erne  
21 and who had then been referred to the Royal, the idea  
22 that there was no reference to her leaves me bewildered.  
23 Can you help?  
24 A. I can understand your bewilderment and it seems strange.  
25 My previous work on the meningococcal working party,

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1 a girl from the Erne'. I also understand that nobody  
2 from Daisy Hill, nobody from any of the other hospitals  
3 said, "How extensive is the problem? How big is the  
4 issue?"  
5 MS GOLLOP: Sir, I hesitate to interrupt, but my  
6 recollection of Dr Jenkins' evidence was that his  
7 understanding was that they would formulate guidelines  
8 and those would then be e-mailed out to, amongst others,  
9 some of the clinicians involved and they would go back,  
10 those clinicians, and look at the clinical records, test  
11 out, do the stress testing, as it were, of the  
12 guidelines against those records, so that process would  
13 happen. But it would sort of happen on a delegated and  
14 disseminated basis like that because of the resource  
15 implications for getting everybody into the same room on  
16 multiple occasions from different hospitals. That's my  
17 recollection of what he said.  
18 THE CHAIRMAN: Ms Gollop, I'll check Dr Jenkins' evidence,  
19 but I think he had trouble on exactly the same point  
20 that Dr Taylor is unable to assist me on about how the  
21 working party possibly met as a group without discussion  
22 about the incidence of recent deaths.  
23 But even if I make the jump of setting aside Adam  
24 and Claire, the fact of two very recent deaths -- and  
25 Raychel's death was recognised as problematic, to put it

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

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

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

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

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

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

2 A. No.

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

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

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

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

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

18 A. Yes.

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

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

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

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1 correct?

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

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

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

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

9 THE CHAIRMAN: That's fair.

10 MS ANYADIKE-DANES: It is fair.

11 But what you say in your e-mail is:

12 "Here are some draft documents for your  
13 consideration in advance of the meeting on  
14 26 September."

15 A. Yes.

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

23 A. No.

24 Q. Sorry?

25 A. No.

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

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

5 Q. You were referring to this audit?

6 A. Yes, I believe so.

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

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

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

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

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

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1 you have?  
2 A. I can't explain.  
3 Q. As soon as you saw it, you would know it's inaccurate.  
4 THE CHAIRMAN: I think you've got the point,  
5 Ms Anyadike-Danes. He said he can't explain.  
6 A. I think I would have made it clear that this was data  
7 that was interrogated from a database and could not be  
8 relied on. I never expected this to be accepted as the  
9 complete -- and I'm convinced that I would have told  
10 Dr Darragh or others that this was not 100 per cent  
11 foolproof data.  
12 THE CHAIRMAN: Did you add "For instance, I personally know  
13 of a death in 1995"? Because there's no point in  
14 telling Dr Darragh and others that this isn't foolproof  
15 if you don't then go on to say, "There was definitely  
16 one more death in 1995".  
17 A. Well, Adam's death was a coroner's inquest and, in 1996,  
18 when the inquest was being held, it was very well  
19 reported in the local press, and my view was that every  
20 clinician working with paediatrics was aware of the  
21 inquest and the findings of the coroner. It was very  
22 prominent.  
23 THE CHAIRMAN: Dr Chisakuta wasn't.  
24 A. Well, I can't explain that.  
25 THE CHAIRMAN: Dr Chisakuta, in fact, just to make this

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

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

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

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1 was receiving Solution No. 18 fluids and you were aware  
2 that she had low sodium levels and that her sodium level  
3 had fallen from 132 to 121 within a space of about  
4 23 hours in that case. That was your evidence: you were  
5 aware of that.  
6 A. Yes.  
7 Q. And in fact, if you had looked at her documents, and if  
8 her case note discharge summary, which I think Dr Crean  
9 gave evidence the other day to say would be on file,  
10 which is 090-009-011, you would see that under "other  
11 diagnosis", it says, "hyponatraemia". So whilst  
12 you weren't as intimately involved with Claire's case as  
13 you were with Adam, if you were doing what you said you  
14 were doing in your evidence then that was a case that  
15 should have come to your attention.  
16 MR UBEROI: I'm not sure that's fair, if I may say. To use  
17 the statement "while you weren't as intimately as  
18 involved as you were in Adam" is rather the  
19 understatement of the century. Dr Taylor was involved,  
20 as I have said before, in a very specific stage in the  
21 care of Claire Roberts, no doubt doing as good a job as  
22 he could, accepted he would have looked back through the  
23 records in administering the clinical tasks which he  
24 did, but to suggest that five years on he would be  
25 recognising or remembering a term such as that which has

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

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1 been put to him is not fair, in my submission.  
2 MS ANYADIKE-DANES: What you're trying to do, Dr Taylor, is  
3 you're trying to engage in a bit of research as to what  
4 the incidence is, and you accepted from me that as part  
5 of that you'd be talking to your other colleagues to see  
6 what their experiences were.  
7 MR UBEROI: That's an entirely different point. If the  
8 question is "Did no clinician raise Claire Roberts with  
9 Dr Taylor in 2001?", that's completely separate.  
10 MS ANYADIKE-DANES: It is. Dr Taylor, if you'll allow me,  
11 what I'm trying to put to you is that there was  
12 information there for you to have in relation to  
13 Claire's case being one that could and should have been  
14 included on your bar chart; would you accept that?  
15 A. I accept the bar chart was based on incomplete data.  
16 What I believe I was trying to do with Dr Darragh and  
17 the members of the group was to confirm that the  
18 incidence of hyponatraemia, even without death -- but  
19 the incidence of admission to ICU with hyponatraemia was  
20 a real problem. I wanted to make sure that the working  
21 party were aware that Raychel wasn't isolated, that we  
22 had also, as well as Dr Arieff and Dr Halberthal  
23 reporting this is a growing concern worldwide, that  
24 children presenting with hyponatraemia in tragic  
25 circumstances because of hypotonic fluids -- but this

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1 was also a problem in Northern Ireland. So that gave  
2 a focus. If we had turned up at the working party and  
3 it hadn't been seen as an increasing incidence then the  
4 working party might not have concluded that the  
5 guidelines -- I don't know, I'm speculating -- would  
6 have been such an important and rapid requirement to  
7 produce guidelines. They might have waited for the NPSA  
8 or, in those days, the Medicines Control Agency, to  
9 produce guidelines. What I tried to do was the best  
10 effort that I could and I recognise that I missed  
11 important information on that. But all I was trying to  
12 do was to give a narrative and at the working party  
13 I didn't produce this graph, I gave a narrative, and my  
14 narrative was to say that incidence of hyponatraemia in  
15 Northern Ireland is as described in the literature and  
16 it's something that we have to work quickly towards  
17 resolving.  
18 Q. I appreciate that.  
19 A. I believe that was my recollection.  
20 THE CHAIRMAN: Let's move on, Ms Anyadike-Danes, we need to  
21 keep going.  
22 MS ANYADIKE-DANES: Can you see, doctor, from the families'  
23 point of view, that if you provide a graph like that  
24 without the caveats that you have now provided to the  
25 chairman that, from the families' point of view, that

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1 from the chief medical officer's office for somebody to  
2 do a background paper, which you have done, and you have  
3 done a PowerPoint presentation, that's to put people  
4 in the picture as to what the issues are and you might  
5 then expect that that information be shared with the  
6 members of the working party who are coming, who don't  
7 all have the advantage of working in the  
8 Children's Hospital and might not be as familiar as  
9 you are with the problems.  
10 A. I think I've said before I recollect coming away from  
11 that meeting very disappointed that no one had said to  
12 me "That's a good start with your incidence and with  
13 what you've shown. You've told us the data is  
14 incomplete". For the meningococcal I wasn't able to get  
15 all the data I needed from the PICU database and I had  
16 to undertake a chart review with my secretary and  
17 I fully expected to be told "Go back and get some more  
18 reliable figures, including deaths, on this chart and we  
19 might use it". But I remember coming away quite  
20 disappointed -- as you said, I'd done quite a bit of  
21 work and no one said to me "Well done" or "But we can't  
22 use it because it's incomplete, go and finish it". That  
23 never happened and it was a source of great  
24 disappointment to me and I was never invited back to the  
25 drafting of the document either. So I came away from

