PUBLIC RECORD

Dates: 30/05/2022 - 21/06/2022

Medical Practitioner's name:	Dr Robert TAYLOR
GMC reference number:	2619707
Primary medical qualification:	MB BCh 1982 Queens University of Belfast

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Erasure

Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Graham White
Lay Tribunal Member:	Mr John Elliott
Medical Tribunal Member:	Dr Joanne Topping

Tribunal Clerk:	Mr Josh Dayco

Attendance and Representation:

Medical Practitioner:	Not present and not represented
Medical Practitioner's Representative:	N/A
GMC Representative:	Mr Tom Forster, QC

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 15/06/2022

Background

1. Dr Taylor qualified in medicine from Queens University of Belfast in 1982, becoming a Senior House Officer in 1983. He undertook a two-year fellowship in Paediatric Critical Care and Paediatric Anaesthesia at the Hospital for Sick Children in Toronto from 1989 to 1990. Dr Taylor became a Senior Registrar in 1990 and subsequently a consultant in 1991. At the time of the events which are the subject of these proceedings, Dr Taylor was practising as a Consultant Paediatric Anaesthetist at the Royal Belfast Hospital for Sick Children ('the Hospital').

2. Patient A was born on 4 August 1991 with a congenital kidney abnormality, which resulted in renal failure. Patient A was placed on the transplant register in 1994. On 26 November 1995 he was admitted for a kidney transplant at the Hospital. He did not survive surgery and died on 28 November 1995 aged 4 years.

3. Dr Taylor was the consultant paediatric anaesthetist during Patient A's transplant surgery. He was responsible for monitoring Patient A's vital signs and managing the administration of fluid / blood. During the operation Dr Taylor administered 'Solution 18' (so called because it contains only 0.18% sodium chloride). It is a low in saline or hypotonic solution.

4. If administered excessively and/or too quickly, Solution 18, can create a dilutional effect on sodium levels in the body resulting in what is known as dilutional hyponatraemia where there is a lower than normal level of sodium in the bloodstream. If this condition is left untreated, a significant fall in sodium concentration may induce cerebral oedema, leading to raised intracranial pressure, swelling of the brain stem, coma, respiratory arrest and death.

5. During Patient A's surgery Dr Taylor administered 1500mls of Solution 18. He administered about 750mls of this fluid in the first hour of surgery. In the period immediately following the operation the treating nephrologists, Dr B and his colleague Dr D, examined Patient A and his medical notes. They both concluded he had been given too much fluid resulting in a dramatic fall in his sodium levels which caused hyponatraemia leading to cerebral oedema and brain death. Dr B notified Patient A's death to the Coroner.

6. The Coroner instructed Dr E, a Senior Registrar in Forensic Pathologist, to conduct a post-mortem. She concluded the cerebral oedema was caused by the onset of dilutional hyponatraemia. The Coroner also instructed two expert anaesthetists Dr C and Dr G. They agreed with Dr F and were of the view the hyponatraemia was the result of the administration of an excess volume of fluids containing small amounts of sodium.

7. The verdict following an Inquest held on 18 and 21 June 1996 was that Patient A's death was caused by cerebral oedema due to dilutional hyponatraemia and impaired cerebral performance suffered in consequence of an excess administration of fluids containing only very small amounts of sodium. This was exacerbated by blood loss and possibly the overnight dialysis and an obstruction of the venous drainage to the head. Dr Taylor resisted any criticism of his fluid management in his evidence to the Coroner. He robustly maintained his stance. In particular, he refused to accept Patient A had suffered dilutional hyponatraemia caused by his administration of too much of the wrong type of fluid.

8. It is alleged that there were a number of failings in Dr Taylor's pre-operative and intra-operative treatment of Patient A. In particular, Dr Taylor infused the wrong type of fluid in an excessive quantity at dramatically too fast a rate. In addition, it is alleged that Dr Taylor knew this was the true position when he provided evidence to the Coroner in which he stated the opposite was true. Accordingly, it is alleged that Dr Taylor's evidence in the Coronial proceedings, during his interview with the Police Service Northern Ireland ('PSNI') and the Inquiry into Hyponatraemia Related Deaths ('the Inquiry') was dishonest.

The Outcome of Applications Made during the Facts Stage

9. The Tribunal granted the GMC's application, made pursuant to Rules 40 and 31 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that notice of this hearing had been served on Dr Taylor and that this hearing should proceed in his absence. The Tribunal's full decision on the application is included at Annex A.

10. On 6 June 2022, Mr Forster, QC, on behalf of the GMC made an application pursuant to Rule 34(1) of the Rules, to admit further evidence, namely a transcript of Dr B's final evidence to the Inquiry into Hyponatraemia Deaths on April 2012. He submitted that Dr Taylor is aware of this transcript, and it had been disclosed to him previously. He submitted this would not cause a disadvantage to Dr Taylor.

11. The Tribunal accepted Mr Forster's submission. Dr Taylor was aware of this document and had voluntarily absented himself from these proceedings. He would not be disadvantaged if the Tribunal were to admit the document as evidence. Accordingly, the Tribunal granted the application under Rule 34(1).

12. On 15 June 2022, after the Tribunal had retired to consider its decision on the facts but before this had been delivered, Mr Forster made an application pursuant to Rule 17 (6), to amend the Allegation. He submitted that in error Paragraph 17 concluded with the words "by reason of paragraph 11d" whereas it was clear from the face of the papers that it should have referred to paragraph 12e.

13. The Tribunal considered that the error was obvious and that the amendment could be made without injustice to Dr Taylor. It amended the Allegation so that in Paragraph 17 "12e" should be substituted for "11d".

The Allegation and the Doctor's Response

14. The Allegation made against Dr Taylor is as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 27 November 1995 your pre-operative assessment of Patient A was inadequate in that you failed to:

    a. ensure you had sufficient information about fluid intake/ output by:

        i. meeting with patient A's Mother before surgery and / or;
        To be determined

        ii. reviewing Patient A's medical records;
        To be determined

b. have sufficient regard to Dr B's:

i. advice about Patient A's:

1. history of fluid Balance;
To be determined

2. propensity to hyponatraemia
To be determined

ii. request to check electrolyte concentrations prior to surgery;
To be determined

c. obtain Laboratory arterial blood gas sample to check for electrolyte concentrations as soon as the arterial catheter had been sited;
To be determined

d. accurately calculate the pre-operative fluid balance in that you estimated patient A's:

i. fluid deficit on arrival in theatre as 400mls;
To be determined

ii. required maintenance rate as 200mls per hour;
To be determined

iii. rate of normally hourly urinary output on a fixed basis.
To be determined

2. On 27 November 1995 your intra-operative fluid management was inadequate in that you:

a. miscalculated urine output and relied on this to determine the amount and type of fluid patient A required during surgery;
To be determined

b. administered a low sodium content intravenous fluid ('Solution 18):

i. which was the wrong type of intravenous fluid;
To be determined

ii. in excessive quantity;
To be determined

iii. at an excessive rate;
To be determined

iv. without sufficient regard to:

1. Patient A's weight of 21kg;
To be determined

2. Patient A having received 952mls Dioralyte solution enterally overnight;
To be determined

v. in conjunction with 1000mls of human albumin solution;
To be determined

c. overestimated blood loss;
To be determined

d. in the alternative to paragraph 2c. knew or ought to have known that total blood loss was less then 1128mls;
To be determined

e. incorrectly interpreted the high central Venus pressure ('CVP') readings;
To be determined

f. inappropriately silenced the high-pressure alarm;
To be determined

g. failed to make an assessment of Patient A's sodium levels until a blood gas sample was tested at 9:32;
To be determined

h. disregarded the low serum sodium reading of 123mmols/L measured at 9:32;
To be determined

i. failed to repeat the arterial blood gas analysis after 9:32;
To be determined

j. failed to recognise the:

i. development of acute hyponatraemia;
To be determined

ii. potential risk of hyponatraemia.
To be determined

3. On 30 November 1995 you prepared a statement for the Coroner's Inquest in which you:

a. failed to disclose:

i. the low serum sodium reading 123mmols of the arterial blood gas analysis taken at 9:32;
To be determined

ii. the low serum sodium reading of 119mmols/L measured at the end of the surgery;
To be determined

b. claimed:

i. the CVP readings had given you no cause for concern throughout the case;
To be determined

ii. there had been normal monitoring signs;
To be determined

iii. the estimated blood loss was 1128mls;
To be determined

iv. your management of Patient A was 'caring, appropriate, expert and representative of the highest quality of intensity of care that I can provide'.
To be determined

4. You knew that:

a. your use of large quantities of Solution 18 created a risk of dilutional hyponatremia of cerebral oedema;

To be determined

b. you had administered Solution 18 at an excessive rate and volume which was not clinically indicated;
To be determined

c. total blood loss was less then 1128mls;
To be determined

d. by providing a higher estimated blood loss figure you could justify your fluid management described at paragraph 2a. and 2b.
To be determined

5. Your actions as set out in paragraphs 3a. were dishonest by reason of one or more of paragraphs 4a. and 4b.
To be determined

6. Your actions as set out in paragraphs 3b. were dishonest by reason of one or more paragraphs 4a. – 4d.
To be determined

7. On 2 December 1995, during an inspection of theatre equipment (Technician's Report), you failed to clarify the Siemens Patient Monitor being inspected was not the equipment used during Patient A's surgery.
To be determined

8. On 21 June 1996, during the Coroners' Inquest you:

a. stated that Patient A:

i. had 300mls fluid deficit at start of surgery;
To be determined

ii. required maintenance fluid at 150mls per hour;
To be determined

iii. had blood loss of 1128mls;
To be determined

b. claimed that you did not have an opportunity to measure urinary output because the bladder had been opened early in the surgery;

To be determined

c. failed to acknowledge that it was your administration of Solution 18 which caused:

   i. the acute hyponatremia;
   To be determined

   ii. reduction in plasma oncotic pressure;
   To be determined

   iii. cerebral oedema;
   To be determined

d. failed to clarify the matters described in paragraph 7;
To be determined

e. inappropriately:

   i. disputed the opinion of the coroner's Experts that the cause of death was dilutional hyponatraemia caused by fluid overload;
   To be determined

   ii. demonstrated no willingness to address any shortcomings in that care you provided to Patient A.
   To be determined

9. You knew:

   a. in advance of the Coroner's Inquest that Patient A:

      i. had a fixed urinary output of about 70-80mls per hour;
      To be determined

      ii. required maintenance fluid of up to about 100ml per hour;
      To be determined

      iii. did not have his bladder opened immediately at the start of surgery;
      To be determined

   b. that you had provided the higher estimated figures described at paragraph 8a., knowing they were wrong, in order to justify your fluid management

described at paragraph 2.
To be determined

10. Your actions as set out in paragraphs 8a and 8b. were dishonest by reason of one or more of paragraphs 9a and 9b.
To be determined

11. On 18 October 2006 during a Police Interview you claimed that:

a. your pre-operative assessment included gaining information from speaking with Patient A's mother;
To be determined

b. your reason for not obtaining a laboratory arterial blood gas analysis was due to:

i. this being lower down on your list of priorities;
To be determined

ii. you not being able to spare any member of your team until 9.30 to send for a laboratory blood test;
To be determined

iii. your knowledge that Patient A's sodium concentration did not vary;
To be determined

c. The Technicians Report did refer to the equipment you were using during Patient A's surgery;
To be determined

d. The low serum sodium reading of 123 mmols/L measured at 9:32 was a rogue result because:

i. the blood gas analyser did not provide reliable measurements;
To be determined

ii. you knew from Patient A's previous blood tests that he tolerated sodium of 124 mmols/L without ill effect;
To be determined

iii. you were at a loss to associate the change in sodium with any clinical deterioration of Patient A;

To be determined

e. you did not accept the findings from the Coroner's Inquest because:

   i. you disagreed with the Coroners Expert evidence that the quantities of fluid you planned to give were exceeded in the early stages of the operation;
   To be determined

   ii. Patient A was exceptional, and you didn't feel the Coroner's Experts really understood him;
   To be determined

   iii. it was impossible for Patient A to get dilutional hyponatremia because he was unable to concentrate urine and slow down his urine output;
   To be determined

   iv. when you spoke with Mr C and Dr B outside the confines of court, they both acknowledged that dilutional hyponatremia could not have happened to Patient A, yet in court they said it did;
   To be determined

f. Your intra-operative fluid management was calculated on the basis of:

   i. fluid deficit of 300mls;
   To be determined

   ii. maintenance rate of 200mls an hour;
   To be determined

   iii. Patient A passing 200mls an hour of dilute urine containing 30mmol/L of sodium for the previous four years;
   To be determined

   iv. your knowledge of Patient A's kidney disease meant there may be an unlimited urine output;
   To be determined

g. You had recalculated Patient A's fluid requirements after reviewing the medical records for the Hyponatraemia Inquiry ('Inquiry') and determined that:

i. there had been significant blood loss which you estimated at 1400mls;
To be determined

ii. the fluid deficit was 400mls after reviewing the pre-operative fluid balance chart and seeing a deficit of 2 hours;
To be determined

iii. maintenance requirements were 200mls, based on an overnight feed of 1600mls over 8 hours and the operation commencing during his nocturnal period.
To be determined

12. You knew that you had:

a. not spoken with Patient A's mother preoperatively;
To be determined

b. previously stated during your evidence at the inquest that you had never planned to perform electrolyte tests;
To be determined

c. failed to disclose the matters described in paragraph 7;
To be determined

d. changed your clinical practice after the Coroner's Inquest on the basis you had accepted:

i. there had been errors in your fluid management;
To be determined

ii. the Coroner's verdict that the cause of the death was dilutional hyponatraemia;
To be determined

iii. that Patient A's polyuric condition meant:

1. he had a fixed urinary output;
To be determined

2. he was able to develop dilutional hyponatremia;
To be determined

iv. the matters described in paragraphs 4c. and 9a.i;
To be determined

e. recalculated and increased your figures for fluid deficit, maintenance requirements and blood loss in order to conceal the fact you knew you had given too much fluid during surgery.
To be determined

13. Your action as set out in paragraph 11a. was dishonest by reason of paragraph 12a.
To be determined

14. Your actions as set out in paragraph 11b. were dishonest by reason of paragraph 12b.
To be determined

15. Your action as set out in paragraph 11c. was dishonest by reason of paragraph 12c.
To be determined

16. Your actions as set out in paragraphs 11d – 11f. were dishonest by reason of one or more of paragraphs 12d.
To be determined

17. Your actions as set out in paragraph 11g. were dishonest by reason of paragraph ~~11d.~~ 12e.
Amended under Rule 17(6)
To be determined

18. On 18 July 2005 you provided a statement to the Inquiry in which you:

a. failed to disclose the error(s) made by :

i. your pre-operative fluid calculations as described at paragraph 1d;
To be determined

ii. you replacing blood loss which you calculated as 1411mls;
To be determined

iii. you accepting the initial CVP reading of 17mmHg as a marker for relative change;
To be determined

b. Falsely claimed there was no sign that inappropriate or excessive fluids had been given for Patient A's complex surgery and pre-existing medical problems.

