	Witness Statement Ref. No. 280/2
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: *[As at the time of the child's death]* **Consultant Paediatric Anaesthetist, Paediatric Intensive Care Unit, Royal Belfast Hospital for Sick Children**	
Membership of Advisory Panels and Committees: *[Identify by date and title all of those between January 2000 – December 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]* *2/11/2012 WS-280-1 Dr Robert Taylor*	
OFFICIAL USE: **List of previous statements, depositions and reports attached:**	
Ref: | **Date:**	

WS-280/1	02-11-2012	Statement to the Inquiry

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) Arising out of your answer to question 3(a) of WS-280/1, fully describe your responsibilities as Audit Co-Ordinator?

I believe I was responsible for ensuring that clinicians were given the opportunity to present clinical audit projects that they had completed at monthly audit meetings. I was responsible for producing the agenda and displaying it in prominent areas for the monthly audit meeting, organising tea and coffee and booking the room. I was responsible for chairing the monthly clinical audit meetings, including the mortality section, and passing the attendance record to the Trust Clinical Audit Department.

In addition, please clarify whether those responsibilities were recorded in any written policy or procedure?

I don't believe there were any written policies or procedures for this

(2) Arising out of your answer to question 3(b) of WS-280/1, was there a procedure for disseminating lessons learnt from the death of a child to clinicians other than those who attended any particular Audit meeting?

I do not recall any procedures for this.

If so, please describe that process and how it was supposed to work within the RBHSC, and outside of the RBHSC (if applicable).

(3) Arising out of your answer to question 3(e) of WS-280/1, identify by name the person who was PICU/Audit secretary in August 2000?

Mrs Maureen O'Reilly

(4) Arising out of your answer to question 3(l) of WS-280/1, where you refer to it being usual for the lead consultant to prepare the presentation. Clarify whether the lead consultant would typically be the consultant under whose care a patient was admitted?

The lead Consultant was typically the consultant who was on duty when a patient was admitted.

In addition, please clarify whether there was any expectation that the presentation would be prepared in a written form, and what was the general practice at that time?

The presentation was usually with the aid of transparencies and an overhead projector at that time. More recently Powerpoint presentations are typically used.

(5) In answer to question 7(c) of WS-280/1 you describe the purpose of the Sick Children's Liaison Group as being to agree best practice guidelines for improving the stabilisation and transfer of children to PICU.

Please clarify whether guidelines were agreed and if so, whether they were written up into a document. If document containing guidelines was created please provide a copy to the Inquiry or direct the Inquiry to where they might be obtained.

Two guidelines were agreed by this group, a Guideline on Meningococcal Disease and one for Bronchiolitis. I have recently provided these two guidelines to the Inquiry.

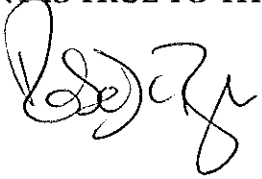
(6) Do you recognise the document at Ref: 061-005-012? If so, please explain what it refers to.

I do not recognize this document. It is not my handwriting.

(7) Please clarify the arrangements which were in place at RBHSC in April 2000 for receiving patient notes by fax from another hospital and for delivering them to relevant clinicians in PICU? Were the notes sent directly to an office within PICU, and did a member of admin staff place the notes on the patient's chart?

I do not recall what arrangements were in place for receiving a fax in PICU. I do not recall ever receiving a patient's notes by fax. It was usual for a transfer summary letter to accompany the transferred child and the patient's notes remained at the originating hospital. It was usual practice for all of the accompanying documents to be filed in the RBHSC notes.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed:  **Dated:** 15/1/13