Witness Statement Ref. No. **176/1**

NAME OF CHILD: **Claire Roberts**

Name: Anthony Peter Walby

Title: Mr.

Present position and institution:

Retired

Previous position and institution:
[As at the time of the child's death]
Consultant ENT Surgeon - Royal Group of Hospitals Trust

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-August 2012]

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

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

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number. If the document does not have such a number then please provide a copy of the document.

(1) Please state your medical qualifications as at 1996 (and kindly provide a copy of your Curriculum Vitae);

MB, BCh., FRCS Ed.

CV already provided.

(2) Please describe your career history before you were appointed Associate Medical Director;

Consultant ENT Surgeon from 01.01.83
Clinical Director ENT Directorate 1990 – July 1996

(3) Please provide relevant information regarding your work within the Trust from the date of your appointment to 2006;

Consultant ENT Surgeon from 01.01.83
Clinical Director ENT Directorate 1990 – July 1996
Associate Medical Director from 01.01.99

(4) Please describe the role, function and accountability of your post as at 2004, including those individuals to whom you reported, and who reported to you;

See (5) Job Description.
Reported to the Medical Director.
Admin. and Secretarial staff reported to AMD.

(5) Was there a written job description for your post in 2004? If so, please provide copy of the same.

Yes. Job Description enclosed.

(6) In relation to the Litigation Management Office of which you were Associate Medical Director, kindly advise:

(a) The date this Office was established;

1998

(b) The identity of your predecessor and successor as Director of the Litigation Management Office;

I do not believe the title Director of the Litigation Management Office was used by the Trust. The duties had previously been part of the responsibilities of the Director of Medical Administration, Dr. George Murnaghan who resigned during 1998. The duties were then covered in the interim period by the Medical Director, Dr. Ian Carson until my

appointment. I have not been succeeded.

(c) **The remit, authority and responsibilities of the Litigation Management Office;**

To provide a claims investigation and management service on behalf of the Trust in relation to claims of litigation in respect of employer liability, occupier liability, clinical negligence and associated matters. To assist HM Coroner with enquiries and preparation of statements prior to Inquests. To liaise with Trust solicitors, give advice and support to staff involved in litigation, Coroner's cases or the complaint process.

(d) **Whether the Litigation Management Office analysed information from Inquests for the purposes of distilling lessons to be learned;**

Yes

(e) **Whether the Litigation Management Office analysed information from litigation for the purposes of distilling lessons to be learned;**

Yes

(f) **If not who did?**

(g) **If so, what steps were taken to share these lessons?**

In cases where changes in practice had already been implemented by the Trust before Inquest, I would advise the Medical Director of the outcome of the Inquest. I also advised the Medical Director of the outcome of Inquests where the Coroner indicated he/she would be writing to the Medical Director regarding changes in Trust practice he/she might be recommending as the result of a particular case.

During the 2000s I introduced a service in which a case summary with lessons learned was sent to the relevant Trust manager when litigation had resulted in the payment of damages.

(7) **Please identify whether any lessons deriving from the case of Claire Roberts were disseminated either before or after the Inquest. If so please state how, where, when and to whom.**

I am not aware of any. See **8b**.

(8) **With hindsight could or should anything have been done to heighten awareness of hyponatraemia amongst practising clinicians:**

(a) **After the death of Adam Strain;**

(b) **After the death of Claire Roberts.**

I was not in post as AMD after the deaths of these two patients so I had no knowledge of the cases in 1995 and 1996. My understanding from the Inquiry evidence in the case of Adam Strain is that practising clinicians had no lack of awareness of the significance of hyponatraemia but that appreciation of its presence was not acted on. In the case of Claire Roberts the part hyponatraemia played in the cause of her death was not clear to the involved clinicians at the time nor to the Coroner from the Inquest Verdict. The need for timely measurement of serum electrolytes and appropriate action on the results would be

the learning I would take from these cases but this should not need to be highlighted to practising clinicians.

(9) Please describe how the 'learning culture' within the Royal Groups of Hospitals/RBHSC has changed since 1996?

The introduction of Clinical Governance during the 2000s within the Trust changed the learning culture.

(10) In 1996-2006, what steps were taken to achieve a change in the 'learning culture' within the Royal Group of Hospitals/RBHSC?