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1 might look as if you were excluding from that chart the  
2 two rather contentious deaths in which the  
3 Children's Hospital had been involved?  
4 A. I accept that.  
5 Q. Thank you. Was there any discussion about the  
6 possibility that Dr Darragh might present at the working  
7 party meeting the two documents that you had given him  
8 as perhaps rather helpful summaries of the situation?  
9 Had you that in mind, that they might find their way to  
10 the meeting?  
11 A. My recollection was that my PowerPoint was not taken  
12 forward and I remember -- so that document was not used.  
13 Q. No, I asked you a different question. Did you think  
14 that he might or were you prepared for those documents  
15 to be provided to the meeting?  
16 A. Yes.  
17 Q. Thank you. We had a document up just earlier,  
18 026-016-031.  
19 THE CHAIRMAN: I'm sorry, I'm not quite sure what that  
20 means. Does that mean that having done the work, gone  
21 out of your way to do the work, taking on this extra  
22 risk, that you expected Dr Darragh to share that work  
23 with the working party?  
24 A. Yes.  
25 THE CHAIRMAN: Because if there's a message coming through

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1 that party quite upbeat that I was going to have an  
2 impact on the guidelines and perhaps the impact I had  
3 wasn't quite as good as I'd anticipated.  
4 MS ANYADIKE-DANES: Does that mean that the figures were  
5 presented? I'm just looking at the transcript that's  
6 coming up. You referred to coming away from the meeting  
7 disappointed.  
8 A. I presented a narrative.  
9 Q. But you referred to figures.  
10 A. I didn't present the presentation. I didn't use the  
11 PowerPoint. There was nothing there to use. There was  
12 no PowerPoint projector in my recollection.  
13 Q. Let me just take you to what I am talking about. You  
14 say:  
15 "I fully expected to be told 'Go back and get some  
16 more reliable figures, including deaths on this chart we  
17 might use'."  
18 A. Well, this is what I anticipated Dr Darragh saying to  
19 me. I believe I told him this was PICU database, pure  
20 data, raw data, that I couldn't rely on it, and I fully  
21 expected someone to say to me "Go and get something  
22 reliable before we use it".  
23 Q. Okay.  
24 A. And that didn't happen. And I remember coming away from  
25 the meeting quite disappointed with the work, albeit

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1 poor, incomplete, missing data -- I knew that and  
2 I believe I informed at least Dr Darragh, if not others,  
3 not to rely on the data.  
4 Q. Who else did you show it to?  
5 A. I don't believe it was tabled at the meeting.  
6 Q. No, no, sorry, it was a different question. Who else  
7 did you show the chart to?  
8 A. It wasn't tabled or shown at the meeting to anybody in  
9 my recollection.  
10 Q. Well, what I think you have just said is that you  
11 believe you told Dr Darragh and others not to rely on  
12 it, so who were the others?  
13 A. No, when I sent it to Dr Darragh, I believe ... I can't  
14 remember the words, but I don't believe I gave them the  
15 impression that this was accurate data.  
16 MR UBEROI: If I might add for clarity, what the witness  
17 said he was anticipating that would be an exchange which  
18 would occur, not that it did in fact occur.  
19 A. It did not occur and I was disappointed that it  
20 different occur.  
21 THE CHAIRMAN: Can I just get this clear in my own mind?  
22 The bar chart was not put before the meeting; is that  
23 right?  
24 A. Correct.  
25 THE CHAIRMAN: The PowerPoint presentation was not put

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1 passing on to the CMO?  
2 A. I clearly spoke to him. I don't recall the conversation  
3 and I don't have a record of it.  
4 Q. And at the stage of 30 July, where would he be getting  
5 or where would you be getting it to give it to him, the  
6 information that the Children's Hospital would have  
7 approximately one referral from within the hospital per  
8 month?  
9 A. I think this e-mail is a follow-up e-mail from the one  
10 that I gave you earlier on the 27th.  
11 Q. Yes.  
12 A. So on the 27th at 14.47, Dr Carson e-mails me to say  
13 would I do some work.  
14 Q. Yes.  
15 A. And then he contacts me on or before 11.52 on  
16 30 July 2001, and I clearly -- I don't deny, I clearly  
17 give him information. Whether that is all my  
18 information, I don't know.  
19 Q. No, sorry, my question to you is --  
20 MR UBEROI: If I might add to an answer that a witness has  
21 just given, just perhaps to make this point now before  
22 -- I completely understand my learned friend is about to  
23 embark on one or two questions on this document. The  
24 extract quoted is not clearly put in the mouth of  
25 Dr Taylor. The early sentences read equally as if they

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1 before the meeting.  
2 A. Correct.  
3 THE CHAIRMAN: And the background paper which you had been  
4 asked to write?  
5 A. I don't believe it was put to the meeting. I believe  
6 the paper you showed me earlier with my notations on it  
7 was what was produced for the meeting, which is actually  
8 a template. I think it's from --  
9 THE CHAIRMAN: You're guessing it's Miriam McCarthy.  
10 A. I think it's Miriam McCarthy and I believe it's an  
11 abbreviation of my other documents that I sent to  
12 Dr Darragh. I don't think either of my papers were  
13 actually tabled, but I do understand that the minutes  
14 show that I gave a narrative that the incidence in  
15 Northern Ireland was reflective of the papers that were  
16 in the literature, such as the lesson of the week. In  
17 other words, there was a real need for Northern Ireland  
18 to progress to produce guidelines urgently because  
19 we were experiencing an incidence of hyponatraemia not  
20 unlike that which is experienced in the literature. I  
21 believe that is what that refers to.  
22 MS ANYADIKE-DANES: In relation to this e-mail here,  
23 Dr Carson has clearly spoken to you or has got your  
24 views from someone -- maybe I should ask you. Did you  
25 speak to him to give him the information that he's now

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1 could be a compendium of Dr Carson's knowledge accrued  
2 from other individuals. I of course accept that one  
3 sentence begins "Bob Taylor thinks", and in using that  
4 terminology it would be my position that that rather  
5 makes that sentence attributable to Dr Taylor in a way  
6 that other sentences aren't.  
7 MS ANYADIKE-DANES: I haven't asked a question like that.  
8 I said --  
9 THE CHAIRMAN: Sorry, Ms Anyadike-Danes, Mr Uberoi was  
10 anticipating a line of questioning. He wasn't saying  
11 you'd asked a question, he was anticipating a line of  
12 questioning.  
13 MS ANYADIKE-DANES: Sorry, I thought he was going back to  
14 something I had asked. What I'd asked was:  
15 "At the stage of 30 July, where would he [that's  
16 Dr Carson] be getting that information?"  
17 Or where would you be getting it from to give to  
18 him? I don't know where that would have come from. And  
19 the information that I'm talking about is the  
20 anaesthetists in the Children's Hospital would have  
21 approximately one referral from within the hospital per  
22 month. Where in your view would Dr Carson be getting  
23 that kind of information from?  
24 A. Well, he's getting it from the anaesthetists in the  
25 RBHSC, which is myself and Dr Crean and Dr McKaigue and,

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1 at that time, Dr Loan and Dr Chisakuta.  
2 Q. I know it's put approximately, but in order to get that  
3 order of magnitude, where would you go back to to get  
4 a view of what the level of referral from within the  
5 hospital was? What would be the source of your  
6 information?  
7 A. I don't know what the source of information is. That  
8 may well just be a compendium of views that we would  
9 have given him. I don't know where he gets that  
10 information.  
11 Q. And is that information being given him as if that is  
12 significant? Is it significant that there was  
13 approximately one referral from within the hospital per  
14 month?  
15 A. It depends, of course, how you define hyponatraemia.  
16 Sodium frequently ... Even today, I wouldn't say  
17 frequently, but there would be still cases of children  
18 with sodiums less than 135. If a sodium is less than  
19 135, the laboratory highlight that with an asterisk and  
20 say, "This is hyponatraemia". And then there's a clear  
21 audit path line through the labs about the number of  
22 hyponatraemic, in other words children with sodiums of  
23 less than 134. Now, it could be -- or less than 135.  
24 In other words, 134 or below.  
25 Now, it could well be an anaesthetist giving an

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1 information to be giving him? What's the source of your  
2 information?  
3 A. I'm not sure I've given him that information. I think  
4 the labs would be the best place to give the information  
5 about the number of children who had low sodiums, but  
6 I don't know where you'd get the information if he is  
7 referring only to children who had developed iatrogenic  
8 or dilutional hyponatraemia. That's information that  
9 I was not in a position to give him.  
10 Q. And in your bar chart you actually have the incidence of  
11 the admitted and not leading to death. They are on the  
12 rise after 1995 by comparison with the figures before  
13 1995.  
14 A. You see, that's why I went about in my poor manner --  
15 I accept that it wasn't accurate, but I tried to get  
16 some data that could be useful to inform the working  
17 party, and I accept all the criticism you've given me  
18 that there's data missing and that it's not complete,  
19 but it's the only data that I could quickly access  
20 in the summer holidays with the benefit of my secretary,  
21 who was very good at getting data out of the computer.  
22 But it was incomplete data and it wasn't always recorded  
23 accurately in the coding.  
24 Q. Yes. That incidence of hyponatraemia, Dr Taylor, did  
25 you consider that to be of concern, that level of

