Witness Statement Ref. No. WS-280/1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: ROBERT TAYLOR

Title: DR.

Present position and institution: Consultant Paediatric Anaesthetist, Paediatric Intensive Care Unit, Royal Belfast Hospital for Sick Children

Previous position and institution: Consultant Paediatric Anaesthetist, Paediatric Intensive Care Unit, Royal Belfast Hospital for Sick Children
[As at the time of the child's death]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 2000 – August 2012]

1999-2005, Sick Child Liaison Group
2001-2, Hyponatraemia Working Party
2002, Paediatric Long-term Ventilation Working Party
2003-4, Neonatal/Paediatric Interhospital Transport Working Party
2003-5, Chairman, Clinical Audit Committee, RGH Trust
2008-10, End-of life Working Party. General Medical Council, London
2002-12, Clinical Ethics Committee, RGH Trust then Belfast HSC Trust
2007-12, Clinical Ethics Committee, NI Hospice

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

N/A

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached

(1) **Please outline the processes which were available within the Royal Belfast Hospital for Sick Children in the year 2000 to facilitate investigation or review of a death, where that death was considered to have been unexpected, unexplained, or where there might have been concerns that it had arisen out of an adverse clinical incident.**

I am aware of mortality meetings that provided for the review of deaths within the Royal Belfast Hospital for Sick Children. As stated below, the goal of these meetings was to discuss every child's death for learning purposes among the clinicians present.

I do not have any knowledge of the processes involved in the investigation of deaths. It was not my role to investigate deaths in children. That would be a matter for the Trust.

(2) **Was Lucy's death investigated or reviewed under any of the processes set out in your answer at 1 above? If so, outline the nature of any investigation or review which took place and the conclusions which were reached. If no such investigation or review took place, please explain why this omission occurred.**

Regarding a review of Lucy's death it would have been my expectation that her death was presented and discussed at one of the monthly mortality meetings which were part of the Clinical Audit Meeting. This would have involved a presentation by her named Consultant and the Pathologist if a post-mortem was done followed by a discussion by the clinicians present. I can not recall what if any conclusions were reached.

I am not aware of the nature of any investigation that took place. It was not my role to investigate child deaths.

(3) *"2. Lucy's death was discussed in the mortality section of an RBHSC Audit meeting. This meeting was chaired by Dr. R H Taylor, Consultant Paediatric Anaesthetist, Paediatric Intensive Care Unit, Royal Belfast Hospital for Sick Children, 10 August 2000."* **(Ref: 061-038-123)**

Arising out of the foregoing please address the following matters:

(a) **Confirm that you chaired the mortality section of the Audit meeting which discussed Lucy's death on the 10 August 2000.**

I was the Audit Co-ordinator at this time so it would have been my expectation that I chaired this section of the Audit meeting.

(b) What was the function or purpose of the mortality section of Audit meetings?

To discuss the child's death for learning purposes among the clinicians present.

(c) How often did mortality meetings take place in the period around 2000?

Monthly, according to a Rolling Audit Calendar published by the EH&SSB

(d) Describe the process by which a particular death is identified for discussion at Audit meetings, and outline the factors that determine that a particular death will be discussed?

Every death was identified by the PICU/Audit secretary for presentation. She would have contacted the Consultant responsible for the child's care, and the Pathologist if a post-mortem had been performed, and agree a date for presentation.

(e) Who identified Lucy's death as one which ought to be discussed at the Audit meeting?

It would have been the PICU/Audit secretary who identified Lucy's death for presentation as for every child death.

(f) Why was Lucy's death discussed at the Audit meeting?

To my knowledge every child's death was presented and discussed in the mortality section of the Audit meeting.

(g) Identify all of those persons who attended that meeting and who were present when Lucy's death was discussed.

I have no records of attendance. The PICU/Audit secretary would have sent these to the Trust Audit Department

(h) Specify the documentation that was available to the meeting when the death of Lucy was discussed.

I do not know. It was usual for the PICU/Audit secretary to have the child's RBHSC notes including the letters and materials that had been transferred from the Erne, as well as investigations and post-mortem reports, to be available to the Consultant(s) presenting her case.

(i) Describe the information that was given to the meeting in relation to the death of Lucy, and identify the person(s) who provided that information to the meeting.

I do not remember what information was given to the meeting. It would have been my expectation for her death to be presented by the lead Consultant and a Pathologist as a post-mortem was performed in Lucy's case.

(j) Please outline and describe the matters that were discussed in relation to the death of Lucy.

I can not remember what matters were discussed. It would have been my expectation that the lead Consultant and Pathologist would have presented all relevant materials and answered any questions raised by the clinicians present.

(k) Clarify whether the meeting discussed the relevance of fluid management in relation to Lucy's death? If so, please fully outline the nature of those discussions. If those matters were not discussed, please explain why they were not discussed.