The introduction of Clinical Governance in the 2000s within the Trust changed the learning culture.

(11) When did you first become aware of the death of Claire Roberts?

In November 2004 after the Roberts' family contacted the Trust's Medical Director.

(12) Would you have expected the death of Claire Roberts to have been brought to your attention? If so how? If not, how do you explain this?

No. I was not in post as AMD in 1996.

(13) Did you carry out a review of the case notes of Claire Roberts in 2004-2005? If so, who requested the same and what was the outcome?

Yes. After the Medical Director asked me to refer the case to HM Coroner, I obtained the case notes and prepared the review contained in my letter to Mr. Leckey dated 16th December 2004.

(14) With reference to your letter dated 16th December 2004 to H.M. Coroner (Ref: 089-004-008) and your statement *"the circumstances are as follows. Claire had a history of epileptic seizures since aged 10 months..."* please state:

(a) Where this appears in the medical notes and records;

This appears in the Autopsy Report (090-003-003), not the medical notes.

(b) Whether you checked this with Dr. Steen?

I did not check the letter with Dr. Steen before writing to Mr. Leckey. I copied the letter to the Medical Director and I believe he shared it with Dr. Steen as the note on my letter to Dr. Steen dated 22nd December 2004 in the Trust Inquest file indicates I had become aware that she considered there were errors in my letter and I requested her to provide corrections for me to forward to the Coroner. The only correction I was asked to make was that contained in my letter to Mr. Leckey dated 25th January 2005 (the Trust Inquest file has been forwarded to the Trust solicitor for consideration of provision to the Inquiry).

(15) Did you have any communication with Dr. Steen regarding the death of Claire Roberts in 2004-2006?

I requested Dr. Steen to provide a Witness Statement for the Coroner on 22nd December 2004. I advised her by letter of 11th January 2005 of Mr. Leckey's decision to request Dr. Bingham to provide an expert report. Her email of 11th January 2005 and my reply of 12th January 2005

addressed her concern about a paediatric anaesthetist reporting. I issued a reminder dated 20th January 2005 that her witness statement remained outstanding. Dr. Steen provided a draft witness statement dated 1st February 2005 and asked me by email dated 8th February 2005 for comments. I provided typographical suggestions by email of 9th February 2005. I issued a further reminder dated 4th March 2005 and received her revised version which was transferred onto a witness statement form for her to sign and date. I forwarded Dr. Bingham's report to Dr. Steen on 25th April 2005. I forwarded an article from 'Paediatrics' to Dr. Steen on 30th August 2005 at Mr. Leckey's request. I forwarded Dr. Machonachie's expert report to Dr. Steen for comment on 27th September 2005. I forwarded Mr. Leckey's letter of 3rd October 2005 containing Mr. Roberts' statement to Dr. Steen on 6th October 2005. I issued reminders to Dr. Steen on 5th December 2005, 16th and 30th January 2006, and 23rd February 2006, and 15th March 2006. I wrote to Dr. Steen on 7th March 2006 to advise her of the date of the Inquest, and on 14th March 2006 I sent her witness summons. I attended a pre-Inquest consultation with the Trust solicitor and Dr. Steen. I wrote to Dr. Steen on 11th April 2006 to provide the witness statements of Dr. Sands, Dr. Webb, and Prof. Young, and the PM report. The Coroner's Verdict was forwarded to Dr. Steen on 10th May 2006 with my query as to whether the error in the Verdict arising from the error she had signed in her Deposition in the witness box should be pointed out to the Coroner. Dr. Steen replied on 11th May 2006 that she agreed it should. I wrote to Dr. Steen on 4th August 2006 advising of the outcome that because the note was not queried in open court the Coroner now regarded himself as functus officio. Copies of this correspondence are contained in the Trust Inquest file which has been provided to the Trust solicitor for consideration of provision to the Inquiry.

(16) Please specify all investigations into the treatment and death of Claire Roberts.