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

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

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

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

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1 adverse report.  
2 Q. Yes. We've heard one of the outcomes of the RQIA in  
3 2008 was that Antrim had actually developed a trigger.  
4 Is that the sort of thing you're talking about?  
5 A. Well, it's throughout Northern Ireland, not just Antrim.  
6 It is regional.  
7 Q. Which was ultimately taken up --  
8 A. I believe it's the same thing. I'm not exactly sure.  
9 Q. Thank you.  
10 A. And I think the lab also have a proactive adverse  
11 incident reporting. If the lab gets a low result, it  
12 has to report to its directorate control.  
13 Q. Can I just ask you about your five to six deaths? Well,  
14 you are reported as having said that you thought there  
15 were five to six deaths over a 10-year period of  
16 children with seizures. And I think in your evidence,  
17 in your witness statement in this case, you said that  
18 that doesn't appear plausible. What you actually say  
19 is:  
20 "Five to six deaths over 10 years does not appear  
21 plausible to me."  
22 The reference for it is 330/1, page 4. Why did you  
23 think that wasn't plausible?  
24 A. Well, I've thought a lot about this statement,  
25 obviously, in advance of this. The only deaths I was

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

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1 answer that I can remember from that time, but I've read  
2 so much stuff I can't be sure.  
3 Q. This e-mail was copied to you.  
4 A. Um ... Can I just see it again?  
5 Q. 026-016-031. Cc --  
6 A. Yes, I'm on the cc, thank you.  
7 Q. If there was a potential misunderstanding for how the  
8 information that you are being recorded as having been  
9 provided, don't you think you might correct that and  
10 say, "Hang on second, you've got that out of context.  
11 We're talking about five to six deaths internationally",  
12 or something like that, whatever the points are that you  
13 think are misleading or not accurate. Did you not think  
14 you might correct your medical director on that?  
15 A. I don't know.  
16 MR UBEROI: If I might add, I'm not sure it's been  
17 established that there's anything to correct,  
18 necessarily.  
19 THE CHAIRMAN: If Dr Taylor understood the reference to five  
20 or six deaths to be internationally, that e-mail does  
21 not need to be corrected.  
22 MR UBEROI: That'd be my point, sir. I'd also add that was  
23 Dr Carson's best recollection of how he interpreted that  
24 figure when he drafted it in his e-mail.  
25 MS ANYADIKE-DANES: Also, I think Dr Taylor's evidence was

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1 deaths."  
2 You have given evidence about Raychel. Who is the  
3 "we", and how were you aware of Lucy's death?  
4 A. Yes, I can see what I've answered. I'm just trying to  
5 work out the context, if you don't mind. I don't know  
6 how that's -- in the context, Lucy obviously died in the  
7 PICU, and, as I said earlier, I think there was concern  
8 or confusion that because her sodium was 127 ...  
9 I don't know if I know this information now, after 2001.  
10 Q. I'm only asking you how you answered the question.  
11 You have answered the question:  
12 "At this time in 2001, we were aware of Lucy and  
13 Raychel's deaths."  
14 If you leave Raychel's aside, what do you mean by  
15 that in relation to Lucy?  
16 A. I understand, but what I'm trying to feel and remember  
17 is when this was written. Presumably, in 2010.  
18 Q. When your statement was produced? I can tell you that.  
19 Your statement was produced 21 September 2012.  
20 A. 2012. So it's information -- I'm obviously saying in  
21 2001 I was aware of it, but it was written in 2012, so  
22 what I'm now struggling to understand is is it really  
23 information that I knew in 2001 or is it information  
24 I knew in 2012 that I think I remembered in 2001. My  
25 other evidence was -- and it's consistent with my

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1 he wasn't sure about where the figure of one referral  
2 from within the hospital -- and I think your view was  
3 that didn't necessarily accord with the sort of case  
4 that would be part of this kind of concern.  
5 THE CHAIRMAN: Okay, I've got the point.  
6 MS ANYADIKE-DANES: Thank you.  
7 THE CHAIRMAN: Let's break for lunch. We'll resume at  
8 2 o'clock, doctor. Thank you.  
9 (1.12 pm)  
10 (The Short Adjournment)  
11 (2.00 pm)  
12 MS ANYADIKE-DANES: Could we please pull up a statement that  
13 you made in relation to Claire's death, which is witness  
14 statement 157/2, page 3? If you see in the answer  
15 to (e):  
16 "Did you seek information from colleagues as to  
17 hyponatraemia cases in the RBHSC within the preceding  
18 10 years to assist in the work of the Northern Ireland  
19 working group?"  
20 You say to that:  
21 "Yes, I did discuss the hyponatraemia deaths with  
22 other colleagues."  
23 Which is what you have told the chairman today:  
24 "I cannot recall what information was discussed. At  
25 this time in 2001 we were aware of Lucy and Raychel's

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1 feeling -- that I did not know that Lucy's death was due  
2 to dilutional hyponatraemia at that time and wasn't  
3 included in the audit.  
4 Q. Or it could be quite simply that you did, either you  
5 knew that directly or somebody told you. And A person  
6 who could have told that was Dr Crean because you and  
7 Dr Crean were on that working party, you were colleagues  
8 together, it's a rather small specialism, paediatric  
9 anaesthesia, at consultant level. It is quite possible  
10 that you discussed it and that is how you knew.  
11 A. It's possible, but it's not my memory in the context of  
12 the other questions that were put. So I don't know if  
13 it's memory that I have post the events of the inquiry  
14 or it is genuinely evidence that I had at the time. I'm  
15 sorry.  
16 THE CHAIRMAN: Can I ask you this: if Raychel's death was  
17 a shocking death in 2001 and you come into work on the  
18 Monday and you're told about it and people are in  
19 a state of disbelief, at the risk of comparing the  
20 deaths of two children, Lucy's would be equally  
21 shocking, wouldn't it? Lucy didn't even have an  
22 operation. Lucy went into the Erne Hospital with some  
23 sort of bug or whatever and was to be rehydrated and  
24 died in a very, very short timescale. If Raychel's  
25 death was shocking in 2001, Lucy's death, by definition,

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

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

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1 If that's the picture for 2000 and the picture for  
2 2001, I am once again lost as to why you didn't know  
3 about or didn't have concerns about Lucy's death, not  
4 because of your personal involvement in it but because  
5 of what goes on within the children's unit, adding  
6 in the fact that I'm continually told children's deaths  
7 are very, very rare. Can you help me?  
8 A. I struggle to understand that. Looking back now it  
9 seems incredible that Lucy's death did not have the same  
10 impact as Raychel's and I have no explanation for that,  
11 sir.  
12 THE CHAIRMAN: Thank you.  
13 MS ANYADIKE-DANES: Then just while we're on the deaths,  
14 very briefly, if I can ask you about Claire Roberts.  
15 I've already been there with you before, but bear with  
16 me. You had some input into Claire's care.  
17 A. Yes.  
18 Q. You have already said that. You have already said that  
19 you read her notes, you have already said that you were  
20 aware that her sodium levels had fallen from 132 to 121,  
21 and that's within 23 hours, and that is potentially  
22 an issue.  
23 A. Yes.  
24 Q. That would register with you, as a paediatric  
25 anaesthetist, the significance of that. And you were

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

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1 have the same impact as Raychel, and I think it's very,  
2 very unfortunate and tragic that they didn't.  
3 Q. Yes. Then if I might pull up this letter that you write  
4 to the coroner on 1 November 2001. So obviously, this  
5 is after that first meeting you attended, and we'll come  
6 to the minute of that meeting of September, but before  
7 the guidelines are actually issued. Okay? The  
8 reference for it is 012-071b-409.  
9 Can you see where it says in the middle of the page:  
10 "As you will remember, I also had a child's death  
11 related to this type of fluid."  
12 And then you go on to talk about writing to the MCA,  
13 the Medicines Control Agency. So it would appear, as at  
14 1 November 2001, if you hadn't done it before, that you  
15 had associated Solution No. 18 with Adam's death unless  
16 there's some other child you might be talking about. Is  
17 this Adam?  
18 A. I think this is Adam because I've started the sentence  
19 "as you will remember", so it's obviously a case that  
20 has been through the coroner's system.  
21 Q. Exactly. So at that time you have managed to associate  
22 Adam's death with this type of fluid; is that right?  
23 A. That would appear to be so.  
24 Q. You also knew, because you'd been told, that Raychel's  
25 death was associated with Solution No. 18. That's part