To be determined

19. On 16 May 2011 you provided a second statement to the Inquiry in which you falsely claimed:

    a. you did not carry out electrolyte tests at the commencement of surgery because it would have meant absenting a member of the team at a very busy time;
    To be determined

    b. you did not believe Patient A's hyponatraemia was caused by fluid overload;
    To be determined

    c. Patient A's native kidneys could not concentrate urine and therefore large volumes of dilute urine was lost;
    To be determined

    d. the equipment referred to in the Technician's Report was that present in the operating theatre when Patient A's operation took place;
    To be determined

    e. you first noticed the face, hands and feet were swollen when the sterile towels were removed at the end of the surgery.
    To be determined

20. In the lead up to and following Coroner's Inquest you knew:

    a. about the matters described at paragraphs 2, 4, 7, 9, 12b., 12c. and 12d.;
    To be determined

    b. sterile towels were not over Patient A's face.
    To be determined

21. Your actions as set out in paragraphs 18a.i, 18a.ii. 18b, and 19b. were dishonest by reason of paragraphs 9.a.i, 9a.ii and 9.b.
    To be determined

22. Your actions as set out in paragraphs 18.iii was dishonest by reason of paragraphs 2e. and 2f.
    To be determined

23. Your action as set out in paragraph 19c. was dishonest by reason of paragraph 12d.iii.
To be determined

24. Your action as set out in paragraph 19d. was dishonest by reason of paragraph 7.
To be determined

25. Your action as set out in paragraph 19a. was dishonest by reason of paragraph 12b.
To be determined

26. Your action as set out in paragraph 19e. was dishonest by reason of paragraph 20b.
To be determined

Witness Evidence

15. The Tribunal received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Ms E, Patient A's mother;
- Dr B, Consultant Paediatric Nephrologist at the Hospital;
- Mr H, Surgeon at the Hospital;
- Mr I, Consultant Paediatric Surgeon at the Hospital;
- Dr J, Consultant Paediatric Anaesthetist at Our Lady's Children's Hospital in Dublin;
- Dr D, Consultant Paediatric Nephrologist at the Hospital;
- Mr L, HM Coroner for Greater Belfast;
- Dr F, Senior Registrar in Forensic Pathology; and
- DS M, Detective Inspector of the Police Service of Northern Ireland ('PSNI').

Expert Witness Evidence

16. The Tribunal also received a written statement from Dr N, Consultant Anaesthetist. In addition, Dr N gave oral evidence to the Tribunal.

Documentary Evidence

17. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:

- Inquiry Chronology of Events (Clinical);
- Inquiry Chronology of Hospital management and Governance;

- Report of Autopsy;
- Various relevant medical records of Patient A;
- Coroner's statement of Dr Taylor, Dr B, Mr H, Mr I and Ms E;
- Expert reports of Dr G, Dr C and Professor O;
- Trust Notes of Pre-Inquest Consultation;
- Report on Equipment used during the surgery;
- Various notes, documents and exhibits provided leading up to the Coroner's Inquest;
- Coroner's Deposition of Dr Taylor, Dr B, Ms E, Mr H, Dr F, Dr C and Dr G;
- Handwritten notes of the Inquest;
- Various other documents provided in the Inquest;
- Inquiry statements of Dr Taylor, Dr B, Ms E and Dr D;
- PSNI statements of Dr Taylor, Dr B, Mr H, Dr D, Mr P, Mr Q, Mr I, Dr J and DS M;
- Transcript of Dr Taylor's oral evidence to PSNI;
- First Inquiry Statements from Dr F and Dr J;
- Dr B's second, third and fifth Inquiry Statements;
- Dr D's third Inquiry Statement;
- The Arieff article 'Hyponatraemia and death or permanent brain damage in healthy children';
- Mr H's third Inquiry Statement;
- Dr F's fourth Inquiry Statement;
- Dr B's perioperative fluid balance;
- Dr Taylor's second to eight Inquiry Statements;
- Oral evidence transcripts of Dr Taylor, Dr B, Mr M and Dr R to the Inquiry; and
- A statement by Dr Taylor's Responsible Officer, Dr S.

The Tribunal's Approach

18. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof throughout rests on the GMC. It is for the GMC to prove the Allegation. Dr Taylor does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the alleged events occurred.

19. Where relevant to its decision-making process, the Tribunal had regard to the test for dishonesty set out in *Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67*, as confirmed in *Barton and Booth v R [2020] EWCA Crim 575*:

'When dishonesty is in question the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'

20. The Tribunal was cautious in its approach to admissible evidence provided by written statements and documentary records untested by questioning at the hearing.

The Tribunal's Analysis of the Evidence and Findings

21. The Tribunal has considered each paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

22. In determining whether there had been a failure, the Tribunal reminded itself that there must be a duty to act in that way, taking into account Good Medical Practice ('GMP').

Paragraph 1 of the Allegation

23. The Tribunal noted that the stem of the allegation is whether Dr Taylor's pre-operative assessment of Patient A on 27 November 1995 was inadequate in that he failed to do matters set out in the sub-particulars. It was mindful in this respect that there should have been a duty to do that which was alleged not to have been done.

Paragraph 1a of the Allegation

24. The Tribunal considered whether Dr Taylor failed to ensure that he had sufficient information about Patient A's fluid intake/output by meeting with Patient A's mother before surgery and/or by reviewing Patient A's medical records.

25. The Tribunal considered the statement of Patient A's mother where she said the following:

'I was not spoken to by any consultant on the morning of the operation… One of the first concerns I had was when Dr Taylor did not appear on the morning of the surgery to see [Patient A] and take his blood before [Patient A] went into theatre.'

'I went with [Patient A] down to theatre. Dr Taylor was there and that was the first time I saw him regarding this operation… Dr Taylor didn't discuss anything with me and I was ushered out of the room as the operation started'

26. The Tribunal relied on the unchallenged account given by Patient A's mother and found that Dr Taylor should have met but failed to meet with Patient A's mother prior to surgery.

27. Further, the Tribunal rejected the account given by Dr Taylor to the Inquiry that he met Patient A's mother and reviewed Patient A's medical notes. This means that from Patient A leaving the ward at 06:45am to commencement of anaesthesia documented at 06:55am, there was only 10mins for Dr Taylor to review extensive patient records. The Tribunal found that on the balance of probabilities, Dr Taylor had not reviewed Patient A's medical records and had not afforded himself the opportunity to do so as he should have done.

28. Accordingly, the Tribunal determined and found the entirety of paragraph 1a of the Allegation proved.

Paragraph 1b of the Allegation

29. The Tribunal considered whether Dr Taylor failed to have sufficient regard to Dr B's advice about Patient A's history of fluid balance, propensity to hyponatraemia and request to check electrolyte concentrations prior to surgery.

30. In relation to the history of fluid balance and propensity to hyponatraemia, the Tribunal considered Dr B's witness statement where he stated the following:

'I believe that in my telephone conversations with Dr Taylor on the evening of the 26 November 1995, I reminded him of [Patient A's] medical history and informed him of [Patient A's] current status at the time. I believe I explained that [Patient A] was, at that time, passing urine and required two litres of fluid a day, to keep his fluid balance

correct, which required this to be given to him via a gastrostomy tube… I believe I also explained that [Patient A] had a propensity for his blood sodium levels to drop and to develop hyponatremia in the past.'

31. The Tribunal noted that Dr B's account was not challenged.

32. In relation to the request to check electrolyte concentrations prior to surgery, the Tribunal again considered Dr B's witness statement where he said that:

'I had advised Dr Taylor that further electrolyte tests should be conducted prior to [Patient A] being taken into theatre… Dr Taylor then decided that [Patient A's] electrolyte levels should instead be tested once he was anaesthetised. It is usual practice for electrolyte levels to be tested immediately prior to surgery.'

33. The Tribunal also considered Dr Taylor's second inquiry statement. Dr Taylor was asked to explain why it was not practical in [Patient A's] case to carry out electrolyte tests at the commencement of surgery? Dr Taylor answered: '*This would have meant absenting a member of the team at a very busy time'.* Dr Taylor was then asked to describe the arrangements that are made, or could have been made, for a member of medical personnel who was a member of Dr Taylor's 'Team' to have done a blood test. Dr Taylor answered: '*obtaining the blood test was not considered an urgent priority and it was done in sequence when time permitted. I did not consider I needed to divert one of the team or ask another doctor to do the test'.*

34. The Tribunal noted that the expert witnesses in this case agreed that it is important to carry out an electrolyte test prior to surgery. The Tribunal was of the view that Dr Taylor did not have an appropriate plan to prioritise the electrolyte test. Therefore, on the balance of probabilities, Dr Taylor had failed to have sufficient regard to Dr B's request to check for electrolyte concentrations prior to surgery.

35. Accordingly, the Tribunal determined and found the entirety of paragraph 1b of the Allegation proved.

<u>Paragraph 1c of the Allegation</u>

36. The Tribunal considered whether Dr Taylor failed to obtain a laboratory arterial blood gas sample to check for electrolyte concentrations as soon as the arterial catheter had been sited.

37. The Tribunal considered the expert opinion of Dr N. He said that:

> *'In my opinion arterial blood gas analysis (indicating serum sodium concentration amongst other variables) should have been performed earlier, ideally shortly after arterial access had been established, particularly given the inability of the surgical paediatric registrar to obtain a sample for laboratory analysis that morning.'*

38. The Tribunal was of the view that it was clear from the evidence that Dr Taylor did not obtain a laboratory arterial blood gas sample to check for electrolyte concentrations as soon as the arterial catheter had been sited. The Tribunal considered that Dr Taylor had a duty to do so and failed to act upon it.

39. Therefore, the Tribunal determined and found paragraph 1c of the Allegation proved.

Paragraph 1di of the Allegation

40. The Tribunal considered whether Dr Taylor failed to accurately calculate the pre-operative fluid balance when he estimated Patient A's fluid deficit on arrival in theatre as 400mls.

41. The Tribunal considered the letter dated 7 June 1996 from Dr B to the Hospital Director Dr T. Dr B said that:

> '*On the night prior to [Patient A's] surgery, because of his admission to hospital and early transfer to theatre he only received 900mls of clear fluid by continuous gastronomy feed. This means that he would have been some 600mls behind compared to normal. In calculating his maintenance fluids one would therefore take this deficit into account.'*

42. The Tribunal was of the view that Dr Taylor's estimation of 400mls fluid deficit was within acceptable parameters and was therefore sufficiently accurate.

43. Therefore, the Tribunal determined and found paragraph 1di of the Allegation not proved.

Paragraph 1dii of the Allegation

44. The Tribunal considered whether Dr Taylor failed to accurately calculate the pre-operative fluid balance when he estimated Patient A's required maintenance rate of 200mls per hour.

45. The Notes of the Pre-Inquest Consultation 14 June 1996 included a table of the following: *'100mls per hour to compensate for urinary output; 60mls per hour for metabolism; 160mls per hour total requirement; less 10-20mls per hour urinary output of a normal child; and 150mls per hour total fluid requirement'.* This was a calculation provided by Dr Taylor.

46. The Tribunal again considered the letter from Dr B to Dr T in which Dr B said that:

> '*Assuming the normal urine output for [Patient A] was approximately 70mls per hour… I think it is acceptable that the maintenance fluids during surgery should have taken into account the overnight fluid deficit… Giving 200mls per hour would have ensured that the deficit was corrected in four to five hours. Giving 150mls per hour this would have taken much longer…'*

47. The Tribunal also noted the transcript of Dr Taylor's oral evidence to the Inquiry in which he said that:

> '*I miscalculated and for some unknown reason, which I can't explain, I made an assumption, which is false, that he could pass 200ml per hour.'*

48. However, the Tribunal noted that there was evidence to explain why Dr Taylor had estimated a maintenance rate of 200mls per hour. It noted that none of the experts either to the Coroner or the GMC's expert overtly criticised that calculation.

49. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1dii of the Allegation not proved

Paragraph 1diii of the Allegation

50. The Tribunal considered whether Dr Taylor failed to accurately calculate the pre-operative fluid balance when he estimated Patient A's rate of normal hourly urinary output on a fixed basis.

51. The Tribunal considered Dr Taylor's transcript of evidence to the Inquiry. Dr Taylor said that:

> *'…that is something that I have come, on reflection, to agree with the experts, that I now agree that he did have fixed urinary output.'*

52. In light of Dr Taylor's acceptance, the Tribunal determined and found paragraph 1diii of the Allegation proved.

Paragraph 2 of the Allegation

53. The Tribunal noted that the stem of the allegation is whether Dr Taylor's intra-operative fluid management on 27 November 1995 were inadequate.

Paragraph 2a of the Allegation

54. The Tribunal considered whether Dr Taylor's intra-operative fluid management was inadequate in miscalculating the urine output and relying on this to determine the amount and type of fluid Patient A required during surgery.

55. The Tribunal took into account the transcript of Dr Taylor's evidence to the Inquiry in which he said that:

> *'…for whatever reason, I miscalculated his urinary output for the time period of his operation to be 200ml per hour. I accept that that was a miscalculation and my fluids input was based on that miscalculation.'*

56. In the light of Dr Taylor's acceptance, which accords with Dr N's findings, the Tribunal determined and found paragraph 2a of the Allegation proved.

Paragraph 2b of the Allegation

57. The Tribunal considered whether Dr Taylor's intra-operative fluid management was inadequate when he administered a low sodium content intravenous fluid ('Solution 18'). It is alleged that Solution 18 was the wrong type of intravenous fluid, it was in excessive quantity and was at an excessive rate. In addition, it is alleged that Dr Taylor had administered Solution 18 without sufficient regard to Patient A's weight of 21kg and Patient A having received 952mls Dioralyte solution enterally overnight. It is also alleged that Dr Taylor administered Solution 18 in conjunction with 1000mls of human albumin solution.

58. The Tribunal considered the expert opinion of Dr N. He stated the following:

> *'During surgery Dr Taylor administered 1000mls of hypotonic 0.18% saline between 07.00hrs and 08.30hrs and a further 500mls of the same solution thereafter. This is a considerable quantity of low-sodium hypotonic fluid in a child who only weighted 20kg and, in conjunction with the 900mls of Dioralyte solution he had received enterally overnight, it is unsurprising arterial blood gas analysis timed at 09.32hrs demonstrated significant hyponatraemia (123 mmol/L). In my opinion the administration of 1.5L of 0.18% saline/4% dextrose intravenous fluid was sufficient to cause an acute reduction in serum sodium concentration to 123 mmol/L and would also have been sufficient to reduce plasma oncotic pressure and induce cerebral oedema. It is difficult to envisage circumstances under which it would have been clinically appropriate to administer this quantity of hypotonic saline over this time frame to a child weighing 20kg.'*
>
> *'Hyponatraemia may have been further compounded by the subsequent administration of 1000mls of human albumin solution that may also be relatively hyponatraemic.'*
>
> *'…the critical issue is that, had the fluid administered been more appropriate with respect to sodium content, (even with this volume), hyponatraemia and subsequent cerebral oedema would have been avoided.'*

59. The Tribunal was of the view that Dr N's expert evidence is clear in respect of all the matters encompassed by paragraph 2b of the Allegation. The Tribunal was satisfied that it could rely upon it in determining that paragraph.