Post mortem, Inquest, PSNI investigation, IHRDNI

(17) Please specify to whom the death of Claire Roberts was reported in 1996, and in particular please state whether any of the following were informed of her death:

(a) Dr. Peter Crean;

(b) Dr. Elaine Hicks;

(c) Dr. George Murnaghan;

(d) Dr. Joseph Gaston;

(e) Mr. William McKee;

(f) Nurse Manager in Paediatric Directorate;

(g) Miss Elizabeth Duffin;

(h) Mr. George Brangam.

I was not in post as AMD in 1996 and, therefore, had and have no knowledge as to whether any of the above were informed of Claire's death.

(18) Please state whether you would have expected nursing staff to mount an investigation into the death of Claire Roberts and whether you would have expected statements to have been obtained from the nurses in respect of same?

I was not in post as AMD in 1996, but would not have expected nursing staff to mount an

investigation.

(19) Was there an audit of the following aspects of the case of Claire Roberts:

(a) Record keeping;

(b) Drug prescription and administration?

I was not in post as AMD in 1996.

(20) Do you think that there was an iatrogenic contribution to the death of Claire Roberts?

I am not an expert witness and was not in post as AMD in 1996.

(21) If there was a possibility that medical care and treatment might have contributed to a death would you have expected that to have been the cause of an investigation?

Yes.

(22) Please state whether you were asked for your opinion as to whether or not Claire Roberts' death should be referred to the Coroner.

No. I was not in post as AMD in 1996. In 2004 I was instructed by the Medical Director, Dr. Michael McBride to report the death to the Coroner.

(23) Please state what procedures and protocols were extant in 1996 and 2004 with respect to the referral of deaths to the Coroner?

There are statutory requirements to report deaths to the Coroner. These did not change between 1996 and 2004. The Certifying practitioner must notify the Coroner if there is reason to believe that the death took place (directly or indirectly) (a) as a result of violence or misadventure or by unfair means; or (b) as a result of negligence or misconduct or malpractice on the part of others; or (c) from any cause other than natural illness or disease for which the deceased person had been seen and treated by a registered medical practitioner within 28 days prior to death; or (d) in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic).

(24) Please state whether the input of the Director of Medical Administration, Dr. George Murnaghan, was sought in respect of any matter relating to the death of Claire Roberts.

I was not in post as AMD in 1996, and am not aware of any input by Dr. Murnaghan.

(25) What, in 1996, did you understand the purpose of an Autopsy Report to be?

I was not in post as AMD in 1996, but as a medical practitioner I would then and now expect an Autopsy Report to be the means by which a pathologist would advise the clinician of their opinion as to the cause of death having carried out a hospital post-mortem examination, or to advise the Coroner in a similar manner in a Coronial investigation.

(26) Please state whether any guidelines or conventions existed in 1996 governing post-mortem examinations with specific reference to:

(a) When consent was required for a post-mortem examination;

(b) When a limited post-mortem could be requested;

(c) Authorisation for the same;

(d) The information and options given to the parents of the deceased child in respect of this decision;

(e) Whether parents of the deceased child should be asked for their views on whether or not the Coroner be notified;

(f) Whether parents of the deceased child should be asked for their views on whether a full or restricted post-mortem should be carried out;

(g) Whether the Autopsy report should have been shared with the parents and GP of the deceased child?

I was not in post as AMD in 1996 and cannot recollect now if there were any guidelines in relation to post-mortem examinations. I cannot recollect a paediatric death in my clinical practice where I would have had to consider the above.

(27) With reference to document (Ref: 090-006-008), please state:

(a) Does the handwritten note in the top right hand corner, namely *"File per S McK 22/11"* refer to Dr. Seamus McKaigue's initials? If so why was this note made? If not, what is your interpretation of this note?

I do not know.

(b) Were the papers of Claire Roberts filed with a cause of death categorisation of 'respiratory arrest'?

Dr. McKaigue should be asked this question but I believe this categorisation will be the reason for admission to ICU not the cause of death.

(c) Who is the "Dr. Allen" copied in at the foot of this note, and what was his/role role in relation to this matter?

I do not know, but I believe this will be a clerical error for "Dr. Steen's sec. (Allen ward) for Discharge". Dr. McKaigue should be asked about this.

(d) What were the usual filing procedures in relation to these matters?

I do not know but Dr. McKaigue would be able to explain 1996 procedures in relation to ICU Discharge Summaries.