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1 Dr Nesbitt's evidence is that he discussed Raychel's  
2 case because that was so raw with him at that meeting.  
3 A. I think even after -- up until recently, we -- myself  
4 and my colleagues -- did see Adam's death as being  
5 different. Raychel did die post-operatively, Adam had  
6 polyuria. There were similarities, they were both  
7 children and they received Solution No. 18. Adam  
8 received Solution No. 18 as a bolus in a unique  
9 situation of polyuria and I've accepted that. I don't  
10 believe Raychel received a bolus. I think the  
11 pathogenesis, the disease process, that led to Raychel's  
12 death was more akin to the papers that were coming out  
13 from lesson of the week and Arieff. I still obviously  
14 was having a problem accepting that Adam had died by  
15 that mechanism.  
16 So in some ways, I agree with you, I had established  
17 a link by 1 November 2001, but I still think perhaps  
18 there was some differences between the two cases that we  
19 had already learnt our lesson from the coroner's inquest  
20 about Adam's death in terms of changing the blood gas  
21 analyser, giving better sodiums in the theatre and  
22 improving our management of major surgery  
23 intraoperatively. I think what Raychel's death was  
24 highlighting was the fact that that was a child who had  
25 gone through surgery and survived anaesthesia and was

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1 of the trigger of getting the meetings going.  
2 A. Yes.  
3 Q. So did you ever make a link between Adam and Raychel in  
4 terms of surgical cases where Solution No. 18 had played  
5 a role?  
6 A. Um ... I don't really understand what --  
7 Q. Did you make a link between Adam and Raychel, two  
8 paediatric deaths, surgical cases, if I use that  
9 expression, where Solution No. 18 had been implicated in  
10 the death? Did you make a link between those two?  
11 A. I can't remember.  
12 MR UBEROI: If I might assist, in fairness, he's making the  
13 link in the very text that's on the screen. It's  
14 a yellow card with regard to Raychel Ferguson and he has  
15 put the text which has already been put to him.  
16 THE CHAIRMAN: Yes, I think Ms Anyadike-Danes is accepting  
17 that that's the link which was made in 2001 and what  
18 she's asking is: at what point prior to that, between  
19 June and November 2001 --  
20 MR UBEROI: I'm sorry, I thought the question was "Did you  
21 make a link?" rather than "When did you make the link?"  
22 A. I don't remember.  
23 MS ANYADIKE-DANES: Because if you had made a link earlier,  
24 then that's all the more reason to have mentioned that  
25 case during the course of the September meeting.

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1 now in a post-operative position, was now going through  
2 the ADH double whammy response.  
3 I don't think I associated the double whammy  
4 response with the death of Adam at this stage. So  
5 there's some similarities but there's also some  
6 differences that I think I still get confused about.  
7 Q. Whatever the differences between them, what you have  
8 identified here is a common feature, which is in both  
9 those deaths Solution No. 18 was implicated.  
10 A. Two deaths.  
11 Q. And the simple point that I was putting to you is that  
12 if you had appreciated that by the beginning  
13 of November 2001, had you appreciated that  
14 by September 2001?  
15 A. I don't know. I can't remember the date I started  
16 appreciating that.  
17 Q. Sorry, giving a date probably doesn't help. Had you  
18 appreciated, before you went to the meeting, that  
19 Solution No. 18 was implicated in Adam's death?  
20 A. I don't know. I think when I spoke to Dr Carson,  
21 I would have known about Adam's death and Raychel's  
22 death amongst those five to six deaths that he has  
23 picked up from our conversation.  
24 Q. Yes.  
25 A. I am certainly sure that Adam's death and Raychel's

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1 death would have been among those two. They were the  
2 only two deaths in Northern Ireland that I was aware of  
3 at that time.  
4 Q. Thank you very much. If we then go to the actual minute  
5 of the meeting. It's 007-048-094. The chairman has the  
6 clinicians who are from the hospitals who are involved  
7 in this investigation in terms of children who have  
8 died. There's yourself, of course. Dr Lowry,  
9 Dr Nesbitt, Dr Marshal and Dr Crean are all in that  
10 category. Leaving aside the introduction, when you are  
11 recorded as informing the meeting about the background  
12 and incidence of cases seen in the Children's Hospital  
13 and patients who are particularly at risk of  
14 hyponatraemia, what are you drawing on in terms of  
15 conveying the incidence of cases? You don't have your  
16 PowerPoint presentation, imperfect as it was, so what  
17 are you drawing on to convey that?  
18 A. Well, I can't remember. I speculate that I was trying  
19 to draw on some of the basic research in terms of the  
20 bar chart that we'd gathered, that they seemed to be  
21 increasing over 10 years and that was in keeping with  
22 the number of case reports or papers coming through. So  
23 I think, as I said earlier, what I was trying to do was  
24 make sure that any information I gave to this working  
25 party was to say, "This is a real problem in

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1 near misses. They did end up in PICU, they did end up  
2 with what we think is dilutional hyponatraemia. We know  
3 that one of them certainly highlighted as a death in  
4 1997 probably wasn't hyponatraemia, although he was  
5 a coroner's case, the coroner would have -- he was  
6 referred to the coroner, certainly, at that time. So  
7 although he came up on the bar chart as a death with  
8 hyponatraemia as another diagnosis -- I'm trying to be  
9 very careful about not identifying the patient. We know  
10 from the bar chart, in a redacted way, that it was  
11 a death, it was a coroner's case, it was a tragic death  
12 of a child. Hyponatraemia was present at some stage  
13 during his intensive care admission.  
14 I don't think what I was trying to convey was my  
15 knowledge of his death or Raychel's death or Adam's  
16 death. I believe what I was trying to convey was that  
17 we were having a trend in general terms, spiky as it is,  
18 but a trend over a 10-year period, confirmed by my very  
19 rapid contacting other colleagues in English and  
20 Canadian hospitals, which was coming back to say that,  
21 yes, we're now hearing about cases coming through,  
22 seriously ill children coming through. These weren't  
23 just children with a low, you know, slightly low sodium,  
24 these were children who were coming to intensive care  
25 and that that was what I was talking about by incidents,

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1 Northern Ireland as well as globally --  
2 Q. Yes.  
3 A. -- and we need to get on with the guidelines". I think  
4 that was the point.  
5 Q. I understand that's the tenor of it, but if you're  
6 actually talking about the incidence of cases, the  
7 implication, the most natural thing in the world is,  
8 apart from referring to papers and articles and so  
9 forth, the most natural thing in the world is to talk  
10 about actual cases in which you have been involved. As  
11 I put to Dr Crean when he was giving his evidence, most  
12 of the clinicians, when asked to deal with an area that  
13 I've explored with them, have different examples from  
14 their actual experience because that's the most natural  
15 thing to do. So if you are being recorded here as  
16 giving the incidence of cases seen in the  
17 Children's Hospital, even if you don't identify by  
18 name -- and I can quite understand that -- are you not  
19 seeking to convey actual cases of which you either have  
20 direct knowledge yourself or of which people have told  
21 you about?  
22 A. I honestly don't see it that way. I see it in terms  
23 that this is a growing problem, there's more than one or  
24 two deaths, this is down to a rising number of cases  
25 which could, some people have said, be classified as

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1 not why should we discuss one case and go through the  
2 minutiae, if you like, of that patient's management,  
3 which would have distracted perhaps.  
4 When I sit on this committee, time is limited and my  
5 knowledge of sitting on working parties is there's  
6 a real need to progress the guidelines, and if you hold  
7 them back by -- if there's an argument that develops and  
8 somebody says, "That is not true, that patient didn't  
9 die of that cause", or, "That patient did die", it  
10 distracts the team and, as I said, the composition of  
11 the team was directed towards developing a guideline,  
12 not to go over a death that might have already been  
13 subject to a coroner's inquest.  
14 Q. Did Dr Nesbitt discuss Raychel's death?  
15 A. I believe he brought Raychel's death up. I know that  
16 because a volunteer was asked to yellow card Raychel's  
17 death.  
18 Q. Yes. So he did discuss Raychel's death?  
19 A. He must have discussed it.  
20 Q. Yes, and if he was bringing that death as part of the  
21 significance of this thing, a child has died, this is  
22 real, we need to do something about it, did that not  
23 prompt anybody else to say, "Well, actually, we've had  
24 a child die as well"?  
25 A. Apparently not.