60. Accordingly, the Tribunal determined and found the entirety of paragraph 2b of the Allegation proved.

Paragraph 2c and 2d of the Allegation

61. The Tribunal considered whether Dr Taylor's intra-operative fluid management was inadequate in overestimating blood loss or in the alternative that he knew or ought to have known that total blood loss was less than 1128mls.

62. The Tribunal considered the expert opinion of Dr N. He stated that:

> *'Dr Taylor estimates blood loss to have been 1100 mls, [Mr H] estimates it was lower. Blood loss is estimated by measurement of blood in the sucker bottles, weighing the swabs and by a visual assessment of blood on the drapes, floor and elsewhere. It is not an exact science and errors are compounded by the use of surgical wash and other fluids. Even were the Tribunal to consider Dr Taylor overestimated blood loss, unless he was being deliberately disingenuous or his overestimation was gross, such a failing would not fall below an expected standard.'*

63. The Tribunal also considered Mr H's PSNI Statement. He said that:

> '*During the operation there was very little blood loss.'*

64. The Tribunal cannot be satisfied as to whether Dr Taylor had overestimated the blood loss nor that he knew or ought to have known that the total blood loss was less than 1128mls. The Tribunal noted that even taking account of Mr H's statement, he could not provide an estimation of the blood loss apart from *'very little'.* Nevertheless, Dr N's expert opinion was '*unless [Dr Taylor] was being deliberately disingenuous or his overestimation was gross, such a failing would not fall below an expected standard.'*

65. Therefore, the Tribunal determined and found paragraphs 2c and 2d of the Allegation not proved.

Paragraph 2e of the Allegation

66. The Tribunal considered whether Dr Taylor's intra-operative fluid management was inadequate when he incorrectly interpreted the high Central Venous Pressure ('CVP') readings.

67. The Tribunal noted the transcript of Dr Taylor's evidence to the Inquiry. Dr Taylor said: '*I knew that the CVP was in the wrong place and it was providing an abnormal reading, one that I ought to have paid more attention to, and I'm sorry I didn't.* Dr Taylor was asked if he had become convinced that the CVP catheter was not in continuity with the great veins draining to the heart and he could not rely on them. It was followed by Dr Taylor did rely on the CVP recordings and relied on them for relative change. Dr Taylor answered: *'Well, I stated that I did, but on reflection I'm not sure if I paid them the attention that I did, even when they were reading as a trend.'* It was also put to Dr Taylor that on a number of statements he said that he was not getting an accurate recording and referred to it as being up a 'dead end'. Dr Taylor replied: *'Yes, I think that was my conclusion at that time'.* Dr Taylor also added: *'I reflected over it and I felt that even when it was changing, it wasn't providing me with information that I was usefully using to manage [Patient A's] fluids.'*

68. In light of the evidence and acceptance from Dr Taylor, the Tribunal found that Dr Taylor had incorrectly interpreted the CVP.

69. Accordingly, the Tribunal determined and found paragraph 2e of the Allegation proved.

Paragraph 2f of the Allegation

70. The Tribunal considered whether Dr Taylor's intra-operative fluid management was inadequate when he inappropriately silenced the high-pressure alarm.

71. The Tribunal considered Dr Taylor's transcript of evidence to the Inquiry in which he said that:

> '*Alarms can be very disturbing to the operating staff… As the anaesthetist stands beside and watches the monitor, then cancelling that alarm does not put the patient in any danger.'*

72. The Tribunal also considered Dr N's expert opinion. He said that:

> *'I do not consider cancelling the high alarms represents poor care.'*

73. The Tribunal relied upon the expert opinion of Dr N that silencing the high-pressure alarm does not represent poor care.

74. Therefore, the Tribunal determined and found paragraph 2f of the Allegation not proved.

Paragraph 2g of the Allegation

75. The Tribunal considered whether Dr Taylor's intra-operative fluid management was inadequate when he failed to assess Patient A's sodium levels until a blood gas sample was tested at 09:32.

76. The Tribunal adopts the similar reasoning it had reached on paragraph 1c of the Allegation. The Tribunal also considered the chronology of hospital management and governance of Patient A. It is evident that on the day of the surgery, blood gas sample was first tested on 09:32.

77. Therefore, the Tribunal determined and found paragraph 2g of the Allegation proved.

Paragraph 2h of the Allegation

78. The Tribunal considered whether Dr Taylor's intra-operative fluid management was inadequate when he disregarded the low serum sodium reading of 123mmols/L measured at 09:32.

79. The Tribunal noted Dr Taylor's statement to the Coroner when he said that:

> '*[Patient A's] haemoglobin at the start of the procedure was 10.5 g/dl and fell to an estimated 6.1 g/dl during the case was 10 g/dl at the end.'*

80. The Tribunal also considered the evidence which shows the result of the blood gas, which was taken on 09:32. The low serum sodium reading of 123mmols/L was listed in the same paper result where Dr Taylor had regard to Patient A's haemoglobin. In Dr N's view there was a serious failure by Dr Taylor to take the reading into account. In Dr Taylor's first statement to the Inquiry, he said that: '*The saline/glucose infusion was*

further reduced following this blood test to stop any further reduction in the serum sodium and only fluids containing sodium at 130mmol/l or greater were administered in addition.'

81. The Tribunal found that on the balance of probabilities, Dr Taylor knew of the low serum sodium reading and altered his management.

82. Accordingly, the Tribunal determined and found paragraph 2h of the Allegation not proved.

Paragraph 2i and 2j of the Allegation

83. The Tribunal considered whether Dr Taylor's intra-operative fluid management was inadequate when he failed to repeat the arterial blood gas analysis after 09:32.

84. The Tribunal considered the chronology of hospital management and governance of Patient A. The Tribunal could not find any other arterial blood gas analysis apart from the one taken at 09:32.

85. The Tribunal also considered Dr N's expert opinion. He said that:

'…it is unsurprising arterial blood gas analysis timed at 09.32hrs demonstrated significant hyponatraemia (123 mmol/L).'

'I am concerned that in his initial statement dated 30 November 1995, when referring to the results of the arterial blood gas analysis, Dr Taylor discusses [Patient A's] good arterial oxygenation and the absence of an acidosis but makes no reference to the finding of significant hyponatraemia.'

'I am concerned, subsequent to the identification of [hyponatraemia] at 09.32hrs, why arterial blood gas analysis was not repeated frequently and regularly to ensure the situation was improving.'

'In my opinion this was a serious oversight. Dr Taylor's failure to obviously recognise hyponatraemia subsequent to these arterial blood gas results (09.32hrs) represents a major failing and care seriously below the standard expected of a competent paediatric anaesthetist.'

'It is particularly concerning that no repeat sample was sent after the results timed at 09.32hrs became available. This omission suggests Dr Taylor neither noticed the development of acute hyponatraemia nor appreciated the potential risk.'

86. In light of the evidence and expert opinion of Dr N, the Tribunal was of the view that Dr Taylor had failed to repeat the arterial blood gas analysis after 09:32. Also, Dr Taylor failed to recognise the development of acute hyponatraemia and the potential risk of hyponatraemia.

87. Accordingly, the Tribunal determined and found paragraphs 2i and the entirety of 2j of the Allegation proved.

Paragraph 3 of the Allegation

88. The Tribunal noted that the stem of the allegation relates to Dr Taylor's statement dated 30 November 1995 for the Coroner's Inquest.

Paragraph 3a of the Allegation

89. The Tribunal considered whether, in that statement, Dr Taylor failed to disclose the low serum sodium reading of 123mmols of the arterial blood gas analysis taken at 09:32 and the low serum sodium laboratory reading of 119mmols/L measured at the end of surgery.

90. The Tribunal was of the view that Dr Taylor was aware of the low serum sodium reading of 123mmols at 09:32 because he had regard to the haemoglobin level within the same result paper. It was extremely relevant and therefore Dr Taylor should have disclosed it in his statement for the Coroner's Inquest.

91. The Tribunal also considered the Autopsy report of Patient A from Dr F dated 29 November 1995. Within the report, Dr F said that:

'*[Patient A] was transferred from theatre to paediatric Intensive Care Unit… Electrolytes revealed a sodium of 119mmol/l*'

This reflected the information Dr Taylor provided in the autopsy request form he completed.

92. Accordingly, the Tribunal determined and found the entirety of paragraph 3a of the Allegation proved.

Paragraph 3b of the Allegation

93. The Tribunal considered whether Dr Taylor had claimed that: the CVP readings had given him no cause for concern throughout the case; there had been normal monitoring signs; the estimated blood loss was 1128mls; and his management of Patient A was *'caring, appropriate, expert and representative of the highest quality and intensity of care that [he] can provide'.*

94. The Tribunal considered Dr Taylor's statement for the Coroner's Inquiry. He said the following:

> *'the blood loss I estimated to be 1128 mls.'*
>
> '*The pulse rate, CVP and arterial blood pressure gave me no cause for concern throughout the case…'*
>
> *'I remain extremely perplexed and concerned that this happened to [Patient A] and cannot offer a physiological explanation for such severe pulmonary and cerebral oedema in the presence of normal monitoring signs.'*
>
> *'My only consolation is that is I consider the management to have been caring, appropriate, expert and representative of the highest quality and intensity of care that I can provide.'*

95. The Tribunal was of the view that the each claim was evident within Dr Taylor's statement. Therefore, the Tribunal determined and found the entirety of paragraph 3b of the Allegation proved.

Paragraphs 4a and 4b of the Allegation

96. The Tribunal considered whether Dr Taylor knew: that his use of large quantities of Solution 18 created a risk of dilutional hyponatremia or cerebral oedema; and that he had administered Solution 18 at an excessive rate and volume which was not clinically indicated.

97. The Tribunal considered the expert opinion of Dr G, one of the experts for the Inquest, in which he said the following:

> '*There is very little firm information available concerning dilutional hyponatraemia (low serum sodium) in children, either in standard textbooks or in the recent literature, although the condition is well recognised in neonates and in adults who have certain operations which result in an excess of water entering circulation.'*

98. The Tribunal also considered the expert opinion of Dr N. He said the following:

> *'In my opinion intra-operative fluid management, particularly in respect to volume, is as much of an art as it is a science and there are multiple variables to consider, not all of which can be accurately measured.'*
>
> *'In my opinion, however, the total volume of fluid administered for a 4hr procedure in which estimated blood loss according to Dr Taylor was approximately 1100mls was considerable but not obviously grossly excessive, irrespective of exactly how the figure was arrived at.'*
>
> *'In my opinion, therefore, and irrespective of any issues there may have been with central venous pressure measurement… and/or calculations pertaining to ongoing fluid requirements, fluid management from a volume or rate of administration perspective did not fall below an acceptable standard if blood loss was approximately 1100mls.'*

99. The Tribunal emphasised that it is asked to determine whether the use of Solution 18 in large quantities had created a risk of dilutional hyponatremia or cerebral oedema and that the excessive rate and volume administered was not clinically indicated. Having regard to both expert witnesses, the Tribunal, on the balance of probabilities, found that Dr Taylor was not aware that the large quantities of Solution 18 would create a risk of dilutional hyponatremia or cerebral oedema. In addition, Dr Taylor was also not aware that the excessive rate and volume was not clinically indicated.

100. Accordingly, the Tribunal determined and found paragraphs 4a and 4b of the Allegation not proved.

Paragraphs 4c and 4d of the Allegation

101. The Tribunal considered whether Dr Taylor knew that the total blood loss was less than 1128mls and that by providing a higher estimated blood loss figure, he could justify his fluid management described at paragraphs 2a and 2b.

102. The Tribunal relied on the similar reasoning it had reached in respect of paragraphs 2c and 2d.

103. Therefore, on the balance of probabilities, the Tribunal determined and found paragraphs 4c and 4d of the Allegation not proved.

Paragraph 5 of the Allegation

104. The Tribunal considered whether Dr Taylor's conduct in relation to paragraph 3a by reason of one or more of paragraphs 4a and 4b of the Allegation was dishonest.

105. The Tribunal, having determined that paragraphs 4a and 4b of the Allegation were not proved, concluded that paragraph 5 of the Allegation must fall.

106. Accordingly, the Tribunal determined and found paragraph 5 of the Allegation not proved.

Paragraph 6 of the Allegation

107. The Tribunal considered whether Dr Taylor's conduct in relation to paragraph 3b by reason of one or more of paragraphs 4a – 4d of the Allegation was dishonest.

108. The Tribunal having determined that paragraphs 4a – 4d of the Allegation were not proved, concluded that paragraph 6 of the Allegation must fall.

109. Accordingly, the Tribunal determined and found paragraph 6 of the Allegation not proved.

Paragraph 7 of the Allegation

110. The Tribunal considered whether, during an inspection of theatre equipment (Technician's Report) on 2 December 1995, Dr Taylor failed to clarify the Siemens

Patient Monitor being inspected was not the equipment used during Patient A's surgery

111. The Tribunal considered the statement to the PSNI of Mr Q, Chief of Medical Technical Officer in the Anaesthetics, Theatres and Intensive Care Directorate at the Hospital in 1995. Mr Q said that:

> '*We highlighted in our report that the Siemens monitor…that was present on 2 December 1995 in the theatre was functioning within specification. However, we also highlighted that another Siemens monitor was out for repair in relation a new display screen. I would state that I did not know the reason for our examination of the equipment related to an operation on 27 November 1995 and therefore I cannot say with certainty that the Siemens Monitor which we examined was actually the monitor used on 27 November 1995 in an operation on [Patient A]. These monitors are not easily moved and are not routinely replaced unless they are defective. Therefore I would say from my experience it is very likely the monitor which we examined on 2 December 1995 was the monitor used in theatre on 27 November 1995 unless records show that a monitor was removed from theatre…after 27 November 1995 and before 2 December 1995.*

112. The Tribunal was of the view that the Hospital was aware that a monitor was out for a repair. However, similar to the opinion of Mr Q, the Tribunal could not be certain if the monitor were out for a repair prior or after the surgery on 27 November 1995. Furthermore, there is no evidence before the Tribunal to specify the precise date when the monitor was out for repair.

113. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 7 of the Allegation not proved.

Paragraph 8 of the Allegation

114. The Tribunal noted that the stem of the allegation refers to statements and claims alleged to have been made and failures to acknowledge facts by Dr Taylor during the Coroner's Inquest on 21 June 1996.

Paragraph 8a of the Allegation

115. The Tribunal considered whether Dr Taylor stated that Patient A: had 300mls fluid deficit at start of surgery; required maintenance fluid at 150mls per hour; and had a blood loss of 1128mls.

116. The Tribunal considered the Coroner's deposition of Dr Taylor. He said the following:

'…the total blood loss I estimated to be 1128mls.'

'At 20kg [Patient A] had a calculated blood volume of 1600mls and calculated fluid requirement of 60ml/hr. However, [Patient A] would 'normally' receive a sugar solution at 150mls/hour. Thus I gave him the deficit of fluid 300-500mls plus his ongoing requirements (150mls/hour).

117. The Tribunal is in no doubt from the Deposition to the Coroner that Dr Taylor stated that Patient A had 300mls fluid deficit at start of surgery, required maintenance fluid at 150mls per hour, and had a blood loss of 1128mls.