(28) How was the death of Claire Roberts categorised within the RBHSC statistical data in 1996?

The letter from DLS dated 26.03.12 to the Inquiry (BPC-0072-11) contains the diagnostic codes used. I am not aware of categorisation of cause of death by the Trust.

(29) Was this classification subsequently amended in the light of the Coroner's findings at her Inquest?

I do not know.

(30) Was any consideration given to inviting external specialists to review the case of Claire Roberts?

I was not in post as AMD in 1996 and do not know whether any consideration was given then to inviting external specialists to review the case, and I am not aware of it being considered in 2004 or thereafter.

(31) Did you receive a copy of, or see the signed, final Autopsy report?

No. The original final autopsy report in the notes is not signed.

(32) Did you send a signed, final copy of the Autopsy report to H.M. Coroner?

No. I sent a copy of the original unsigned final autopsy report to H.M. Coroner.

(33) Was the death of Claire Roberts reported to the Chief Executive and Director of Nursing;

I was not in post as AMD in 1996. I did not report the death to the Chief Executive and Director of Nursing.

(34) Did any change in the training/teaching provided by the RBHSC/ Trust to clinicians result from Claire's death?

I was not in post as AMD in 1996. I do not know of any change in training/teaching resulting from Claire's death.

(35) In your preparation for the Inquest hearing did you consult with the witnesses? If so please state:

The Trust solicitor and Counsel consulted with witnesses. I attended the consultations. The information below has been extracted from the Trust Inquest file.

(a) When these consultations took place;

03.04.06 - Dr. Steen and Dr. Sands
07.04.06 – Prof. Young
25.04.06 - Dr. Webb

(b) Who was present;

03.04.06 – Dr. Steen, Dr. Sands, Mr. Daly and me
07.04.06 – Prof. Young, Mr. Daly and me
25.04.06 – Dr. Webb, Mr. Daly, Mr. Lavery and me

(c) Who took notes;

03.04.06 – The Trust solicitor may have made notes. I made a file note after the consultation.
07.04.06 – The Trust solicitor may have made notes. I made no notes
25.04.06 – The Trust solicitor and Counsel may have made notes. I made no notes.

(d) Where such notes were kept;

My file note for 03.04.06 is in the Trust Inquest file.

(e) **Where such notes are now?**

My file note for 03.04.06 is in the Trust Inquest file

(36) In respect of your letter dated 11th January 2005 to Dr. Bingham (Ref:090-049-053) and your statement *"the original hospital notes are being used at present to obtain statements from the staff involved in Claire's care"*, please state:

The information below has been extracted from the Trust Inquest file.

(a) **Who was asked to prepare a statement and by whom;**

Dr. Steen, by me,
Dr. Sands, by me,
Dr. Webb, by me,
Prof. Young, by me

(b) **When were they asked;**

Dr. Steen, 22.12.04
Dr. Sands, 14.03.05
Dr. Webb, 22.03.05, and 31.03.05 (the first letter was likely not sent as the notes required photocopying)
Prof. Young, 31.03.05

(c) **For what purpose were these statements to be used;**

To provide witness evidence to H.M. Coroner.

(d) **What statements did you receive and when;**

Dr. Steen, 14.02.05
Dr. Sands 04.07.05
Dr. Webb 22.06.05
Prof. Young 01.06.05

(e) **What did you do with these statements;**

Prepared the statements as witness depositions for signing and dating:
Dr. Steen, 16.03.05
Dr. Sands, 06.07.05
Dr. Webb, (undated)
Prof. Young (undated)

(f) **If these statements were prepared on police witness paper; and if they were please explain why;**

This was the historical format preferred by HM Coroner.

(37) Did you conduct a search for documentary materials relating to Claire Roberts, if so please specify what you sought, what you found and where you found it?

Yes, see (38)

(38) Did you attempt to trace:

(a) Paediatric Audit/Mortality meeting minutes reviewing Claire's case?

Yes. At the request of IHRDNI, I asked the RBHSC Directorate Office and the Trust Audit Office to provide copies of Audit/ Mortality Meeting Minutes for the period after Claire's death and her Inquest. Minutes as found have already been provided to the Inquiry although as the Minutes are normally annonymised it would not be expected that Claire's case would be identifiable from the Minutes.