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

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1 group on the 26th, but then there was a subgroup, which  
2 moved on afterwards, which Dr Taylor wasn't a part of,  
3 and I wonder whether that distinction might be relevant.  
4 I simply wish to place it before you --  
5 THE CHAIRMAN: It may also be journalistic bluff.  
6 MR UBEROI: Absolutely, sir.  
7 MS ANYADIKE-DANES: I refrain from putting the first  
8 question, because if he wasn't there, he's unlikely to  
9 be able to help us on what was discussed.  
10 Then you had said before that you weren't aware of  
11 any guidelines at all. Can we have back up the minutes?  
12 007-048-094. This is recording your contribution to the  
13 discussion, and then you say:  
14 "Fluid replacement in children is complex and while  
15 guidelines are in place for acute management, chronic  
16 management is not as well covered."  
17 What did you mean by "guidelines for acute  
18 management"?  
19 A. I think that's the APLS guidelines for resuscitation  
20 fluids that I was referring to. It could only have been  
21 that because there were no -- and I have to say again  
22 that Dr Crean and myself, we have been to many  
23 committees and Dr Crean has certain -- one of the  
24 phrases I've learnt from Dr Crean, as my senior  
25 colleague over the years, is, "Bob, don't re-invent the

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

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1 wheel". And when we go to a meeting, we're busy people,  
2 and Dr Crean is very quick to say, "Let's not re-invent  
3 the wheel here. Let's pick the guidelines that the  
4 Royal have and slot them in here and make them  
5 department guidelines". That didn't happen because I am  
6 certain we did not have written guidelines for the  
7 management of post-operative or medical fluid in the  
8 Royal Belfast Hospital for Sick Children prior to the  
9 working party's guidelines. I'm very convinced of that.  
10 THE CHAIRMAN: Okay, thank you very much. That fits.  
11 A. But there were APLS guidelines, which every doctor in  
12 Northern Ireland had access to, every paediatric doctor.  
13 MS ANYADIKE-DANES: Yes. Ultimately, the guidelines didn't  
14 require the actual mention of Solution No. 18 by name.  
15 A. Well, I wasn't part of --  
16 Q. You have seen --  
17 A. The wall chart?  
18 Q. Yes. You have seen the product.  
19 A. The wall chart didn't mention the ban of No. 18, that's  
20 correct.  
21 Q. And that was something with which you had a concern  
22 about; would that be fair?  
23 A. I think that was well-known.  
24 Q. In fact, when you write to the coroner, 064-004-033, on  
25 23 February 2003, so this is after they've come out, and

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1 you're providing feedback from your notification of  
2 Raychel's death to the MCA. You say that:  
3 "Several members of the committee were not happy  
4 that Solution No. 18 should be banned. Others, like  
5 myself, were adamant that this fluid should be named and  
6 shamed so that clinicians would only use it if there was  
7 a clinical indication."  
8 Like, for example, the cases that were always  
9 specialist cases. But the expression used is "named and  
10 shamed". I beg your pardon, I think it's actually on  
11 the next page.  
12 A. Yes, I read that.  
13 Q. Yes. Can you see it? It's point number 1, the last  
14 three lines of point 1:  
15 "Several members ... Others like myself were  
16 adamant this fluid should be named and shamed."  
17 And that's a view that you had really from the  
18 outset when there was an issue as to whether the choice  
19 of fluid should be included in the guideline or not;  
20 is that correct?  
21 A. Yes. I believe so.  
22 Q. Yes. And the others who shared that view, amongst that  
23 group, one of them was Dr Nesbitt; isn't that right?  
24 A. From what I've read in his transcript, that's correct.  
25 Q. Yes. In fact, just to outline the point or underscore

1 Q. Why I'm putting this to you is when they are making this  
2 case for how Solution No. 18 should be treated, they  
3 specifically refer to the death they've had. That, as  
4 far as they're concerned, makes it very important that  
5 appropriate reference to Solution No. 18 is given. But  
6 you also, by this time, have linked Solution No. 18 with  
7 Adam's death. Is there any reason why, when you were  
8 communicating with either the Medicines Control Agency  
9 or anyone else, for that matter, that you weren't also  
10 saying, "It's not just a matter of an incidence of  
11 difficulties with Solution No. 18. I personally know of  
12 a child's death in which that fluid was implicated",  
13 in the same way that Dr Nesbitt does?  
14 A. I can't recall.  
15 MR UBEROI: Sir, is I understand it's an important question,  
16 but strictly for accuracy, we've seen the correspondence  
17 earlier where he does mention it to the coroner,  
18 Mr Leckey.  
19 MS ANYADIKE-DANES: You can't think of why you wouldn't have  
20 done that?  
21 A. No.  
22 Q. During the discussions in terms of what should be the  
23 detail, if I can put it that way, on the guidelines,  
24 this is Altnagelvin's position about that. You have  
25 your own view about that and I'm only asking you why, in

1 the point, can we pull up next to each other  
2 095-010-046bo and, alongside that, 007-003-005.  
3 So this is the Altnagelvin group. So Dr Fulton  
4 there, medical director, is writing to his  
5 chief executive. They've got the intravenous fluid  
6 draft guidelines at this stage, this is  
7 14 November 2001:  
8 "I have told Dr Nesbitt that I think the 'Choice of  
9 fluids' section is totally inadequate considering the  
10 gravity of our local experience. As Geoff says, it's  
11 a fudge and fails to address the use of No. 18  
12 Solution."  
13 Then if we go over the page you can see an e-mail  
14 from Dr Nesbitt himself to Miriam McCarthy. He is  
15 speaking of his disappointment of the plan to drop the  
16 reference to Solution No. 18:  
17 "What evidence do you need exactly? We had a child  
18 who died and for that reason I feel strongly that No. 18  
19 Solution is an inappropriate fluid to use."  
20 So they appear to be supportive of your position  
21 that Solution No. 18 needed to be named and shamed on  
22 the guidelines in some way; is that correct?  
23 A. Or I was supportive of their position.  
24 Q. Or you were supportive of theirs.  
25 A. Yes, that's correct.

1 order to strengthen your view, you too aren't making the  
2 case to the other members of the working party that  
3 you have a direct knowledge of a child who died with  
4 Solution No. 18 being implicated?  
5 A. I can't explain.  
6 THE CHAIRMAN: To be fair to the doctor, that might at least  
7 in part depend on the number of meetings he's at to  
8 press that issue.  
9 MS ANYADIKE-DANES: Yes. Then if I come to that slightly  
10 out of order, but I can come to it. You, I think, said  
11 that although you attended that first meeting, you  
12 weren't involved in the design group or those who were  
13 establishing the smaller group to take away and actually  
14 draft the guidelines; that's correct, isn't it?  
15 A. That's correct, yes.  
16 Q. That decision was made at the meeting of 26 September  
17 itself. It's on the second page of the note, we don't  
18 need to pull it up. It simply says:  
19 "It was decided that a small group should undertake  
20 the drafting of guidelines and audit protocol."  
21 Do you know whether it was decided then who should  
22 be in that small group?  
23 A. No.  
24 Q. You know it's not going to be you.  
25 A. Yes.

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

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

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1 you tend to get sidelined, and maybe that's why I wasn't  
2 offered ... I didn't refuse -- I don't think I was  
3 offered the chance. I wouldn't have turned it down,  
4 I don't think.  
5 Q. Yes. Then just because I'm asked to do this, and it  
6 might help, although I think we've had the point,  
7 007-048-095. This is the second page of the note. If  
8 you see at point 3:  
9 "A general discussion then followed on the  
10 management of children in hospital."  
11 In that general discussion, was there any discussion  
12 about actual cases? Not by name, I mean, but actual  
13 cases.  
14 A. I can't remember. I think if other cases apart from  
15 Raychel had been discussed there would have a demand to  
16 yellow card more than Raychel. It's just circumstantial  
17 evidence, I don't remember. There was just general  
18 discussion involved, but it does say the issues were  
19 highlighted, so I presume that is what the discussion  
20 was about.  
21 Q. Just to clarify something that your counsel, Mr Uberoi,  
22 said when I was putting questions to Dr Crean, he  
23 suggested -- the first page which talks about:  
24 "... calculation of replacement fluid can be  
25 calculated in a number of ways, either on an hourly

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1 A. No, I didn't attend any further meetings after  
2 26 September.  
3 Q. So is your involvement confined to that first meeting on  
4 26 September and the e-mail traffic when you're  
5 commenting on various parts of the draft that will  
6 ultimately be the guidelines?  
7 A. I believe that's correct.  
8 Q. Thank you. You are, though, subsequently invited to  
9 take part in another exercise. You get a letter from  
10 Miriam McCarthy, and the reference for it, we don't need  
11 to pull it up, is 007-955-123. You receive a letter on  
12 12 August 2004, which is further to an earlier letter of  
13 5 July. Maybe it would help you to see it. Sorry,  
14 I don't mean to keep you in the dark. 007-055-123. She  
15 says she has received helpful comments on the current  
16 guidance and suggestions regarding amendments. If  
17 I just pause there. Do you know what she meant by that?  
18 A. I think it turns up again in another paper to say that  
19 they wanted to update the guidelines around 2004.  
20 Q. Yes.  
21 A. But I felt that was by e-mail, but I can't be sure.  
22 I don't remember attending another meeting. Maybe I was  
23 unavailable, I can't remember.  
24 Q. Just to help you, Dr McAloon had conducted a review of  
25 compliance with the guidelines.