118. Therefore, the Tribunal determined and found the entirety of paragraph 8a of the Allegation proved.

Paragraph 8b of the Allegation

119. The Tribunal considered whether Dr Taylor had claimed that he did not have an opportunity to measure urinary output because the bladder had been opened early in the surgery.

120. The Tribunal considered carefully the Dr Taylor's Deposition to the Coroner. It was unable to find evidence of any claim by Dr Taylor that he did not have an opportunity to measure urinary output because the bladder had been opened early in the surgery.

121. The Tribunal also considered the transcript of Dr Taylor's oral evidence to the Inquiry. It noted that Dr Taylor was asked the following question:

'Dr R has indicated during the course of the procedure, Dr Taylor did not have an opportunity of accurately measuring urinary output due to the fact that the bladder had been opened early on in surgery.'

122. However, the Tribunal was of the view that whilst referring to the bladder being opened, that question does not specifically relate to the matter in the allegation. Further, the Tribunal noted that Dr Taylor answered the question by saying:

'*I don't recall. I don't think it was in any of the written papers I was sending to the solicitors. So, I can't answer that question.'*

123. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 8b of the Allegation not proved.

Paragraph 8c of the Allegation

124. The Tribunal considered whether Dr Taylor failed to acknowledge that it was his administration of Solution 18 which caused the acute hyponatremia, reduction in plasma oncotic pressure and cerebral oedema.

125. The Tribunal noted Dr Taylor's deposition to the Coroner, in which he stated:

'*In the final analysis the blood sugar gives a reliable indication of the quantity of glucose solution given. Since the blood sugar at the end of this case was 4mmol/l then there was not an excess of this type of solution given.'*

126. The Tribunal also considered the expert opinion of Dr G. Dr G stated that:

'*The complex metabolic and fluid requirements of this child having major surgery led to the administration of a large volume of hypotonic (0.18%) saline which produced a dilutional hyponatraemia and subsequent cerebral oedema.'*

127. In addition, the Tribunal considered the expert opinion of Dr C. He stated that:

'*…I believe that on the balance of probabilities [Patient A's] gross cerebral oedema was caused by the acute onset of hyponatraemia…from the excess administration of fluids containing only very small amounts of sodium…'*

128. The Tribunal noted that the Coroner's Inquest was approximately six months after Patient A's surgery. The Tribunal was of the view that Dr Taylor had been aware of two expert opinions which are both similar in their findings. Further, he was also aware that he would be under scrutiny as indicated in the letter from the Solicitor to the Hospital Trust, Mr K to Dr T dated 30 May 1996. Therefore, the Tribunal was of the view that Dr Taylor had or should have had the information, reflected and been aware that his administration of Solution 18 had caused the acute hyponatremia, reduction in plasma oncotic pressure and cerebral oedema.

129. Accordingly, the Tribunal determined and found the entirety of paragraph 8c of the Allegation proved.

Paragraph 8d of the Allegation

130. The Tribunal considered whether Dr Taylor failed to clarify the matters described in paragraph 7 of the Allegation.

131. The Tribunal relied upon the similar reasoning it had reached in determining paragraph 7 of the Allegation.

132. Therefore, the Tribunal determined and found paragraph 8d of the Allegation not proved.

Paragraph 8e of the Allegation

133. The Tribunal considered whether Dr Taylor had inappropriately disputed the opinion of the Coroner's Experts that the cause of death was dilution hyponatraemia caused by fluid overload. Also, if Dr Taylor had inappropriately demonstrated no willingness to address any shortcomings in the care, he provided to Patient A.

134. The Tribunal considered the response of Dr Taylor to the expert opinions provided. He said that:

> *'…both have failed to comprehend the physiological differences in this case and have used dubious scientific argument in an attempt to explain cerebral oedema.'*

135. The Tribunal also relied upon the similar reason it had reached in determining paragraph 8c of the Allegation. The Tribunal was of the view that Dr Taylor should have reflected and acknowledged his shortcomings because of the time between the surgery and the Coroner's inquest, the opinions of both expert witnesses and the Trust's declared changes in policy. Instead, Dr Taylor was emphatic that the experts were wrong.

136. Therefore, the Tribunal determined and found the entirety of paragraph 8e of the Allegation proved.

Paragraph 9ai and 9aii of the Allegation

137. The Tribunal considered whether Dr Taylor knew in advance of the Coroner's Inquest that Patient A had a fixed urinary output of about 70-80mls per hour and required maintenance fluid of up to about 100ml per hour.

138. The Tribunal considered Dr B's letter to Dr T dated 7 June 1996. Dr B stated that:

> *'Since [Patient A] was receiving 2100mls per day and his insensible loss from sweat etc. would be possibly of the order of 300-400mls then his urine output per hour is likely to have been around 75mls.'*

139. The Tribunal also considered the Trust Notes of the Pre-Inquest Consultation which took place on 14 June 1996. The attendees were listed within the notes, and they included Dr Taylor. It was noted that Patient A's maintenance requirements were: *'100mls per hour to compensate for urinary output; 60mls per hour for metabolism; 160mls per hour total requirement; less 10-20mls per hour urinary output of a normal child; and 150mls per hour total fluid requirement.'*

140. Further the Tribunal considered Dr B's first statement to the Inquiry in which he said that:

> '*I discussed [Patient A's] underlying diagnosis, his past medical history and the current management of his condition in terms of dialysis and fluid with Dr Taylor so that he was aware…'*

141. Having had regard to the evidence, it was clear to the Tribunal that Dr Taylor was present within the consultation prior to the Coroner's Inquest and was aware of the estimated requirements of Patient A. In addition, Dr Taylor was advised by Dr B in relation to Patient A's underlying diagnosis, past medical history and the current management of Patient A's condition in terms of dialysis and fluid. Therefore, Dr Taylor would have known that Patient A had a fixed urinary output of about 70-80mls per hour and required maintenance fluid of up to about 100ml per hour.

142. Therefore, the Tribunal determined and found paragraphs 9ai and 9aii of the Allegation proved.

Paragraph 9a.iii of the Allegation

143. The Tribunal considered whether Dr Taylor knew that in advance of the Coroner's Inquest, Patient A did not have his bladder opened immediately at the start of the surgery.

144. The Tribunal noted the transcript of Dr Taylor's oral evidence to the Inquiry which pre-dated the Inquest. Dr Taylor was asked if he was aware of when Patient A's bladder was opened during surgery. Dr Taylor answered and said the following:

'… I was only aware of [Patient A's] bladder being opened at the end of the procedure.'

'It's usual practice, and I would imagine that [Patient A] was no different.'

145. Having had regard to Dr Taylor's evidence and acceptance that he was only aware of Patient A's bladder being opened at the end of the procedure. Therefore, Tribunal found that Dr Taylor knew in advance of the Coroner's Inquest that Patient A did not have his bladder opened immediately at the start of surgery.

146. Accordingly, the Tribunal determined and found paragraph 9aiii of the Allegation proved.

Paragraph 9b of the Allegation

147. The Tribunal considered whether Dr Taylor knew that he had provided the higher estimated figures described at paragraph 8a, knowing they were wrong, in order to justify his fluid management described at paragraph 2.

148. Again, the Tribunal considered the expert of opinion of Dr N, where he stated that:

'In my opinion intra-operative fluid management, particularly in respect to volume, is as much of an art as it is a science and there are multiple variables to consider, not all of which can be accurately measured… It is not uncommon to administer intravenous fluid in a volume two to three times greater than
measured blood loss.'

'In my opinion, however, the total volume of fluid administered for a 4hr procedure in which estimated blood loss according to Dr Taylor was approximately 1100mls was considerable but not obviously grossly excessive, irrespective of exactly how the figure was arrived at.'

'However, the critical issue is that, had the fluid administered been more appropriate with respect to sodium content, (even with this volume), hyponatraemia and subsequent cerebral oedema would have been avoided.'

149. Having considered the expert opinion of Dr N, the Tribunal was of the view that Dr Taylor's estimates and calculation were not wrong. Dr N emphasised that the inadequacy by Dr Taylor was the administration of the wrong type of fluid with respect to the sodium content rather than the volume.

150. Therefore, the Tribunal determined and found paragraph 9b of the Allegation not proved.

Paragraph 10 of the Allegation

151. The Tribunal having found paragraphs 8b, 9a.iii and 9b not proved, the Tribunal considered whether Dr Taylor's actions under 8a were dishonest by reason of paragraphs 9a.i and 9a.ii. The Tribunal has found that an estimated deficit of 300mls was an acceptable estimate. It has also found that none of the expert witnesses overtly

criticised and estimate a maintenance regime of 150mls and that it had accepted an estimate of blood loss of 1128mls. Therefore, it could not find Dr Taylor's statements were dishonest.

152. Therefore the Tribunal determined and found paragraph 10 of the Allegation not proved.

Paragraph 11 of the Allegation

153. The Tribunal noted that the stem of the Allegation is whether during a Police Interview on 17 October 2006, Dr Taylor claimed the following.

Paragraph 11a of the Allegation

154. The Tribunal considered whether Dr Taylor claimed that his pre-operative assessment included gaining information from speaking with Patient A's mother.

155. The Tribunal noted the transcript of Dr Taylor's oral evidence to the PSNI. He said that:

> '*At about 05:45hrs I met with [Patient A] and his mother and reviewed all available information pre-operatively.'*

156. The Tribunal determined that this was factual evidence from Dr Taylor that he had claimed to have spoken with Patient A's mother during his pre-operative assessment.

157. Therefore, the Tribunal determined and found paragraph 11a of the Allegation proved.

Paragraph 11b of the Allegation

158. The Tribunal considered whether Dr Taylor claimed in his PSNI interview that his reason for not obtaining a laboratory arterial blood gas analysis was due to this being lower down on his list of priorities, not being able to spare any member of his team until 9.30 to send for a laboratory blood test and his knowledge that Patient A's sodium concentration did not vary.

159. The Tribunal noted the transcript of Dr Taylor's oral evidence to the PSNI in which he said that:

'There's a priority to be set and at that time I need all the experienced personnel with me to be able to monitor everything about [Patient A] including his fluids in particular. To have done a blood test would have meant absenting a member, a crucial member of my team.'

'…and a blood test would be… down the list of priorities'

'All of [Patient A's] life he's passed urine with a sodium concentration of 30…'

'…sometimes I think one of the medical technicians… would be sent to do a blood test… but obviously I couldn't spare anybody until 9:30'

160. The Tribunal determined that this was factual evidence from Dr Taylor that he made the claims alleged.

161. Accordingly, the Tribunal determined and found the entirety of paragraph 11b of the Allegation proved.

Paragraph 11c of the Allegation

162. The Tribunal considered whether Dr Taylor claimed that the Technician's report did refer to the equipment he was using during Patient A's surgery.

163. Again, the Tribunal considered the transcript of Dr Taylor's interview by the PSNI during which he was referred to the report produced by Mr Q and Mr P. Dr Taylor was asked if he was happy that the equipment that they were referring to was the equipment that he was using, to which he answered: '*Yes*'.

164. The Tribunal determined that this was factual evidence from Dr Taylor. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 11c of the Allegation proved.

Paragraph 11d of the Allegation

165. The Tribunal considered whether Dr Taylor claimed that the sodium reading of 123mmols/L measured at 09:32 was a rogue result because the blood gas analyser did

not provide reliable measurements, that he knew from Patient A's previous blood tests that he tolerated sodium of 124mmols/L without ill effect and that he was at a loss to associate the change in sodium with any clinical deterioration in Patient A.

166. The Tribunal considered the transcript of Dr Taylor's interview by the PSNI. During that interview, it was put to him that: *'…it appears to me that the sodium level at 9.30 the result that you got with the low sodium… Ought to have highlighted the fact that there's every likelihood of an osmotic fluid shift now because of the depressed sodium concentration.'* Dr Taylor answered: *'…we were reminded not to rely absolutely on that.'*

167. Dr Taylor also said that:

'…we know from [Patient A's] previous blood tests that he's tolerated [sodium] of 124 without ill effect.'

'I was at a loss to associate the change in sodium that you've highlighted with any clinical deterioration in my patient.'

168. The Tribunal concluded that this was factual evidence from Dr Taylor himself that he had made the claims set out in Paragraph 11d.

169. Accordingly, the Tribunal determined and found the entirety of paragraph 11d of the Allegation proved.

Paragraph 11e of the Allegation

170. The Tribunal considered whether Dr Taylor claimed that he did not accept the findings from the Coroner's Inquest because: he disagreed the Coroners Expert evidence that the quantities of fluid he planned to give were exceeded in the early stages of the operation; Patient A was exceptional and he did not feel the Coroner's Experts really understood him; it was impossible for Patient A to get dilutional hyponatremia because he was unable to concentrate urine and slow down his urine output; and when he spoke with Dr C and Dr B outside the confines of court they both acknowledged that dilutional hyponatremia could not have happened to Patient A, yet in court they said it did.

171. The Tribunal noted the transcript of Dr Taylor's interview by the PSNI. During that interview It was put to Dr Taylor that: *'I'm sure you're aware of what Doctor C and others said to the inquest and there seems to have been a consensus that the quantities that you planned to give in practice were exceeded particularly in the in the early stages of the operation, can you comment on that.'* Dr Taylor replied: *'To have been there and to have given the fluids at the time that we did and the quantity that we did was justified there was a reason for doing what we did.'*

172. Dr Taylor also said that:

> *'I agree with Doctor C and Dr G that any other child would not have been given that quantity of fluid.'*
>
> *'[Patient A] was very exceptional and I don't feel that those 2 individuals really understood really understood [Patient A].'*
>
> *'It was impossible for [Patient A] to get dilutional hyponatremia as we understand it, impossible, he can't concentrate his urine… [Patient A] can't get dilutional hyponatremia and yet the coroner put that as the cause of death and I'm adamant in the belief that [Patient A] cannot concentrate urine and pass small quantities of concentrated urine.'*
>
> *'…when the coroner has concluded that dilutional hyponatremia is a factor I assume that a number of the experts there have agreed with him on that certainly [Dr C] did. Now my recollection and I may later to be proved wrong on this but I think [Dr B] agreed that that was that the coroner's verdict was accurate.'*
>
> *'Frustrating thing for me… is because when I have spoken to [Dr C]… Dr B outside… the confines of the court… They both acknowledge that the cause of the papers on dilutional hyponatremia couldn't have happened to [Patient A] and yet in court they say it did.'*

173. The Tribunal determined that this was factual evidence from Dr Taylor that he had claimed all the matters set out in Paragraph 11e

174. Accordingly, the Tribunal determined and found the entirety of paragraph 11e of the Allegation proved.

Paragraph 11f of the Allegation

175. The Tribunal considered whether Dr Taylor claimed that his intra-operative fluid management was calculated on the basis of: fluid deficit of 300mls; maintenance rate of 200mls an hour; Patient A passing 200mls an hour of dilute urine containing 30mmol/L of sodium for the previous four years; and his knowledge of Patient A's kidney disease meant there may be an unlimited urine output.