I can not recall if fluid management was discussed.

(l) Clarify whether the meeting reviewed the case records from the Erne Hospital? If so, please outline the conclusions, if any, which were drawn from a review of those records.

It was usual for the lead Consultant to prepare the presentation and request any relevant records. It was not usual practice for the complete medical records from other hospitals to be transferred with a patient to RBHSC. It was usual practice for a summary transfer letter and copies of relevant materials such as drug charts, X-rays and investigations from other hospitals to be included in the RBHSC medical records. It is my expectation that these materials, not the complete Erne Hospital records, would be included in the mortality presentation and thereby discussed. I can not recall if this occurred in Lucy's case or what conclusions were drawn.

(m) Clarify whether the meeting made any assessment of the correctness of the treatment which Lucy received at the Erne Hospital? If so, outline the conclusions, if any, which were reached follow any such assessment.

I can not recall if a review of the correctness of her treatment in the Erne Hospital was made at the RBHSC mortality meeting. Her Erne notes would not have been available. I do not recall what conclusions were drawn if any.

(n) Clarify whether the meeting reviewed the autopsy report which had been prepared by Dr. O'Hara, or the death certificate signed off by Dr. D. O'Donoghue? If either of these

documents were reviewed, please outline the conclusions, if any, which were drawn from them.

I can not recall if the autopsy report was presented or discussed. It was usual for the Pathologist to present the autopsy when a postmortem had been performed. The attendance record would indicate if Dr O'Hara was present at this meeting. I do not recall what discussion or conclusions were drawn from the autopsy report.

The death certificate (013-008-022) would usually be given to the Funeral Director and is not retained in the patient records. Therefore the death certificate would not have been available at this meeting.

(o) **Were any conclusions reached in relation to the death of Lucy following this discussion at the Audit meeting? If so, please outline the conclusions that were reached.**

I can not recall if there were any conclusions reached.

(p) **Were any follow-up investigations or inquiries conducted after this meeting, or was any action taken on foot of what was discussed at this meeting? If so, fully describe the investigations, inquiries or action which resulted.**

I do not know. My role was to chair the Mortality section and the Audit presentations. It was not my role to investigate child deaths.

(q) **Were the circumstances leading to Lucy's death discussed between the RBHSC and the Erne Hospital/Sperrin Lakeland Trust before or after the Audit meeting on the 10 August 2000? If so, please outline the nature of those discussions and identify the persons who participated in them.**

I was not involved in any such discussions and am not aware if there were any.

(r) **Please provide a copy of the minutes of the mortality section of the Audit meeting at which Lucy's death was discussed, and any other documentation which may have been generated as a result of the discussion of her death or actions taken pursuant to that discussion.**

I do not have any copies of the minutes of the Audit meetings. The PICU/Audit secretary would have typed the minutes and sent them to the Trust Clinical Audit Department.

(s) **Following the Inquest into Lucy's death which took place in February 2004, were the issues relating to Lucy's death revisited by the RBHSC in the context of its audit arrangements or otherwise.**

I have no knowledge of this. I stood down as Paediatric Audit Coordinator in January 2003 and handed over this role to Mr Bailie.

(4) Apart from the discussion of Lucy's death as part of the mortality section of the Audit meeting on the 10 August 2000, was her death and/or the cause of her death otherwise the subject of discussions between you and medical colleagues in the Paediatric Intensive Care Unit of the Royal Belfast Hospital for Sick Children.

If her death was otherwise the subject of such discussions please address the following matters:

(a) Who did you have such discussions with?

I do not recall any such discussions

(b) When did such discussions take place?

I do not recall any such discussions

(c) What aspects of her death and/or the cause of her death were discussed, and what views were expressed?

I do not recall any such discussions

(d) Were any conclusions reached as a result of such discussions?

I do not recall any such discussions

(e) Was any action taken on foot of such discussions?

I do not recall any such discussions and do not know if any action was taken.

(5) You have compiled a bar chart showing the incidence of hyponatraemia in the Royal Belfast Hospital for Sick Children [007-051-102]. Please clarify whether Lucy Crawford and Raychel Ferguson were included as part of the data collection for 2000 and 2001 respectively? If they weren't included in the data collection, please explain why?

There was a PICU computer database developed in the 1980's that was used for clinical audit. This was not supported by the Trust IT department. Data was entered and accessed on an "Ad Hoc" basis by the doctors and PICU secretary.

I had prepared a draft powerpoint presentation that included a table of the cases of hyponatraemia admitted to PICU, 1991-2001. The PICU secretary had acquired the information for this bar chart from these PICU computer records. The data was incomplete (1995, 1996 data was missing). This presentation was not taken forward at the next meeting of the Hyponatraemia Working Group. I did not complete the data analysis and this draft powerpoint presentation was not used.