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

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

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

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

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

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

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

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

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1 that has been given during this inquiry.  
2 THE CHAIRMAN: Thank you, Mr McAlinden. I hope that that  
3 adds to whatever else the families are getting from the  
4 inquiry. Thank you.  
5 Mr Coyle, any questions? Mr McAlinden, Mr Lavery,  
6 Mr Uberoi?  
7 MR UBEROI: No, thank you, sir.  
8 THE CHAIRMAN: Mr Quinn?  
9 MR QUINN: I have one, sir.  
10 Dr Taylor, I just want to go back on your knowledge  
11 of Claire Roberts again --  
12 MR UBEROI: Sorry, as a starting point, I would be grateful  
13 if these questions could be put through the chairman, as  
14 is the style.  
15 THE CHAIRMAN: It goes through me, Mr Quinn. Without any  
16 disrespect to Mr and Mrs Roberts, I want to make sure  
17 we're not covering any issues which have not already  
18 been covered both before and after lunch.  
19 MR UBEROI: I would be grateful for that as well, sir.  
20 MR QUINN: I won't ask any questions, sir.  
21 THE CHAIRMAN: Let me explain this so that Mr and  
22 Mrs Roberts understand. I understand that during the  
23 morning and over lunch, Ms Anyadike-Danes had raised  
24 with her, on behalf of the family, some issues which  
25 were then raised by her in her questioning of Dr Taylor.

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1 School; is that correct?  
2 A. Yes.  
3 Q. And that used to be Raychel's old school?  
4 A. Yes.  
5 Q. Were you there when she was there?  
6 A. Yes.  
7 Q. I want to take you back to the early hours of the  
8 morning of Saturday 10 June. This is when you're first  
9 contacted after Raychel's collapse. How do you know  
10 that something untoward has happened to Raychel?  
11 A. Well, my sister, Marie, rang me, about quarter past four  
12 or so in the morning, around that time, to say that  
13 something had happened to Raychel and she was very sick.  
14 And is there any way that I could come over. So I left  
15 immediately, which takes about 10 minutes to get there.  
16 THE CHAIRMAN: Sorry, was that to your sister's home or  
17 Altnagelvin?  
18 A. Altnagelvin Hospital.  
19 THE CHAIRMAN: Thank you.  
20 A. When I arrived there, I found Marie sitting on the floor  
21 in the corridor, crying, and I asked her what had  
22 happened and she said that she just knew that there was  
23 a seizure or something. And I asked her did she see  
24 Raychel, and she said no. And I asked her then, "Where  
25 is she?", and she said, "She's in that room there". So

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1 Those issues having been raised and some of the answers  
2 having been probed, I'm not going to allow, because  
3 we haven't allowed it with any other witnesses, going  
4 back over the same ground again. Okay?  
5 Doctor, thank you very much for coming back. You're  
6 now free to leave. Thank you.  
7 (The witness withdrew)  
8 We'll take a break, ladies and gentlemen, for a few  
9 minutes and then we'll hear from Ms Doherty.  
10 (3.00 pm)  
11 (A short break)  
12 (3.30 pm)  
13 MRS KAY DOHERTY (called)  
14 Questions from MS ANYADIKE-DANES  
15 MS ANYADIKE-DANES: Good afternoon. Mrs Doherty, you have  
16 made a statement for the inquiry, for reference purposes  
17 it's 326/1, and it's dated 20 June 2013. Do you wish to  
18 have that as your evidence together with anything that  
19 you say today?  
20 A. Yes.  
21 Q. Thank you. You are Raychel's maternal aunt; is that  
22 right?  
23 A. Yes.  
24 Q. And just in terms of what you do, you're a cook with the  
25 Western Education Library Board for St Patrick's Primary

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1 I opened the door and went in to find a bed with a lot  
2 of people standing around it, not doing anything or  
3 saying anything, but just standing. There was a gap  
4 where I looked through and I seen Raychel lying, she  
5 was -- with a tube down her throat and wires and her  
6 eyes were slightly open. That's all I can say. It was  
7 awful.  
8 Q. Did anybody say anything to you when you approached?  
9 A. No. Nobody said anything at all. Nobody even moved.  
10 People were just standing there. And I just walked out.  
11 Q. And what happened then?  
12 A. Marie asked me, "Is she all right? What's happening?",  
13 and I just ... I had to sort of take a couple of  
14 minutes to think. When I seen Raychel, I'm not  
15 a medical person, but I knew that Raychel was dead. So  
16 when I came out of that room, and I looked at my sister  
17 and thought, "This is not good". So I told her that I'd  
18 seen her and she had tubes in, whatever, and then I just  
19 sort of thought, "Right, this is not good". I had to  
20 sort of talk to myself and think what I'd do or what I'd  
21 say. I didn't want to tell her that I thought that  
22 Raychel was dead because how would I know that? But  
23 that's the looks -- that was what the look to me was  
24 like.  
25 So then it was around that time then -- I think it

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

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

13 A. Do you mean me or my sister?

14 Q. Yes.

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

18 Q. Why was that?

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

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

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1 like that?

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

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

7 A. No.

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

10 A. Very well.

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

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

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

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

9 Were you there for that discussion?

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

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

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

21 Q. That's what you remember?

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

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

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

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

8 A. Yes, I do, yes.

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

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

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

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

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

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

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1 been taken in. And Mr Nesbitt was -- as I now know who  
2 it was -- was getting into the back of the ambulance,  
3 and he just said to me as we were passing, "She's in the  
4 best place". So we went on in. I think we went  
5 upstairs and we were there -- we went to go in through  
6 the double doors, but I think it was maybe a nurse said  
7 that "We will call you, it will take us maybe up to 40,  
8 45 minutes to get Raychel set up and settled, but we'll  
9 call you as soon as we're ready". But it only took  
10 about, maybe, 35 to 40 minutes we were waiting, and  
11 there was, I take it, a doctor came out, and he just  
12 said that Raychel is very ill, this is very serious and  
13 I am not giving you any false pretence, this is not  
14 looking good, but until the neurologist comes in -- the  
15 neurologist will come in and speak to you, but I don't  
16 want to give you false pretence. He says he should be  
17 here shortly and that was it.

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

22 A. No.

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

24 A. No.

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

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1 there for the results of that?

2 A. No, I stayed the whole time.

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

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

6 Q. I understand.

7 A. I can't ...

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

11 A. Yes.

12 Q. Do you remember doing that?

13 A. I remember ringing him, yes.

14 Q. We can pull up his memo of it to help you. It's  
15 014-001-001. That's his memo. Firstly, why did you  
16 contact Mr Millar?