176. The Tribunal considered the transcript of Dr Taylor's interview by the PSNI in which he said the following:

'I'm looking at the section where I did some calculations for the fluid… maintenance I've listed 200mls an hour… the deficit I've written down here is 300…'

'Because that's [Patient A's] condition…nephrotic syndrome, he passed 200mls an hour for 4 years of dilute urine containing 30 millimoles of sodium.'

'no one knows what [Patient A]'s kidneys are capable of the only thing we do know was he passed a minimum amount of urine which was 200 mis a day and my knowledge of [Patient A] at this time was that this was a minimum loss and in fact my knowledge of the kidney disease was that there may be an unlimited urine output.'

177. The Tribunal concluded that this was factual evidence from Dr Taylor that he had made the claims referred to in Paragraph 11f.

178. Accordingly, the Tribunal determined and found the entirety of paragraph 11f of the Allegation proved.

Paragraph 11g of the Allegation

179. The Tribunal considered whether Dr Taylor claimed that he had recalculated Patient A's fluid requirements after reviewing the medical records for the Hyponatraemia Inquiry and had determined that: there had been significant blood loss which he estimated at 1400mls; the fluid deficit was 400mls after reviewing the pre-operative fluid balance chart and seeing a deficit of 2 hours; and maintenance requirements were 200mls, based on an overnight feed of 1600mls over 8 hours and the operation commencing during his nocturnal period.

180. The Tribunal considered the transcript of Dr Taylor's interview by the PSNI. In that interview, it was put to him that: *'…your estimation is that he has lost 1400 of those and because I've interviewed the nurses and I've heard you go over the, your reasons for giving that figure, that is a reasonably accurate figure… you have measured certain things and weighed swabs and measured how much is in suction bottles that sort of thing, so to lose 1400 out of 1600mls to me is a fairly significant blood loss. Is that your view.'* Dr Taylor answered: *'Absolutely.'*

181. It was also put to Dr Taylor that: *'…your deficit has increased… from 300 to 400 why is that.'* Dr Taylor answered: *'I think it's because when I reviewed the pre-operative fluid balance chart and I saw that there was deficit of 2 hours.'*

182. Further, it was put to Dr Taylor that: *'…is it the case that on one occasion one of your calculations was that he needed a 150mls an hour for maintenance and then laterally you reviewed that upwards to 200, on what basis do you come to any figure for maintenance.'* Dr Taylor answered: *'Well he got 1600mls over 12 over 8 hours… which 200mls an hour, the 8 hour nocturnal period.*

183. The Tribunal determined that this was factual evidence from Dr Taylor that he had made the claims set out in Paragraph 11g.

184. Accordingly, the Tribunal determined and found the entirety of paragraph 11g of the Allegation proved.

Paragraph 12a of the Allegation

185. The Tribunal considered whether Dr Taylor knew that he had not spoken with Patient A's mother preoperatively.

186. The Tribunal considered the witness statement provided by Patient A's mother in which she said that:

> *'I was not spoken to by any consultant on the morning of the operation… One of the first concerns I had was when Dr Taylor did not appear on the morning of the surgery to see [Patient A] and take his blood before [Patient A] went into theatre.'*

'I went with [Patient A] down to theatre. Dr Taylor was there and that was the first time I saw him regarding this operation… Dr Taylor didn't discuss anything with me and I was ushered out of the room as the operation started'

187. The Tribunal found that, albeit Dr Taylor had claimed he had met with Patient A's mother, her statement was clear and unambiguous about the matter. On the balance of probabilities, the Tribunal was satisfied that Dr Taylor knew that he had not spoken to Patient A's mother before the operation.

188. Accordingly, the Tribunal determined and found paragraph 12a of the Allegation proved.

Paragraph 12b of the Allegation

189. The Tribunal considered whether Dr Taylor knew that during his evidence at the Inquest he stated that he had never planned to perform electrolyte tests.

190. The Tribunal noted the transcript of Dr Taylor's deposition, where he said that:

'*In [Patient A's] case it was not practical to carry out electrolyte tests at the commencement of surgery.'*

191. The Tribunal was of the view that whilst Dr Taylor had indicated that it was not practical to carry out electrolyte tests, he did not specifically say that he had never planned to perform electrolyte tests. The Tribunal found no other evidence to support the allegation.

192. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 12b of the Allegation not proved.

Paragraph 12c of the Allegation

193. The Tribunal considered whether Dr Taylor knew that he had failed to disclose the matters describe in paragraph 7 of the Allegation

194. The Tribunal adopts its similar reasoning in determining paragraph 7 of the Allegation. In light of the Tribunal determining paragraph 7 of the Allegation not proved, paragraph 12c of the Allegation must fall.

195. Accordingly, the Tribunal determined and found paragraph 12c of the Allegation not proved.

Paragraph 12di and 12dii of the Allegation

196. The Tribunal considered whether Dr Taylor knew that he had changed his clinical practice after the Coroner's Inquest on the basis that he had accepted that there had been errors in his fluid management and had accepted the Coroner's verdict that the cause of death was dilutional hyponatraemia.

197. The Tribunal considered the evidence of the witnesses in this case. It noted that there was evidence suggesting that there had been errors in Dr Taylor's fluid management. The Tribunal was of the view that Dr Taylor should have accepted the errors and had the duty as a doctor to do so. However, the Tribunal was unable to identify evidence to support the assertion that Dr Taylor's clinical practice had changed after the Coroner's Inquest on the basis of the matters accepted.

198. Therefore, the Tribunal determined and found paragraphs 12di and 12dii of the Allegation not proved.

Paragraph 12diii of the Allegation

199. The Tribunal considered whether Dr Taylor knew that he had changed his clinical practice after the Coroner's Inquest on the basis that he had accepted that Patient A's polyuric condition meant that he had a fixed urinary output and that he was able to develop dilutional hyponatraemia.

200. The Tribunal considered the transcript of Dr Taylor's oral evidence to the Inquiry. Dr Taylor was asked the following question: *'…you would have taught something that was quite contrary to what you actually thought was the case and what you were propounding was the case in the interviews and so forth that you gave?'* Dr Taylor answered: '*Yes'*.

201. Dr Taylor was then asked*: '…to go back to the questions… about whether you were holding a different position internally on dilutional hyponatraemia than you were holding externally. If I understand your answer… correctly, what you would have taught junior doctors about polyuria and fixed urine output was different to the mistake you made in [Patient A's] case, but also then different to what you said to the police, and equally different to what you said to the inquiry.'* Dr Taylor replied: *'I can't account for the fact that I held a different view than what I practised and what I taught.'*

202. Having had regard to that evidence, the Tribunal was of the view that Dr Taylor must have been aware that Patient A's polyuric condition meant that he had a fixed urinary output and that he was able to develop dilutional hyponatraemia.

203. Therefore, the Tribunal determined and found the entirety of paragraph 12diii of the Allegation proved.

Paragraph 12d iv of the Allegation

204. The Tribunal considered whether Dr Taylor knew that he had changed his clinical practice after the Coroner's Inquest on the basis that he had accepted the matters described in paragraphs 4c and 9ai of the Allegation.

205. The Tribunal adopts the reasoning it had reached in determining paragraphs 4c and 9ai of the Allegation. It determined that paragraph 4c of the Allegation was not proved.

206. Therefore, the Tribunal determined and found paragraph 12div of the Allegation proved only in relation to paragraph 9ai, namely that Patient A had a fixed urinary output of about 70-80 mls per hour.

Paragraph 12e of the Allegation

207. The Tribunal considered whether Dr Taylor knew that he recalculated and increased his figures for fluid deficit, maintenance requirements and blood loss in order to conceal the fact that he knew he had given too much fluid during surgery.

208. The Tribunal relied on its determination in respect of earlier paragraphs of the Allegation. It was of the view that Dr Taylor's shortcoming was not that he administered the wrong amount of fluid but rather it was the type of fluid he had used. Although, Dr

Taylor had different figures where recalculated and had increased his estimations, there is no evidence to suggest that he was thereby attempting to conceal the fact that he had given too much fluid.

209. Therefore, the Tribunal determined and found paragraph 12e of the Allegation not proved.

Paragraph 13 of the Allegation

210. The Tribunal considered whether Dr Taylor's action as set out in paragraph 11a by reason of paragraph 12a was dishonest.

211. The Tribunal considered its findings in paragraphs 11a and 12a of the Allegation. It was of the view that Dr Taylor knew he had neither met Patient A's mother nor gained any information from speaking with her during his pre-operative assessment.

212. The Tribunal considered that an ordinary decent person, would consider that Dr Taylor's action in making a claim to the police that he knew to be false was dishonest.

213. Accordingly the Tribunal determined and found paragraph 13 of the Allegation proved.

Paragraph 14 of the Allegation

214. The Tribunal considered whether Dr Taylor's action as set out in paragraph 11b by reason of paragraph 12b was dishonest.

215. The Tribunal has found paragraph 12b of the Allegation not proved and therefore paragraph 14 must fall.

216. Accordingly, the Tribunal determined and found paragraph 14 of the Allegation not proved.

Paragraph 15 of the Allegation

217. The Tribunal considered whether Dr Taylor's action as set out in paragraph 11c by reason of paragraph 12c was dishonest.

218. The Tribunal has found paragraph 12c of the Allegation not proved and therefore paragraph 15 must fall.

219. Accordingly, the Tribunal determined and found paragraph 15 of the Allegation not proved.

Paragraph 16 of the Allegation

220. The Tribunal considered whether Dr Taylor's actions as set out in paragraphs 11d – 11f by reason of paragraph 12d were dishonest.

221. The Tribunal considered its findings in paragraphs 11d – 11f and 12d of the Allegation. The Tribunal noted that it found paragraphs 12di and 12dii of the Allegation not proved. Therefore, it considered only whether found that this paragraph of the Allegation is only found by reason of paragraph 12diii and 12div. The Tribunal was of the view that Dr Taylor must have been aware that Patient A's polyuric condition meant that he had a fixed urinary output and that he was able to develop dilutional hyponatraemia. Further, Dr Taylor knew that he had changed his clinical practice after the Coroner's Inquest on the basis that he had accepted, in advance of the Coroner's Inquest, that Patient A had a fixed urinary output of about 70-80mls per hour.

222. The Tribunal considered that an ordinary decent person would consider that Dr Taylor's statements to the police were dishonest. The Tribunal found paragraph 16 of the Allegation proved in relation to paragraph 12diii and 12div.

Paragraph 17 of the Allegation

223. The Tribunal considered whether Dr Taylor's action as set out in paragraph 11g by reason of paragraph 12e was dishonest.

224. The Tribunal has found paragraph 12e of the Allegation not proved and therefore paragraph 17 must fall.

225. Accordingly, the Tribunal determined and found paragraph 17 of the Allegation not proved.

Paragraph 18 of the Allegation

226. The Tribunal noted that the stem of the allegation refers to the provision by Dr Taylor of a statement to the Inquiry on 18 July 2005.

227. In considering the allegations under paragraph 18 the Tribunal took into account Dr Taylor's first statement to the Inquiry, where he said that:

> '*In 2001 I was invited to be a member of the Working Party on Prevention of Hyponatraemia… I helped to draft guidelines to be used by all hospital departments where children are given intravenous fluids.'*

228. The Tribunal was of the view that, at that point of time and having seen all the information and expert evidence provided, Dr Taylor should have appreciated and understood errors and deficiencies in his management of Patient A.

Paragraph 18ai

229. The Tribunal considered whether Dr Taylor should have disclosed the error(s) made by his pre-operative fluid calculations as described at paragraph 1d of the Allegation but failed to do so.

230. The Tribunal noted its determination in respect of paragraph 1d of the Allegation and that it found the allegation proved only in relation to paragraph 1diii. It was of the view that, having failed to accurately calculate the pre-operative fluid balance of Patient A in respect of the normal urinary output, he should have disclosed this to the Inquiry. Notwithstanding that it was highly relevant he failed to do this.

231. Therefore, the Tribunal determined and found paragraph 18ai of the Allegation proved in relation to paragraph 1diii.

Paragraph 18aii of the Allegation

232. The Tribunal considered whether Dr Taylor should have but failed to disclose the error(s) made by replacing blood loss which he calculated as 1411mls.

233. The Tribunal considered the Inquiry chronology of events, where Dr Taylor had indicated that the total blood loss recorded was 1128mls. The Tribunal then considered Dr Taylor's first Inquiry Statement, where he indicated that: '*swabs weighed 411mls, suction bottle 500mls and towels 'heavily soaked' 500mls.'* Totalling to 1411mls.

234. The Tribunal was of the view that the evidence showed a material change and that the increase in blood loss was not by a small amount. On the balance of probabilities, following the material change in the evidence, the Tribunal found that Dr Taylor should have disclosed his error in replacing blood loss which he calculated as 1411mls. He did not do so.

235. Accordingly, the Tribunal determined and found paragraph 18aii of the Allegation proved.

18aiii of the Allegation

236. The Tribunal considered whether Dr Taylor should have disclosed his error in accepting the initial CVP reading of 17mmHg as a marker for relative change but failed to do so.

237. The Tribunal considered Dr Taylor's updated statement to the Coroner, where he said that: '*On measuring the CVP the initial pressure reading was 17mmHg… However, from the pressure reading I concluded that the tip of the line was not in close relation to the heart. I therefore used the initial reading (17mmHg) as a baseline.'* The Tribunal also took into account considered the transcript of Dr Taylor's interview by the PSNI, where he said that: '*…we accepted the [17mmHg] as a marker to look for a relative change…'*

238. In the light of the evidence before it, the Tribunal concluded that Dr Taylor had a duty to disclose the error(s) he made but had failed to do so.

239. Accordingly, the Tribunal determined and found paragraph 18aiii of the Allegation proved.

Paragraph 18b of the Allegation

240. The Tribunal considered whether Dr Taylor falsely claimed in his statement to the Inquiry on 18 July 2005 that there was no sign of inappropriate or excessive fluids had been given for Patient A's complex surgery and pre-existing medical problems.

241. The Tribunal considered Dr N's expert opinion, which he stated:

> *'In my opinion the injury had already occurred by the time the arterial blood gas sample was taken and, on the balance of probability, was irreversible at this stage.'*
>
> *'…in my opinion it was the choice of intravenous fluid given in this instance that was the primary failure…'*

242. The Tribunal considered the evidence showing the result of the blood gas taken on 09:32. It shows a low serum sodium reading of 123mmols/L.

243. Taking into account the evidence and the expert opinion of Dr N, the Tribunal was of the view that Dr Taylor must have known that there were signs that inappropriate or excessive fluids had been given to Patient A, yet claimed falsely that there were not.

244. Accordingly, the Tribunal determined and found paragraph 18b of the Allegation proved.

Paragraph 19 of the Allegation

245. The Tribunal noted that the stem of the Allegation is whether Dr Taylor made false claims in respect of electrolytes, fluid overload, the ability of Patient A's kidneys to concentrate urine, the equipment in the operating theatre, and when he first noticed swelling in the face, hands and feet.

Paragraph 19a of the Allegation

246. The Tribunal considered whether Dr Taylor falsely claimed that he did not carry out electrolyte tests at the commencement of surgery because it would have meant absenting a member of the team at a very busy time.