(b) Minutes of Neuroscience Grand Rounds?

No.

(c) Neuropathologists file?

No. Tracing was not required. At the request of IHRDNI (BPC-0096-12, 09.01.12) the Neuropathologists' file was obtained from the Neuropathology Department and forwarded to the Inquiry by the Trust solicitor on 15.02.12.

(d) Nursing reports, reviews or audits?

No.

(e) Files of the Director of Risk and Litigation Management/ Director of Administration/Associate Director?

The Claire Roberts' Inquest file was created in my office in 2004 and did not require to be traced. This has been forwarded to the Trust solicitor for consideration of provision to the Inquiry.

(39) Were you in receipt of any information in relation to the case of Adam Strain and/or any clinical negligence litigation documents concerning it?

My office held the Inquest and Clinical Negligence files in relation to Adam Strain and I provided these to the Inquiry.

(40) Were you in any way engaged in the Trust response to enquiries relating to hyponatraemia after the UTV Insight programme (22nd October 2004)?

I wrote to the Trust solicitor on 4th November 2004 to obtain advice regarding the DHSS&PS letter of 28th October 2004. I attended a meeting with the Trust solicitor and the Medical Director on 16th November 2004 and thereafter ensured all the files were retained as required. The Media Interest file containing this correspondence has been forwarded to the Trust solicitor for consideration of provision to the Inquiry.

(41) Did you keep a file or record of your work in relation to the case of Claire Roberts, including:

(a) Correspondence;

(b) Attendance notes;

(c) Telephone memoranda;

(d) Internal communications;

(e) Emails;

(f) Reviews and opinions?

All my records in relation to Claire Roberts are contained in the Inquest file.

(42) Did you liaise with the Press Officer and/or Corporate Affairs/ Public Affairs and Media in respect of the Claire Roberts case?

There are file notes in the Inquest file for 28th March 2006 of a pre-Inquest briefing note I provided to Jo McGinley (Corporate Affairs) and copied to the Medical Director, Dr. McBride, for 25th April 2006 when Christine (Stewart) inquired about the progress of the Inquest, and for the date the Inquest concluded (4th May 2006) that at 3.00pm I spoke with J.McG (Jo McGinley) Corporate Affairs re the Belfast Telegraph requesting a statement.

(43) Please provide any further comments you think may be relevant, together with any documents or materials.

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

Signed: A.P. Walley **Dated:** 8/09/12

THE ROYAL HOSPITALS

JOB DESCRIPTION

Title of Post: ASSOCIATE MEDICAL DIRECTOR (post 2)

Location: ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL HSS TRUST

Responsible To: CHIEF EXECUTIVE

Reports To: MEDICAL DIRECTOR

Main Purpose: **To develop and promote throughout the Trust those aspects of clinical governance outlined below, in partnership with other members of the Clinical Governance Steering Group.**

Main Duties: **To be responsible for the promotion of Clinical Performance and high standards of Personal Effectiveness.**

1. To be a member of the Trust's Clinical Governance Steering Group, ensuring that the Trust's clinical governance duties and responsibilities are promoted and implemented.

2. To attend Hospital Council, and to deputise for the Medical Director when required.

3. To assist the Medical Director, the Director of Nursing, and Clinical Directors in ensuring that all aspects of clinical governance are embraced by management and membership of clinical directorates.

4. In association with other Directors, to ensure that the Trust meets the targets set within the National Framework for Assessing Performance, and to facilitate at a local level the work of the Commission for Health Improvement.

5. To assist the Medical Director with the implementation of an effective process of professional self-regulation for doctors employed by the Trust.

6. To be a member of the Trust's Local Task Force and to be responsible for ensuring that the aims and targets of the New Deal for Junior Doctors' hours are pursued and maintained.

7. To provide a claims investigation and management service on behalf of the Trust in Relation to claims of litigation in respect of employer liability, occupier liability, clinical negligence and associated matters.

8. To assist HM Coroner with enquiries and the preparation of statements prior to inquests.

9. To assist with complaints management where appropriate.

10. To liase with Trust Solicitors, give advice and support to staff involved in litigation, Coroner's cases or the complaint process.

November 1998