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

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

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

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

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

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

20 Q. Of course.

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

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

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

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

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

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

17 A. Yes.

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

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

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1 a clear mind of having that --  
2 Q. That's all right. It is perfectly understandable. Can  
3 you see all these points that he's noted from that  
4 telephone conversation?  
5 A. Yes.  
6 Q. Do you think these points are matters that you might  
7 have raised or matters that he might have found out  
8 independently once he knows the name of the child?  
9 A. Well, I have no doubt that I would have pointed ...  
10 Q. So if I can give you an example of that. For example,  
11 would you have been able to tell him that the morning  
12 after her operation she was in good form? Would you  
13 have been in a position tell him that?  
14 A. Yes. And the reason I would have done that -- my sister  
15 worked at that time in one of our outlying centres so  
16 she rang me that morning at ten to, five to eight to say  
17 she wouldn't be coming to work. Raychel had been  
18 through the operation and she says, she's up and she's  
19 in good form, but she says, I'm not coming to work today  
20 because I'm going over to hospital. So everything  
21 I would have had -- that information.  
22 Q. I understand. Then you see:  
23 "After lunch, she vomited [and then in brackets]  
24 blood in vomit and complained of sore head."  
25 Even if you leave aside the timing, would you have

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1 but I have to go back to hospital, Raychel has been so  
2 sick all day", and she described the vomiting, non-stop  
3 vomiting. And she explained that Ray had been on the  
4 phone and she said, "He's really cracking up because  
5 Raychel is crying with pains in her head and there's  
6 nobody taking them on".  
7 At that time, I said to her, "Well, go over and tell  
8 them that you want to know why -- why Raychel is so  
9 sick. If it was a simple operation, she'll be okay".  
10 My words to her were, "Sure when I spoke to you at ten  
11 to eight this morning, you told me she was okay", and  
12 she said, "But she was okay at ten to 8 this morning,  
13 she was fine, she was able to walk down the corridor  
14 with Ray", but she said, "By the time I got there then,  
15 by the time it came to lunchtime, she was just getting  
16 sicker and sicker".  
17 I still think -- at times I think to myself now  
18 maybe I should have went over, maybe if I had went over,  
19 would things have been different? Because they'd had  
20 a long day of Raychel being sick and I always ask myself  
21 that question. Maybe if I'd been there, maybe if I'd  
22 have said "Is there nobody else that can tell us or  
23 answer us as to why Raychel is so sick?"  
24 Q. Can you remember what you did as a result of your  
25 conversation, what information Stanley Millar gave you,

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1 known either directly or from your sister or  
2 brother-in-law that Raychel had been vomiting with some  
3 blood in her vomit and that she had complained of a sore  
4 head?  
5 A. Well, on the Friday that Raychel took sick my sister  
6 rang me -- it was around, I think, maybe ... It was  
7 after school time, half four, or whatever, and we were  
8 on the phone and she told me about Raychel complaining  
9 first of all about this pain. And while we were on the  
10 phone, we were saying, "We'll give her a pillow and  
11 a wee blanket, sometimes that's all that happens, that's  
12 all she needs". But then later on then, she  
13 contacted -- I just need to get this right. This was on  
14 the Thursday that this happened. So she left me  
15 a message saying -- just to say she'd taken Raychel  
16 because she didn't get any better. And then later that  
17 night, then, just to say that Raychel was kept in, we'll  
18 speak in the morning. Then she rang on the Friday  
19 morning to say that everything was over, she had her  
20 appendix out, and on that day I said to her, "Well,  
21 after work, my husband and I had something to do in  
22 Larne, and we were going to Larne, but keep me posted  
23 and I'll talk to you when I come home". So we were home  
24 around half eight that night, quarter to nine, and just  
25 as we got in the door she rang and she said, "I'm home,

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1 and what was done as a result of it?  
2 A. I have absolutely no idea as to what ...  
3 Q. If you look there at the bottom, he has there the advice  
4 he gave you, and two parts of that --  
5 THE CHAIRMAN: Just before you get there, Ms Anyadike-Danes.  
6 Do you see, Mrs Doherty, all the arrows, point after  
7 point, down that page?  
8 A. Yes.  
9 THE CHAIRMAN: And the line below that says:  
10 "Note: sodium level checks in Altnagelvin.  
11 Six-hourly in RBHSC."  
12 Can you remember, is that information that you gave  
13 to Stanley Millar?  
14 A. No, that wouldn't mean anything to me.  
15 THE CHAIRMAN: Okay, thank you. And then Ms Anyadike-Danes  
16 was then going to ask you about the bottom four bullet  
17 points, which are Stanley Millar's advice:  
18 "To go to solicitor with an allegation of  
19 negligence."  
20 And that would mean that it wasn't a National Health  
21 Service complaint. Do you remember him advising you  
22 like that?  
23 A. Now that I see that --  
24 THE CHAIRMAN: If you don't remember, don't start trying to  
25 guess, but does it ring a bell?

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

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

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1 A. No, I wasn't.  
2 Q. Thank you very much. Then those two items that are  
3 ticked at the bottom of the page, do you have any  
4 recollection as to whether the reason they're ticked is  
5 because there had been some sort of agreement that  
6 that's what would happen, that would be the action, or  
7 do you just not know why they're ticked?  
8 A. I don't know.  
9 Q. Thank you. Just to be clear on it, leaving aside  
10 whether you knew how often sodium checks were done  
11 at the Children's Hospital, did you have any knowledge  
12 about there being an issue about whether or not sodium  
13 checks had been done of Raychel before she died? Were  
14 you aware of that?  
15 A. No, no.  
16 Q. Then if I can now take you to the meeting of  
17 3 September. When did you first know that there was  
18 going to be a meeting between your sister, and whomever  
19 she might take for support, and the trust?  
20 A. I couldn't give you an exact date. It's something that  
21 was talked -- that she wanted to find out.  
22 Q. Yes. Was it something that you understood your sister  
23 to want, to want now to meet with the people at  
24 Altnagelvin?  
25 A. Yes, yes. She told me she wanted to find out what

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

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

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

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

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

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

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

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

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

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1 Q. Whatever it was that they said, it didn't penetrate to  
2 you so that you can understand why Raychel had died?  
3 A. That's right.  
4 Q. And that's what you wanted out of that meeting?  
5 A. Yes.  
6 Q. Did anybody ask you whether you had understood the  
7 medical discussion that was going on or the reasons that  
8 were being given to you?  
9 A. No, but I didn't really feel that there was such a big  
10 discussion going on.  
11 Q. The point that you make about the unusual response,  
12 Mrs Doherty. Dr Nesbitt does go on to refer to that.  
13 He says:  
14 "We explained that the treatment that Raychel had  
15 received had been the same as countless other children  
16 and they had received exactly the same type of fluid.  
17 We said that in Raychel's case she might have had an  
18 unusual response in that she retained free fluid,  
19 causing her brain to swell."  
20 Then he goes on to say -- sorry, I should tell you  
21 where I'm reading from. I'm reading from later on in  
22 witness statement 035/2, at page 22. Then he goes on to  
23 say:  
24 "The family did ask about the vomiting and the  
25 headache and the nursing staff who were there had said

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1 THE CHAIRMAN: Just remind me, is that point by Dr Nesbitt  
2 from his evidence or from the notes?  
3 MS ANYADIKE-DANES: That's from his witness statement,  
4 Mr Chairman.  
5 THE CHAIRMAN: Is it in the notes? Do the notes record  
6 anybody saying that they would review the frequency of  
7 blood tests?  
8 MS ANYADIKE-DANES: I don't think so, but I'll have a quick  
9 scan through.  
10 THE CHAIRMAN: Okay. We don't need to delay now.  
11 MS ANYADIKE-DANES: He says the bit about the fluids,  
12 Mr Chairman, that's on 022-084-223. That's where he  
13 says about the fluids are standard across the country  
14 and:  
15 "We may have to change these if children are getting  
16 too much sodium. There has to be a middle ground.  
17 Nothing we were doing was unusual."  
18 One of the concerns that you had and your sister had  
19 was that, given what was told to you about Raychel when  
20 you were at Altnagelvin and what you discovered shortly  
21 after arriving at the Children's Hospital, your concern  
22 was that effectively you travelled with false hope. You  
23 thought that something could be done, might be done, and  
24 that you might just be two or three weeks away from  
25 finding out whether Raychel would be brain damaged or

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1 that the vomiting had not worried them unduly and it was  
2 a common thing after surgery. I explained that headache  
3 is also a common finding in children post-operatively."  
4 Although that's in more technical language, is that  
5 the sort of exchange that was happening?  
6 A. I would agree with that, yes.  
7 Q. Did anybody explain to you how any of that fitted with  
8 what you and your sister understood about the trickle of  
9 blood in the brain and the possibility of surgery at the  
10 Children's Hospital?  
11 A. No.  
12 Q. Did anybody mention the blood on the brain?  
13 A. I don't recall it being mentioned at that meeting.  
14 Q. Dr Nesbitt goes on to say that he said:  
15 "We would have to review procedures to ensure that  
16 blood tests were done pre and post-operatively, and that  
17 it might be needed to be more frequently than this."  
18 Was there any mention of the fact that it might have  
19 helped if Raychel's blood had been tested more  
20 frequently? Was there any of that discussed so far as  
21 you can recall?  
22 A. Not that I can recall.  
23 Q. And even if it was discussed, did you understand the  
24 significance of that, why that might be important?  
25 A. Not really, no.