247. The Tribunal considered the expert opinion of Dr C, he said that:

> '*I think it was unwise not to have electrolytes values taken before going to theatre and after the PD had been completed'*

248. The Tribunal considered the evidence before it and found that Dr Taylor did make the statement alleged. However, the Tribunal questioned whether the claim was false even though Dr Taylor's reasons were not 'good enough' or otherwise questionable.

249. The Tribunal was of the view that, at the time, it was still Dr Taylor's belief that carrying out electrolyte tests at the commencement of surgery would have meant absenting a member of the team at a very busy time. Further, the Tribunal considered the evidence of Dr C where he said, '*it was unwise'* and did not indicate whether it was inappropriate.

250. Accordingly, on the balance of probabilities, the Tribunal determined and found paragraph 9a of the Allegation not proved.

Paragraph 19b of the Allegation

251. The Tribunal considered whether Dr Taylor falsely claimed that he did not believe that Patient A's hyponatraemia was caused by fluid overload.

252. The Tribunal considered Dr Taylor's second witness statement to the Inquiry and was unable to find any claim by him that *'he did not believe that Patient A's hyponatraemia was caused by fluid overload'.* In the absence of any other evidence the Tribunal could not be satisfied that Dr Taylor had falsely made the claim alleged.

253. Accordingly, the Tribunal determined and found paragraph 19b of the Allegation not proved.

Paragraph 19c of the Allegation

254. The Tribunal considered whether Dr Taylor falsely claimed that Patient A's native kidneys could not concentrate urine and therefore large volumes of dilute urine was lost.

255. The Tribunal considered the expert opinion of Dr G, he said that: *'[Patient A] was in renal failure with a high volume of dilute urine from his own (native) kidneys.* The Tribunal also considered the expert opinion of Dr C, he said that: '*[Patient A] also passed urine, presumably of a poor quality, and has been described as polyuric.'*

256. Further, the Tribunal noted that the GMC had stated within paragraph 12diii of the Allegation that Patient A had a polyuric condition. Having regard to the evidence before it, the Tribunal concluded that Dr Taylor did not falsely claim that Patient A's native kidneys could not concentrate urine and therefore large volumes of dilute urine was lost.

257. Accordingly, the Tribunal determined and found paragraph 19c of the Allegation not proved.

Paragraph 19d of the Allegation

258. The Tribunal considered whether Dr Taylor falsely claimed that the equipment referred to in the Technician's Report was that present in the operating theatre when Patient A's operation took place.

259. The Tribunal has found paragraph 7 of the Allegation not proved. It was of the view that the Hospital was aware that a monitor was out for a repair. However, the Tribunal has seen no reliable evidence of the precise date when the monitor was out for a repair. It could not be satisfied as to whether this was prior or after the surgery on 27 November 1995. On the balance of probabilities, the Tribunal found that Dr Taylor did not falsely claim that the equipment referred to in the Technician's Report was that present in the operating theatre when Patient A's operation took place.

260. Accordingly, the Tribunal determined and found paragraph 19d of the Allegation not proved.

Paragraph 19e of the Allegation

261. The Tribunal considered whether Dr Taylor falsely claimed that he first noticed the face, hands and feet were swollen when the sterile towels were removed at the end of the surgery.

262. The Tribunal considered Dr Taylor's transcript of oral evidence to the Inquiry in which he said that:

> *'Face, hands and feet were swollen. I first noticed this when the sterile towels were removed at the end of the operation.'*

'Well, it was actually my normal practice to keep it visible.'

'Contrary to my normal practice, or notwithstanding it, I actually had his face covered with sterile towels…'

263. Having regard to all the evidence, the Tribunal was of the view that it could not be satisfied to the required standard that Dr Taylor first noticed Patient A's face, hands or feet were swollen before he had removed the sterile towels at the end of surgery. The Tribunal noted that there was no evidence to contradict the recollection of Dr Taylor. Therefore, on the balance of probabilities, the Tribunal determined that Dr Taylor did not falsely claim that he first noticed the face, hands and feet were swollen when the sterile towels were removed at the end of the surgery.

264. Accordingly, the Tribunal determined and found paragraph 19e of the Allegation not proved.

Paragraph 20 of the Allegation

265. The Tribunal considered whether in the lead up to and following the Coroner's Inquest, Dr Taylor knew about the matters described at paragraphs 2, 4, 7, 9, 12b, 12c and 12d of the Allegation.

266. The Tribunal has already concluded that paragraphs 4, 7, 12b, and 12c were not proved.

267. The Tribunal considered and relied upon the Trust Notes of Pre-Inquest consultation. The Tribunal also considered that there was approximately a six-month gap between the surgery and the Coroner's Inquest. The Tribunal was of the view that Dr Taylor was afforded the time and opportunity to reflect on the information and expert opinion surrounding Patient A's surgery. Therefore, the Tribunal determined on the balance of probabilities that Dr Taylor was aware of the matters described at paragraphs 2, and 9, and also 12d iv in relation to 9a i, of the Allegation.

268. Accordingly, the Tribunal determined and found paragraph 20a of the Allegation proved in respect only of paragraphs 2, 9, and 12d iv in relation to 9 a i.

Paragraph 20b of the Allegation

269. The Tribunal considered whether in the lead up to and following the Coroner's Inquest, Dr Taylor knew that sterile towels were not over Patient A's face.

270. Again, the Tribunal considered the transcript of Dr Taylor's oral evidence to the Inquiry in which he said that:

'Face, hands and feet were swollen. I first noticed this when the sterile towels were removed at the end of the operation.'

'Well, it was actually my normal practice to keep it visible.'

'Contrary to my normal practice, or notwithstanding it, I actually had his face covered with sterile towels…'

271. The Tribunal also considered Dr Taylor's second Inquiry Statement, which he stated:

'*The face, hands and feet were swollen. I first noticed this when the sterile towels were removed at the end of the operation.'*

272. The Tribunal noted that the two accounts from Dr Taylor were consistent. There was no evidence to gainsay them. The Tribunal determined, on the balance of probabilities, that the sterile towels had been on Patient A's face and that Dr Taylor' had first noticed them when they were removed.

273. Accordingly, the Tribunal determined and found paragraph 20b of the Allegation not proved.

Paragraph 21 of the Allegation

274. The Tribunal considered whether Dr Taylor's conduct as set out in paragraphs 18ai, 18aii, 18b and 19b by reason of paragraphs 9ai, 9aii and 9b were dishonest.

275. The Tribunal considered its findings in relation to paragraphs 18ai, 18aii, 18b, 19b, 9ai, 9aii and 9b. It noted that it had found each of them proved apart from 18 ai in relation to 1di and 9b and 19b.

276. The Tribunal also took into account Dr Taylor's first statement to the Inquiry, where he stated that:

'I worked with all those involved in the days and weeks following [Patient A's] death to investigate all the possible reasons for that tragic event. This included reviews of all aspects of the anaesthetic and pre-operative management. It also involved a detailed literature search by me for publications relevant to the case.'

'*In 2001 I was invited to be a member of the Working Party on Prevention of Hyponatraemia… I helped to draft guidelines to be used by all hospital departments where children are given intravenous fluids.'*

277. It was clear to the Tribunal that, in the light of what took place after Patient A's death, Dr Taylor was involved in reviews, investigations and research. Dr Taylor was also invited to become a member of the Working Party on Prevention of Hyponatraemia. The Tribunal concluded that Dr Taylor, at this stage, must have known what his failings had been.

278. The Tribunal considered that an ordinary decent person, would consider that Dr Taylor's action in behaving in this way was dishonest. The Tribunal found paragraph 21 of the Allegation proved in respect of paragraphs 18a i, 18a ii, and in respect of 18b by reason of paragraphs 9ai and 9aii.

Paragraph 22 of the Allegation

279. The Tribunal considered whether Dr Taylor's conduct as set out in paragraph 18aiii by reason of paragraphs 2e and 2f were dishonest.

280. The Tribunal has found paragraph 18iii proved only by reason of paragraph 2e .

281. The Tribunal again considered and relied upon the evidence it took into account in respect of paragraph 21 of the Allegation. Given Dr Taylor's involvement in reviews, investigations and research, at this stage, Dr Taylor must have known what his failings were in relation to 18iii.

282. The Tribunal concluded that an ordinary decent person, would consider that Dr Taylor's action in failing to make disclosure to the Inquiry was dishonest. The Tribunal found paragraph 22 of the Allegation proved in relation to paragraph 2e.

Paragraph 23 of the Allegation

283. The Tribunal considered whether Dr Taylor's conduct as set out in paragraph 19c was dishonest by reason of paragraph 12diii.

284. The Tribunal has already found paragraph 19c of the Allegation not proved and therefore paragraph 23 of the Allegation must fall.

285. Accordingly, the Tribunal determined and found paragraph 23 of the Allegation not proved.

Paragraph 24 of the Allegation

286. The Tribunal considered whether Dr Taylor's conduct as set out in paragraph 19d by reason of paragraph 7 was dishonest.

287. The Tribunal has found paragraphs 19d and 7 not proved and therefore paragraph 24 of the Allegation must fall.

288. Accordingly, the Tribunal determined and found paragraph 24 of the Allegation not proved.

Paragraph 25 of the Allegation

289. The Tribunal considered whether Dr Taylor's conduct as set out in paragraph 19a was dishonest by reason of paragraph 12b.

290. The Tribunal considered its findings on paragraphs 19a and 12b of the Allegation. The Tribunal has found paragraphs 19a and 12b not proved and therefore, paragraph 25 of the Allegation must fall.

291. Accordingly, the Tribunal determined and found paragraph 25 of the Allegation not proved.

Paragraph 26 of the Allegation

292. The Tribunal considered whether Dr Taylor's conduct as set out in paragraph 19e was dishonest by reason of paragraph 20b.

293. The Tribunal has found paragraphs 19e and 20b of the Allegation not proved and therefore, paragraph 26 of the Allegation must fall.

294. Accordingly, the Tribunal determined and found paragraph 26 of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

295.The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 27 November 1995 your pre-operative assessment of Patient A was inadequate in that you failed to:

    a. ensure you had sufficient information about fluid intake/ output by:

        i. meeting with Patient A's Mother before surgery and / or;
        Determined and found proved

        ii. reviewing Patient A's medical records;
        Determined and found proved

    b. have sufficient regard to Dr B's:

        i. advice about Patient A's:

            1. history of fluid Balance;
            Determined and found proved

            2. propensity to hyponatraemia
            Determined and found proved

ii. request to check electrolyte concentrations prior to surgery;
Determined and found proved

c. obtain Laboratory arterial blood gas sample to check for electrolyte concentrations as soon as the arterial catheter had been sited;
Determined and found proved

d. accurately calculate the pre-operative fluid balance in that you estimated patient A's:

i. fluid deficit on arrival in theatre as 400mls;
Determined and found not proved

ii. required maintenance rate as 200mls per hour;
Determined and found not proved

iii. rate of normally hourly urinary output on a fixed basis.
Determined and found proved

2. On 27 November 1995 your intra-operative fluid management was inadequate in that you:

a. miscalculated urine output and relied on this to determine the amount and type of fluid patient A required during surgery;
Determined and found proved

b. administered a low sodium content intravenous fluid ('Solution 18):

i. which was the wrong type of intravenous fluid;
Determined and found proved

ii. in excessive quantity;
Determined and found proved

iii. at an excessive rate;
Determined and found proved

iv. without sufficient regard to:

1. Patient A's weight of 21kg;
Determined and found proved

2. Patient A having received 952mls Dioralyte solution enterally overnight;
Determined and found proved

v. in conjunction with 1000mls of human albumin solution;
Determined and found proved

c. overestimated blood loss;
Determined and found not proved

d. in the alternative to paragraph 2c. knew or ought to have known that total blood loss was less then 1128mls;
Determined and found not proved

e. incorrectly interpreted the high central Venus pressure ('CVP') readings;
Determined and found proved

f. inappropriately silenced the high-pressure alarm;
Determined and found not proved

g. failed to make an assessment of Patient A's sodium levels until a blood gas sample was tested at 9:32;
Determined and found proved

h. disregarded the low serum sodium reading of 123mmols/L measured at 9:32;
Determined and found not proved

i. failed to repeat the arterial blood gas analysis after 9:32;
Determined and found proved

j. failed to recognise the:

i. development of acute hyponatraemia;
Determined and found proved

ii. potential risk of hyponatraemia.
Determined and found proved

3. On 30 November 1995 you prepared a statement for the Coroner's Inquest in which you:

a. failed to disclose:

   i. the low serum sodium reading 123mmols of the arterial blood gas analysis taken at 9:32;
   Determined and found proved

   ii. the low serum sodium reading of 119mmols/L measured at the end of the surgery;
   Determined and found proved

b. claimed:

   i. the CVP readings had given you no cause for concern through the case;
   Determined and found proved

   ii. there had been normal monitoring signs;
   Determined and found proved

   iii. the estimated blood loss was 1128mls;
   Determined and found proved

   iv. your management of Patient A was 'caring, appropriate, expert and representative of the highest quality of intensity of care that I can provide'.
   Determined and found proved

4. You knew that:

   a. your use of large quantities of Solution 18 created a risk of dilutional hyponatremia of cerebral oedema;
   Determined and found not proved

   b. you had administered Solution 18 at an excessive rate and volume which was not clinically indicated;
   Determined and found not proved

   c. total blood loss was less then 1128mls;
   Determined and found not proved

   d. by providing a higher estimated blood loss figure you could justify your fluid management described at paragraph 2a. and 2b.