Therefore I did not perform the computer search. I believe the death referred to in 2001 was Raychel Ferguson. Lucy's name was not identified on the PICU computer database as being due to hyponatraemia because either the computer records were incomplete or because "Electrolyte Imbalance" was not entered as a diagnosis that would permit the PICU secretary to highlight it in her search.

(6) **Insofar as you are aware, please explain the circumstances in which the Royal Belfast Hospital for Sick Children ceased the practice of prescribing Solution 18 to post-operative children, and state:**

(a) On what date was the practice of prescribing Solution 18 to post-operative children ended?

I do not know the date. I was not aware of a decision being made in such clear cut terms. Solution 18 is still available in certain controlled areas of the RBHSC and may be administered if clinically indicated under careful monitoring conditions. I believe its use was restricted by the Trust at some stage. I do not know the date when its prescription was restricted. This would be best answered by the Trust.

(b) Who took that decision?

I do not know who took that decision.

(c) What were the reasons for that decision?

I was not aware of a decision being made in such clear cut terms.

(d) Was the decision taken in response to any particular incident(s) or circumstances? If so describe the incident(s) or circumstances which brought about this decision?

I was not aware of a decision being made to cease its prescription in such clear cut terms.

(e) Was any other person or group of persons consulted before the decision was reached to end the practice of prescribing Solution 18 to post-operative children? If so, identify all of those who were consulted in relation to the decision?

I do not know.

(f) If you were consulted in relation to the decision, did you contribute any view and if so what view did you express?

I do not recall being consulted about a decision to cease its prescription although it was my view in 2001 that a Hazard Notice ought to have been considered by the Medicines Control Agency following Raychel's death but this did not happen.

(g) Was the decision by the RBHSC to end the practice of prescribing Solution 18 to post-operative children communicated to any of the following organizations or bodies:

(g.i) Any other hospital or trust;

I do not know

(g.ii) The Eastern Health and Social Services Board;

I do not know

(g.iii) The office of the Chief Medical Officer;

I do not know

(g.iv) DHSSPS;

I do not know

(g.v) Any other organization or body.

I do not know

(h) If the decision by the RBHSC to end the practice of prescribing Solution 18 to post-operative children was communicated to any of the above organizations or bodies, what were they told about the reasons for discontinuing the use of Solution 18 with post-operative children, and when were they given this information.

I do not know

(i) If the decision by the RBHSC to end the practice of prescribing Solution 18 to post-operative children was not communicated to any of the above organizations or bodies, please explain why the decision was not communicated.

I do not know

(j) If you are unable to answer any of the questions set out above (at a-i), please identify any person who may be in a position to address those questions.

I am unable to identify any such person.

(7) Please describe the functions of the Sick Children's Liaision Group in Northern Ireland, and address the following matters:

(a) When was this Group established?

1999

(b) What was its membership?

A Consultant paediatrician and an anaesthetist (responsible for children) from the main hospitals in each Board Area; Antrim (Drs McAloon and McLeod), Altnagelvin (Drs Brown and Morrow), Craigavon (Drs B. Bell and Lowry), the Ulster (Drs A Bell and

Trinder) and RBHSC (Drs Steen and Taylor) were invited to attend these meetings when they began. The members of the group altered over the subsequent years and, with attendance dwindling, the group no longer met after 2005.

(c) Was the death of Lucy Crawford discussed by this Group? If the death of Lucy Crawford was discussed please address the following matters:

I do not recall Lucy's death being discussed. The purpose of this group was to agree best practice guidelines for improving the stabilisation and transfer of children to the PICU. It was not intended as a forum for the review or investigation of child deaths.

(c.i) When was her death discussed?

As above answer

(c.ii) Why was her death discussed?

As above answer

(c.iii) Who was involved in this discussion?

As above answer

(c.iv) In what respects was her death discussed?

As above answer

(c.v) What action, if any, was taken on foot of those discussions?

As above answer

(d) Was the death of Raychel Ferguson discussed by this Group? If the death of Raychel Ferguson was discussed please address the following matters:

I do not recall Raychel's death being discussed. The purpose of this group was to agree best practice guidelines for improving the stabilisation and transfer of children to the PICU. It was not intended as a forum for the review or investigation of child deaths. I believe I informed those present that a Hyponatraemia Working Group was being set up by the DHSSPSNI following Raychel's death.

(d.i) When was her death discussed?

I do not recall her death being discussed.

(d.ii) Why was her death discussed?

I do not recall her death being discussed.

(d.iii) Who was involved in this discussion?

I do not recall her death being discussed. As in above answer, reference was made to the establishment of a Hyponatraemia Working Group.

(d.iv) In what respects was her death discussed?

I do not recall her death being discussed.

(d.v) What action, if any, was taken on foot of those discussions?

No action was taken by this group as there was likely to be forthcoming prevention of hyponatraemia guidance published by the DHSSPSNI

2/11/12