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1 not. Did you still feel at that meeting that you had  
2 travelled in false hope or your sister had?  
3 A. Yes, I did.  
4 Q. Did you convey that to them or did you say that?  
5 A. I would say I probably did, because it was always  
6 something that was there, but I can't just be  
7 100 per cent.  
8 THE CHAIRMAN: Your view, from the moment you saw Raychel,  
9 when you went into that room, was that she wasn't going  
10 to survive?  
11 A. Yes.  
12 THE CHAIRMAN: And when you got down to Belfast and you were  
13 told there by the doctors what you have just told me,  
14 did that confirm to you that your initial impression was  
15 right?  
16 A. Yes. Most definitely. And that was my first -- why did  
17 Altnagelvin put us through this and send us the whole  
18 way here and it only took 40 minutes to be told that the  
19 hopes weren't good and possibly an hour to be told that  
20 it definitely wasn't good, there was no going back.  
21 MS ANYADIKE-DANES: I'm going to put to you Dr McCord's view  
22 when he gave evidence as to that meeting to see the  
23 extent to which that accords with what you thought was  
24 happening.  
25 Just before that, Mr Chairman, you'd asked whether

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

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

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

12 A. No.

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

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

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

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

6 A. No, just a rare thing.

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

10 A. No.

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

14 A. Do you mean at this meeting?

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

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

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

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

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

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

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

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

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

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

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

19 THE CHAIRMAN: Thank you.

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

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1 up alongside each other, 226-002-006. The second is  
2 226-002-008.  
3 If we go to the first one, which is the latter part  
4 of paragraph 16, you'll see it at the top of the  
5 left-hand side, he's expressing the view that:  
6 "It is clear that the doctors and nurses present at  
7 that meeting suspected the use of Solution No. 18 after  
8 an operation and failure to check on electrolytes while  
9 on intravenous fluids, and these were discussed openly  
10 with the family in September."  
11 Do you think you did have an open discussion with  
12 them or they had an open discussion with you about that?  
13 A. No, they most definitely did not.  
14 Q. Then let's go to some of the things that he thinks are  
15 deficiencies in the way that meeting was conducted. He  
16 said:  
17 "Failings in the accurate recording of fluids  
18 administered and to measure urine and vomit output  
19 properly that were important factors do not appear to  
20 have been discussed."  
21 If I pause there, is that right? In your view, were  
22 those things discussed?  
23 A. No, at the meeting, no.  
24 Q. He regards them as important. Even if any of those  
25 things had been discussed, did anybody tell you: these

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1 encourages parties to resolve disputes, reduce delays  
2 and reduce the requirements for litigation, nor one that  
3 encourages staff to offer apologies and/or explanation  
4 as soon as an adverse outcome is discovered."  
5 And those things in quotations are coming from  
6 guidance. Is that your understanding that you didn't  
7 feel you were in an environment of openness where  
8 anybody would concede to you that errors, mistakes, had  
9 been made?  
10 A. Most definitely.  
11 Q. When the meeting concluded, so far as you are concerned,  
12 what was going to happen then? Not just you, but so far  
13 as you and your family were concerned, what was going to  
14 happen then?  
15 A. Well, then when we came out of the meeting, we just  
16 looked at one another and thought, "What a waste of  
17 time".  
18 Q. Did you think that at the time?  
19 A. Yes.  
20 Q. Was that just you or did your other family members think  
21 that?  
22 A. No, the family members felt the same.  
23 Q. You're a group that includes not just family members,  
24 but a family friend, a GP. Was there any discussion  
25 amongst you about what you had just experienced there?

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1 sort of things are really important and, sorry, we  
2 should have done that, we should have measured her urine  
3 or whatever; was any of that said?  
4 A. No, because no one at that meeting had any concern that  
5 Raychel was sick.  
6 Q. Then he goes on to say:  
7 "Nor was there any recognition that the worsening of  
8 Raychel's condition during the evening of 8 June was due  
9 to factors other than normal post-operative recovery."  
10 And that seems to accord with what you're saying.  
11 A. Yes, that's right.  
12 Q. Did anybody at any stage say that mistakes had been made  
13 in Raychel's care?  
14 A. No.  
15 Q. The expression "mistake" was never used?  
16 A. No.  
17 Q. Then if we look to the other side, which is  
18 paragraph 26. He talks about how matters might have  
19 been handled. If we start with the notes taken. He's  
20 saying:  
21 "The notes suggest that the matters discussed were  
22 determined by the questions asked by the family."  
23 Then he goes on:  
24 "There was no attempt by the chief executive, nurses  
25 or doctors to create an environment of openness that

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1 A. No, just that we came out and -- I came out with my  
2 sister and we both just looked at one another. I think  
3 my brother was talking to someone behind and we just  
4 felt it was a total waste of time.  
5 THE CHAIRMAN: I should know this, but would you just  
6 confirm for me, the Helen Quigley who was with you  
7 at the meeting, she's a councillor in the sense that she  
8 was a member of the city council, was that right? Was  
9 she also involved in Altnagelvin?  
10 A. I honestly don't know.  
11 THE CHAIRMAN: There was a reference yesterday to a lady  
12 called Quigley who was on the trust board.  
13 A. Well, she possibly could have been, yes.  
14 THE CHAIRMAN: Okay. If we can double-check that.  
15 When you came out and you thought it was a waste of  
16 time, did you talk after you came out of the meeting  
17 with Dr Ashenhurst?  
18 A. I can't say that I definitely remember a conversation  
19 with her. I don't.  
20 THE CHAIRMAN: Okay.  
21 A. I could safely say I probably did make my view clear to  
22 Mrs Quigley, maybe, as we walked away, that it was  
23 a waste of time.  
24 THE CHAIRMAN: Thank you.  
25 MS ANYADIKE-DANES: I think, Mr Chairman, that Mrs Quigley

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

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

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

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

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

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1 pages, and I just wonder, Mr Chairman -- I did raise  
2 this issue with Mr Quinn before Mrs Doherty gave her  
3 evidence and he assured me she would just be answering  
4 questions. I don't know what she's going to say and  
5 I don't want to stop her from saying anything. I'm  
6 conscious of the fact that she is a family member, she  
7 is Raychel's aunt, but I do have some concerns about  
8 precisely what it is she is going to say and perhaps if  
9 we had some notice of what she was going to say, that  
10 might ease it somewhat.  
11 THE CHAIRMAN: I'm not going to prevent Mrs Doherty from  
12 saying anything, but can there be some discussion  
13 between you before she says anything? If I rise for  
14 a few moments? Just allow me a few moments, okay?  
15 (4.37 pm)  
16 (A short break)  
17 (4.39 pm)  
18 THE CHAIRMAN: I understand the road is clear for you to say  
19 whatever it is.  
20 A. Okay. Mr O'Hara, this is just reflecting on the last  
21 12 years and what the management and staff of  
22 Altnagelvin have put our family through. We take no  
23 comfort in assurances given that changes have been  
24 implemented, especially as we read continually in the  
25 media about hospital failings. Will we ever see the day

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

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1 that the culture of secrecy and behind-the-door meetings  
2 will stop and families will be told the truth and not  
3 treated in the most disgraceful and humiliating way that  
4 our family have been?  
5 Mr Chairman, whatever findings come from this  
6 inquiry, we hope they will be a fitting tribute to  
7 Raychel and also to her mum and dad, who have both  
8 devoted their life to fulfil the last promise they made  
9 to their only daughter, Raychel. And that's justice.  
10 And on behalf of our whole family, I would like to take  
11 this opportunity to thank Des Doherty because we feel,  
12 only for him and the help and the belief that he had in  
13 my sister, that she might not be here today. So from  
14 all of us, Des, we would like to thank you. Thank you.  
15 (The witness withdrew)  
16 THE CHAIRMAN: Thank you very much. That brings today to an  
17 end. We have Professor Swainson tomorrow morning.  
18 We're going to sit a little bit later, 10.30, and get  
19 through the professor's evidence tomorrow. Until then,  
20 thank you very much.  
21 (4.40 pm)  
22 (The hearing adjourned until 10.30 am the following day)  
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I N D E X

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3 DR ROBERT TAYLOR (called) .....1  
4 Questions from MS ANYADIKE-DANES .....1  
5 MRS KAY DOHERTY (called) .....150  
6 Questions from MS ANYADIKE-DANES .....150  
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