Determined and found not proved

5. Your actions as set out in paragraphs 3a. were dishonest by reason of one or more of paragraphs 4a and 4b.
   Determined and found not proved

6. Your actions as set out in paragraphs 3b. were dishonest by reason of one or more paragraphs 4a. – 4d.
   Determined and found not proved

7. On 2 December 1995, during an inspection of theatre equipment (Technicians Report), you failed to clarify the Siemens Patient Monitor being inspected was not the equipment used during Patient A's surgery.
   Determined and found not proved

8. On 21 June 1996, during the Coroners' Inquest you:

   a. Stated that Patient A:

      i. had 300mls fluid deficit at start of surgery;
      Determined and found proved

      ii. required maintenance fluid at 150mls per hour;
      Determined and found proved

      iii. had blood loss of 1128mls;
      Determined and found proved

   b. claimed that you did not have an opportunity to measure urinary output because the bladder had been opened early in the surgery;
   Determined and found not proved

   c. failed to acknowledge that it was your administration of Solution 18 which caused:

      i. the acute hyponatremia;
      Determined and found proved

      ii. reduction in plasma oncotic pressure;
      Determined and found proved

iii. cerebral oedema;
Determined and found proved

d. failed to clarify the matters described in paragraph 7;
Determined and found not proved

e. inappropriately:

i. disputed the opinion of the Coroner's Experts that the cause of death was dilutional hyponatraemia caused by fluid overload;
Determined and found proved

ii. demonstrated no willingness to address any shortcomings in that care you provided to Patient A.
Determined and found proved

9. You knew:

a. In advance of the Coroner's Inquest that Patient A:

i. had a fixed urinary output of about 70-80mls per hour;
Determined and found proved

ii. required maintenance fluid of up to about 100ml per hour;
Determined and found proved

iii. did not have his bladder opened immediately at the start of surgery;
Determined and found proved

b. that you had provided the higher estimated figures described at paragraph 8a., knowing they were wrong, in order to justify your fluid management described at paragraph 2.
Determined and found not proved

10. Your actions as set out in paragraphs 8a and 8b. were dishonest by reason of one or more of paragraphs 9a and 9b.
Determined and found not proved

11. On 18 October 2006 during a Police Interview you claimed that:

a. your pre-operative assessment included gaining information from speaking with Patient A's mother;

Determined and found proved

b. Your reason for not obtaining a laboratory arterial blood gas analysis was due to:

    i. this being lower down on your list of priorities;
    Determined and found proved

    ii. you not being able to spare any member of your team until 9.30 to send for a laboratory blood test;
    Determined and found proved

    iii. your knowledge that patient A's sodium concentration did not vary;
    Determined and found proved

c. the Technicians Report did refer to the equipment you were using during Patient A's surgery;
Determined and found proved

d. the low serum sodium reading of 123 mmols/L measured at 9:32 was a rogue result because:

    i. the blood gas analyser did not provide reliable measurements;
    Determined and found proved

    ii. you knew from Patient A's previous blood tests that he tolerated sodium of 124 mmols/L without ill effect;
    Determined and found proved

    iii. you were at a loss to associate the change in sodium with any clinical deterioration of Patient A;
    Determined and found proved

e. You did not accept the findings from the Coroner's Inquest because:

    i. you disagreed with the Coroner's Expert evidence that the quantities of fluid you planned to give were exceeded in the early stages of the operation;
    Determined and found proved

    ii. Patient A was exceptional, and you didn't feel the Coroner's Experts really understood him;

Determined and found proved

iii. it was impossible for Patient A to get dilutional hyponatremia because he was unable to concentrate urine and slow down his urine output;
Determined and found proved

iv. when you spoke with Mr C and Dr B outside the confines of court, they both acknowledged that dilutional hyponatremia could not have happened to Patient A, yet in court they said it did;
Determined and found proved

f. Your intra-operative fluid management was calculated on the basis of:

i. fluid deficit of 300mls;
Determined and found proved

ii. maintenance rate of 200mls an hour;
Determined and found proved

iii. Patient A passing 200mls an hour of dilute urine containing 30mmol/L of sodium for the previous four years;
Determined and found proved

iv. your knowledge of Patient A's kidney disease meant there may be an unlimited urine output;
Determined and found proved

g. You had recalculated Patient A's fluid requirements after reviewing the medical records for the Hyponatremia Inquiry ('Inquiry') and determined that:

i. there had been significant blood loss which you estimated at 1400mls;
Determined and found proved

ii. the fluid deficit was 400mls after reviewing the pre-operative fluid balance chart and seeing a deficit of 2 hours;
Determined and found proved

iii. maintenance requirements were 200mls, based on an overnight feed of 1600mls over 8 hours and the operation commencing during his nocturnal period.

Determined and found proved

12. You knew that you had:

    a. not spoken with Patient A's mother preoperatively;
    Determined and found proved

    b. previously stated during your evidence at the inquest that you had never planned to perform electrolyte tests;
    Determined and found not proved

    c. failed to disclose the matters described in paragraph 7;
    Determined and found not proved

    d. changed your clinical practice after the Coroner's Inquest on the basis you had accepted:

        i. there had been errors in your fluid management;
        Determined and found not proved

        ii. the Coroner's Verdict that the cause of the death was dilutional hyponatraemia;
        Determined and found not proved

        iii. that patient A's polyuric condition meant:

            1. he had a fixed urinary output;
            Determined and found proved

            2. he was able to develop dilutional hyponatremia;
            Determined and found proved

        iv. the matters described in paragraphs 4c and 9a.i;
        Determined and found proved only in relation to paragraph 9ai

    e. recalculated and increased your figures for fluid deficit, maintenance requirements and blood loss in order to conceal the fact you knew you had given too much fluid during surgery.
    Determined and found not proved

13. Your action as set out in paragraph 11a. was dishonest by reason of paragraph 12a.
Determined and found proved

14. Your actions as set out in paragraph 11b. were dishonest by reason of paragraph 12b.
Determined and found not proved

15. Your action as set out in paragraph 11c. was dishonest by reason of paragraph 12c.
Determined and found not proved

16. Your actions as set out in paragraphs 11d – 11f. were dishonest by reason of one or more of paragraphs 12d.
Determined and found proved only in relation to paragraphs 12diii and 12div

17. Your actions as set out in paragraph 11g. were dishonest by reason of paragraph ~~11d.~~ 12e
Amended under Rule 17(6)
Determined and found not proved

18. On 18 July 2005 you provided a statement to the inquiry in which you:

    a. failed to disclose the error(s) made by :

        i. your pre-operative fluid calculations as described at paragraph 1d;
        Determined and found proved only in relation to paragraph 1diii

        ii. you replacing blood loss which you calculated as 1411mls;
        Determined and found proved

        iii. you accepting the initial CVP reading of 17mmHg as a marker for relative change;
        Determined and found proved

    b. Falsely claimed there was no sign that inappropriate or excessive fluids had been given for Patient A's complex surgery and pre-existing medical problems.
    Determined and found proved

19. On 16 May 2011 you provided a second statement to the Inquiry in which you falsely claimed:

    a. you did not carry out electrolyte tests at the commencement of surgery because it would have meant absenting a member of the team at a very busy time;

Determined and found not proved

b. you did not believe Patient A's hyponatraemia was caused by fluid overload;
Determined and found not proved

c. Patient A's native kidneys could not concentrate urine and therefore large volumes of dilute urine was lost;
Determined and found not proved

d. the equipment referred to in the Technician's Report was that present in the operating theatre when Patient A's operation took place;
Determined and found not proved

e. you first noticed the face, hands and feet were swollen when the sterile towels were removed at the end of the surgery.
Determined and found not proved

20. In the lead up to and following Coroner's Inquest you knew:

a. About the matters described at paragraphs 2,4,7,9,12b.,12c and 12d.;
Determined and found proved in respect of paragraphs 2 and 9 and 12d iv in relation to 9 ai

b. Sterile towels were not over Patient A's face.
Determined and found not proved

21. Your actions as set out in paragraphs 18a.i, 18a.ii 18b, and 19b. were dishonest by reason of paragraphs 9.a.i, 9a.ii and 9.b.
Determined and found proved in respect of paragraphs 18ai, 18aii and in respect of 18b by reason of 9ai and 9aii.

22. Your actions as set out in paragraphs 18.iii was dishonest by reason of paragraphs 2e. and 2f.
Determined and found proved

23. Your action as set out in paragraph 19c. was dishonest by reason of paragraph 12d.iii.
Determined and found not proved

24. Your action as set out in paragraph 19d. was dishonest by reason of paragraph 7.
Determined and found not proved

25. Your action as set out in paragraph 19a. was dishonest by reason of paragraph 12b.
Determined and found not proved

26. Your action as set out in paragraph 19e. was dishonest by reason of paragraph 20b.
Determined and found not proved

Determination on Impairment - 20/06/2022

296. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Taylor's fitness to practise is impaired by reason of misconduct.

The Evidence

297. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

Submissions

298. On behalf of the GMC, Mr Forster QC, submitted that Dr Taylor's fitness to practise is impaired by reason of misconduct. Mr Forster referred to the relevant paragraphs within the versions of Good Medical Practice ('GMP') applicable at the time – 1995 edition, 2001 edition, 2006 edition.

299. Mr Forster referred the Tribunal to its findings on facts. He noted Dr Taylor's: serious clinical failings; failure to disclose important information to the Coroner in a witness statement; failure to acknowledge in his evidence to the Coroner that his infusion of Solution 18 caused hyponatraemia and cerebral oedema; and an unwillingness to address his shortcomings when he disputed the Coroner's Expert's opinion.

300. Mr Forster reminded the Tribunal of Dr N's evidence, that Dr Taylor should have known that giving large quantities of low sodium fluid was the primary and critical problem. That evidence was not challenged by Dr Taylor.

301. Mr Forster submitted that Dr Taylor's clinical failings were grave and amounted to fatal errors. Dr Taylor's pre-operative and intra-operative failings were extremely serious. His failings in pre-operative care led to further intra-operative errors that had catastrophic and fatal consequences. His failure to review the medical records properly and to heed

Dr B's advice lead to him proceeding without understanding Patient A's sodium levels or urine output and with a profound misunderstanding as to his fluid management. He used the wrong fluid, wrongly interpreted CVP readings which provided him with danger signals, failed to conduct critically important blood tests and did not recognise the development of hyponatremia and the potential risk it posed to Patient A. He submitted that this is a case where Dr Taylor's clinical failings are irremediable.

302. Mr Forster also referred the Tribunal to its findings of dishonesty. He submitted that Dr Taylor had been dishonest when he made particular statements to the Inquiry in a witness statement signed under a declaration of truth and to the police whilst under caution. This breached a fundamental tenet of the profession and amounted to misconduct. Mr Forster submitted that the Tribunal's findings on facts and Dr Taylor's breaches of fundamental tenets of the profession amounts to serious misconduct.

303. In relation to Dr Taylor's dishonesty, Mr Forster submitted that these are extremely grave in that Dr Taylor persisted and sought to make misleading assertions and withhold information to conceal the truth. Mr Forster noted that there was no evidence of remediation nor insight, although Dr Taylor eventually admitted to the Inquiry that he had been wrong, irrational and confused. However, he did not make any admission that he had been dishonest or apologise for that.

304. Mr Forster submitted that the context, gravity and persistence of Dr Taylor's clinical failings and dishonesty require a finding of impairment in order to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. Dr Taylor had sought to mislead and deceive about there being no signs of the wrong type of fluid was being used. His dishonesty was persistent and sought to raise misleading assertions and withhold information in an enterprise that was designed to conceal the truth and his own failings in care.

The Relevant Legal Principles

305. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof, and the decision of impairment is a matter for the Tribunal's judgement alone.

306. In approaching its decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct and whether the finding of misconduct could lead to a finding of impairment.

307. The Tribunal must determine whether Dr Taylor's fitness to practise is impaired today, taking into account Dr Taylor's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

308. In determining the issue of impairment, the Tribunal must have regard to both the personal component and the public interest in declaring and upholding proper standards of conduct by practitioners and to maintain public confidence in the medical profession. The Tribunal must apply the 4-fold test established by Dame Janet Smith in her fifth Shipman Report which was approved and followed in *Council for Healthcare Regulatory Excellence v. Nursing and Midwifery Council* and *Grant [2011] EWHC 927*.

The Tribunal's Determination on Impairment

Misconduct

309. In determining whether Dr Taylor's fitness to practise is currently impaired. The Tribunal first considered whether the facts found proved amounted to misconduct.

310. The Tribunal noted that it found a number of paragraphs of the Allegation relating to Dr Taylor's clinical failures proved, set out in detail within the Tribunal's determination on facts. It also considered the expert opinion of Dr N, he said that:

> *'Given the errors that Dr Taylor made with respect to preoperative fluid balance… and how they impacted upon intra-operative fluid management, in my opinion, his care in this area fell seriously below an expected standard.'*
>
> *'In my opinion Dr Taylor's actions fell seriously below an expected standard in a number of areas, including his understanding of [Patient A's] pre-operative urine output/fluid balance and failing to heed/take appropriate advice in this respect, failing to appreciate the presence of hyponatraemia on arterial blood gas analysis at 09.32hrs and failing to repeat the estimation.'*

311. The Tribunal also considered that paragraphs 2 and 3 of GMP (1995 edition) are engaged.

'2 You must take suitable and prompt action when necessary. This must include:

- *an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination;*
- *providing or arranging investigations or treatment where necessary;'*

'3 In providing care you must:

- *be willing to consult colleagues;*

…

- *be competent when making diagnoses and when giving or arranging treatment;*
- *keep colleagues well informed when sharing the care of patients;*

…

- *prescribe only the treatment, drugs, or appliances that serve patients' needs.'*

312. Although the Tribunal acknowledges that there may have been system failures within the Hospital, it determined that Dr Taylor's individual failures before and during surgery were so serious that they amounted to misconduct.

313. In relation to Dr Taylor's evidence to the Inquest, the Tribunal considered its findings on facts. Although the Tribunal did not find Dr Taylor to have acted dishonestly, it was of the view that Dr Taylor still had a duty to disclose highly relevant information to the Coroner. The Inquest was held six months after Patient A's surgery and death. At the time he gave evidence, Dr Taylor had available to him substantial and significant information in relation to Patient A's medical history and care, including the evidence of experts. Dr Taylor should therefore have appreciated that he had a duty to disclose relevant information to the Coroner's Inquest.

314. The Tribunal also considered that paragraphs 11 and 37 of GMP (1995 edition) are engaged.

'11 Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:

- *respond to criticisms and complaints promptly and*

constructively.

'37 You must be…trustworthy.'

315. The purpose of an Inquest is to inquire in to cause of a person's death. The Tribunal determined that Dr Taylor's conduct in failing to disclose highly relevant information during the Coroner's Inquest of which he was fully aware was so serious as to amount to misconduct.

316. In relation to Dr Taylor's statement to the Inquiry and his interview with PSNI, the Tribunal considered its findings on facts. It found that Dr Taylor had acted dishonestly on four occasions:

i. In his statement to the Inquiry on 18 July 2005, Dr Taylor failed to disclose the errors he made involving his pre-operative fluid calculations, replacing the blood loss that he calculated as 1411mls and his false claim that there was no sign that inappropriate or excessive fluids had been given for Patient A's complex surgery and pre-existing medical problems.
ii. In his statement to the Inquiry on 18 July 2005, Dr Taylor failed to disclose the error he made in relation to the CVP readings.
iii. In his Police Interview on 17 October 2006, Dr Taylor claimed that his pre-operative assessment included gaining information from speaking with Patient A's mother. The Tribunal was satisfied that he had not done so.
iv. In his Police Interview on 17 October 2006, Dr Taylor must have been aware that Patient A's polyuric condition meant that he had a fixed urinary output and that he was able to develop dilutional hyponatraemia. Further, Dr Taylor knew that he had changed his clinical practice after the Inquest on the basis that he had already accepted that Patient A had a fixed urinary output of about 70-80mls per hour.

317. The Tribunal considered that paragraphs 30, 32 and 51 of GMP (2001 edition) are engaged.

'30 You must co-operate fully with any formal inquiry into the treatment of a patient and with any complaints procedure which applies to your work. You must give, to those who are entitled to ask for it, any relevant information in connection with an

investigation into your own, or another health care professional's, conduct, performance or health.'

*'**32** Similarly, you must assist the coroner or procurator fiscal, by responding to inquiries, and by offering all relevant information to an inquest or inquiry into a patient's death. Only where your evidence may lead to criminal proceedings being taken against you are you entitled to remain silent.'*

*'**51** You must be honest and trustworthy when writing reports, completing or signing forms, or providing evidence in litigation or other formal inquiries. This means that you must take reasonable steps to verify any statement before you sign a document. You must not write or sign documents which are false or misleading because they omit relevant information...'*

318. Over seven years had elapsed between the death of Patient A and Dr Taylor's statement to the Inquiry and his subsequent interview by PSNI. The Tribunal was of the view that by this time Dr Taylor should have acknowledged his failures in care given that there was evidence that in the meantime he was involved in a working party on hyponatraemia and his teaching practice on fluid management had changed. The Tribunal determined that Dr Taylor's dishonest conduct was an attempt to cover up the truth and mislead both the Inquiry and PSNI.

319. Therefore, the Tribunal found that Dr Taylor's dishonest conduct in relation to the statement he had provided to the Inquiry and his interview with PSNI was so serious as to amount to misconduct.

Impairment

320. Having found that the facts found proved amounted to misconduct, the Tribunal went on to consider whether, as a result of that conduct, Dr Taylor's fitness to practise is currently impaired.

321. In determining whether a finding of current impairment of fitness to practise is necessary, the Tribunal looked for evidence of remediation and insight, considered the likelihood of repetition, balancing these factors against the three elements of the overarching statutory objective.

322. The Tribunal first considered whether Dr Taylor's fitness to practise is impaired by reason of his misconduct in relation to his clinical failings. The Tribunal balanced the seriousness of Dr Taylor's findings against the time that had elapsed. The Tribunal was certain that, in 1995, Dr Taylor's fitness to practise was impaired. However, the Tribunal noted that was almost 27 years ago. The Tribunal was satisfied that Dr Taylor had altered his clinical practice and in his evidence to the Inquiry, Dr Taylor outlined his change in practice relating to the use of Solution 18 following Patient A's death. No other clinical failures had arisen, and Dr Taylor had practised unrestricted since then. The statement by his Responsible Officer dated 1 April 2022 refers to his work having been of a high standard.

323. The Tribunal also noted that, in his evidence to the Inquiry, Dr Taylor had accepted his failures of clinical care and had offered an apology, albeit not directly to Patient A's family.

324. After careful consideration, the Tribunal determined that public confidence would not be undermined if a finding of current impairment in respect of his clinical failings is not found due to the time elapsed and the absence of repetition or any other clinical failure from Dr Taylor. Therefore, Dr Taylor's fitness to practise is not impaired by reason of his misconduct in relation to his clinical failings in 1995.

325. The Tribunal then considered whether Dr Taylor's fitness to practise is impaired by reason of the misconduct found in relation to his dishonest actions and his failure to disclose highly relevant information to the Coroner's Inquest.

326. The Tribunal had regard to paragraph 76 of the judgment in the case of *CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin)*, in which Mrs Justice Cox set out the helpful and comprehensive approach of Dame Janet Smith in her 5th Shipman Report to determining issues of impairment. At paragraph 25.67 of the Report, the following was identified as an appropriate test for panels considering impairment of a doctor's fitness to practise.

> *'Do our findings of fact in respect of the doctor's misconduct…show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or…*
>
> *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

327.In the present case, the Tribunal considered that limbs (b), (c) and (d) are engaged.

328.The Tribunal determined that Dr Taylor had, since 2005, repeatedly acted dishonestly to evade responsibility before the Inquiry and in his interview with PSNI, bodies which are in place to protect the public. The Tribunal have determined that he had a duty to disclose highly relevant information and knowing this, he still failed to do so.

329.Dr Taylor has not provided any evidence of insight in to and remediation of his dishonesty, despite being afforded the opportunity to provide such evidence to the Tribunal. Therefore, the Tribunal found that there is a real risk of repetition.

330.The Tribunal recognised that dishonesty is a breach of a fundamental tenet of the medical profession. Being honest and trustworthy and acting with integrity is at the heart of medical professionalism. Therefore, the Tribunal determined that a finding of impairment is necessary to maintain public confidence in the profession and to declare and uphold proper standards of conduct and behaviour in the profession.

331.Accordingly, the Tribunal found that Dr Taylor's fitness to practise is impaired by reason of misconduct in relation to his dishonest actions and his failure to disclose highly relevant information to the Coroner's Inquest.

Determination on Sanction - 21/06/2022

332.Having determined that Dr Taylor's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

333.The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions

334.On behalf of the GMC, Mr Forster QC, submitted that erasure from the medical register is the proportionate and appropriate sanction in this case. Mr Forster referred the

Tribunal to the relevant paragraphs of the Sanctions Guidance (November 2020 edition) ('the SG').

335. Mr Forster referred the Tribunal to its findings of impairment. He submitted that Dr Taylor had acted with a lack of candour during the Inquest in 1996. Albeit not dishonest, Dr Taylor should have appreciated his duty to disclose highly relevant information to the Coroner. Mr Forster submitted that Dr Taylor had acted dishonestly on four occasions, twice in 2005 before the Inquiry and twice in 2006 during his interview with PSNI. Mr Forster reminded the Tribunal that all these bodies are in place to protect the public and the public interest. He submitted that Dr Taylor acted dishonestly and failed to act with integrity in order to evade responsibility. There is a real risk of repetition.

336. Mr Forster referred the Tribunal to the aggravating and mitigating factors in this case. He conceded that Dr Taylor has an otherwise unblemished fitness to practise history and that there had been a delay since the Inquest, Inquiry and police investigation. However, as Dr Taylor did not admit his failures in care until 2012, his own actions in giving dishonest accounts contributed to the delay. Aggravating features include no evidence of insight or remediation, persistent dishonesty which had occurred over a long period of time. He also said that Dr Taylor had abused his professional position in the Inquest and the Inquiry, and he lacked integrity in his dealings with the police. He submitted that the subject matter of this case could not have been more serious, which is a death of a child in a hospital.

337. In Mr Forster's submission, no other sanction apart from erasure could address Dr Taylor's impairment and restore confidence in the profession. Mr Forster submitted that conditions would be inappropriate given that Dr Taylor has no insight and has retired. In addition, Mr Forster submitted that suspension should not apply because of the seriousness of Dr Taylor's conduct, which was sustained and covered up.

338. Mr Forster submitted that in order to maintain the reputation of the profession and public confidence in it, erasure is the appropriate and proportionate sanction.

Tribunal's Approach to Sanction

339. The Tribunal bore in mind that the decision as to the appropriate sanction, if any, to impose in this case is a matter for the Tribunal exercising its own judgement.

340. In reaching its decision, the Tribunal has taken into account the SG. It has borne in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it may have a punitive effect.

341. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Taylor's interests with the public interest. It has reminded itself of the statutory overarching objective.

342. In addition to the submissions and the totality of evidence adduced, the Tribunal has taken into account its determinations at both the facts and impairment stages when considering the appropriate sanction in this case.

The Tribunal's Determination on Sanction

Aggravating and Mitigating Factors

343. Before deciding what action, if any, to take in respect of Dr Taylor's registration, the Tribunal first considered the aggravating and mitigating factors present.

344. The Tribunal considered the following to be aggravating factors in this case:

- The context and seriousness of the dishonesty involving investigations into the death of a child;
- Dr Taylor's lack of insight;
- No evidence of remediation;
- Dr Taylor's lack of candour at the Inquest;
- Dr Taylor's repeated acts of dishonesty during the Inquiry and police investigation;
- Dr Taylor's acts of dishonesty were intended to evade responsibility.

345. It considered the following mitigating factors to be of relevance:

- There were no previous adverse findings against Dr Taylor's registration;
- The delay since the Inquest, involving an Inquiry and police investigation.

No action

346. In coming to its decision as to the appropriate sanction, the Tribunal first considered whether to conclude the case by taking no action. The Tribunal reminded itself that there should be exceptional circumstances to justify taking no action where a finding of impairment has been made.

347. The Tribunal determined that there were no exceptional circumstances to justify taking no action. It therefore decided that given the serious nature of the Tribunal's findings on impairment, it would be neither sufficient, proportionate nor in the public interest, to conclude this case by taking no action.

Conditions

348. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Taylor's registration. The Tribunal had regard to the various paragraphs of the SG, which indicate the cases in which conditions might be appropriate. The Tribunal took into account that any order of conditions would need to be appropriate, proportionate, workable and measurable.

349. Given the nature of Dr Taylor's misconduct, which involves dishonesty, the Tribunal could not formulate any appropriate conditions which would be workable.

350. Further, it did not consider that conditions would sufficiently mark the gravity of the misconduct. The Tribunal therefore determined that an order of conditions would not be appropriate or proportionate, nor would it be in the public interest.

Suspension

351. The Tribunal then went on to consider whether imposing a period of suspension on Dr Taylor's registration would be appropriate and proportionate.

352. The Tribunal acknowledged that suspension has a deterrent effect and can be used as a signal to the doctor, the profession, and to the public about what is regarded as behaviour unbefitting a registered doctor. It reminded itself that the purpose of a sanction is not to punish a doctor.

353. The Tribunal considered its findings on impairment. The Tribunal noted that Dr Taylor's misconduct and repeated dishonesty breached fundamental tenets of the profession. Given the seriousness of Dr Taylor's dishonesty, the Tribunal determined that his misconduct was fundamentally incompatible with continued registration as a doctor.

354. Therefore, the Tribunal concluded that a period of suspension would not be appropriate to sufficiently maintain and uphold proper professional standards and protect the public confidence in the profession.

Erasure

355. In the circumstances, the Tribunal determined that the only appropriate sanction in this case was one of erasure. In reaching its determination, the Tribunal considered the following paragraphs of the SG:

> *'108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.'*
>
> *'109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *a* *A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.*
>
> *b* *A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
>
> *...*
>
> *d* *Abuse of position/trust (see Good medical practice, paragraph 65: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').*

…

h *Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 120–128).*

i *Putting their own interests before those of their patients (see Good medical practice paragraph 1: – 'Make the care of [your] patients [your] first concern' and paragraphs 77–80 regarding conflicts of interest).*

j *Persistent lack of insight into the seriousness of their actions or the consequences.'*

'128 Dishonesty, if persistent and/or covered up, is likely to result in erasure (see further guidance at paragraph 120–128).'

356. The Tribunal considered that all of the above paragraphs of SG are engaged in this case.

357. The Tribunal was satisfied that in the absence of any evidence of insight into and remediation of his dishonesty, there is a real risk of repetition.

358. The Inquest, Inquiry and police investigation were all seeking to establish, in the public interest, how and why Patient A had died and to learn lessons from his death. The Tribunal has determined that Dr Taylor had a professional duty of candour to explain his actions and to assist in each inquiry. He failed to comply with that duty, repeatedly seeking to evade responsibility. Worse he lied. In doing so, he plainly demonstrated a blatant disregard for safeguards designed to protect members of the public and the wider public interest.

359. Therefore, the Tribunal concluded that no lesser sanction than erasure would adequately promote and maintain public confidence in the medical profession and promote and maintain proper professional standards and conduct for members of that profession.

360. The Tribunal determined that Dr Taylor's name be erased from the Medical Register.

Determination on Immediate Order - 22/06/2022

361. Having determined to erase Dr Taylor's name from the Medical Register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Taylor's registration should be subject to an immediate order.

Submissions

362. On behalf of the GMC, Mr Forster QC, submitted that an immediate order of suspension is necessary in restoring the public interest in the profession. Mr Forster submitted that it would be inappropriate for Dr Taylor to retain the privilege of unrestricted practise before the substantive sanction of erasure takes effect. Mr Forster also submitted that given the risk of repetition, such risk must be prevented by imposing an immediate order of suspension.

The Tribunal's Determination

363. In reaching its decision, the Tribunal has exercised its own judgement, and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, is in the public interest, or is in the best interests of the practitioner.

364. The Tribunal had regard to paragraph 172 and 178 of the SG which state:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.'*
>
> *'178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive*

direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'

365. The Tribunal has decided that erasure is the only appropriate sanction in order to meet the requirements of the statutory overarching objective. Therefore, it is appropriate and necessary to impose an immediate order in light of the particular circumstances of this case.

366. The Tribunal determined to impose an immediate order of suspension on Dr Taylor's registration.

367. This means that Dr Taylor's registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

368. There is no interim order to revoke.

369. That concludes the case.

ANNEX A – 30/05/2022

Application on Service and Proceeding in Dr Taylor's absence

Service of Notice of Hearing

370. Dr Taylor is neither present nor represented at this hearing. The Tribunal has considered whether notice of this hearing has been properly served upon Dr Taylor in accordance with Rules 15 and 40 of the General Medical Council (Fitness to Practise) Rules 2004 (as amended) ('the Rules').

371. Mr Forster, QC, on behalf of the GMC, provided the Tribunal with documents to show proof of service on Dr Taylor. This included a copy of the GMC Notice of Allegation letter, dated 27 April 2022 and a copy of the MPTS Notice of Hearing letter, dated 28 April 2022. The Tribunal noted that these letters were emailed to Dr Taylor's legal representative, both of which had been acknowledged by read receipt. In particular, the Tribunal noted that Mr P, Dr Taylor's legal representative, confirmed receipt of the MPTS Notice of Hearing and said that there is no need to send the MPTS Notice of Hearing to Dr Taylor.

372. The Tribunal was satisfied that all reasonable efforts have been made by the GMC to serve Dr Taylor with notice of the hearing. It was satisfied that the GMC has discharged its duty to serve a notice of hearing in accordance with the Rules.

Proceeding in Dr Taylor's absence

373. The Tribunal went on to consider whether it would be appropriate to proceed with this hearing in Dr Taylor's absence pursuant to Rule 31 of the Rules. The Tribunal was conscious that the discretion to proceed in the absence of a doctor should be exercised with appropriate care and caution, balancing the interests of the doctor with the wider public interest.

374. Mr Forster invited the Tribunal to proceed in Dr Taylor's absence. He referred the Tribunal to the correspondence sent by Dr Taylor's legal representative to the GMC and MPTS, which stated: *"…will neither be attending, nor will he be represented at the hearing. Dr Taylor is content for the hearing to proceed in his absence and you have consent to produce this correspondence to a Tribunal in due course in support of any application to proceed in his absence. We are not intending to adduce any evidence on his behalf."* He submitted that Dr Taylor is aware of the Allegations against him, the date of

the substantive hearing and the consequences of not participating in the hearing. Mr Forster submitted that Dr Taylor has voluntarily chose not to participate nor be represented in the hearing. Therefore, Mr Forster concluded that Dr Taylor had waived his right to both appear and participate in the hearing and his right to be represented.

375. The Tribunal was given legal advice by the LQC on the discretionary nature of proceeding in absence. The Tribunal took account of that advice. The Tribunal had balanced Dr Taylor's interests with the public interest in deciding whether to proceed in his absence. In doing so it took account of the submissions of Mr Forster and considered the correspondence from Dr Taylor's legal representative.

376. The Tribunal was satisfied that Dr Taylor was aware of the investigation process and had previously engaged with the GMC. It also noted that Dr Taylor had the benefit of full legal advice and voluntarily chose not to attend nor be represented in this hearing. The Tribunal found that the public interest, in particular that the hearing should take place within a reasonable time, outweighed Dr Taylor's interests. The Tribunal was aware of its duty to take what evidence there was from Dr Taylor into account, and to discharge its duty of inquiry. The Tribunal was satisfied it could deal with the case fairly and in accordance with the Overarching Objective.

377. Therefore, in accordance with Rule 31, the Tribunal has determined to proceed in Dr Taylor's absence.