Witness Statement Ref. No. 176/2

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-December 2004]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]
06.09.12 WS176/1

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

Ref:	Date:	

Other points you wish to make including additions to any previous Statements, Depositions and or Reports

[Please attach additional sheets if more space is required]

I wish to respond to criticisms made of me by Dr. MacFaul, Consultant Paediatrician (1.) in his independent expert report, and to comments made by the Chairman (2.) at the Hearing on 24th September 2012 beginning at page 130 line 12, and I wish to comment on the evidence of Dr. Steen (3.) on 17th October 2012 where she refers to me, PAS and IT.

1.)

Dr MacFaul at 238-002-075 states that I provided incorrect evidence to the Coroner in my letter of 16th December 2004 in two respects. The two passages he quotes were written following my personal examination of the original hospital notes and records. The first derived from the Department of Neuropathology Autopsy Report (090-003-003) filed in the notes, and the second from the clinical note of Dr. Stewart (090-022-056).

Dr. MacFaul comments that there is an implication that Claire had continuing epilepsy whereas I believe it only indicates when the epilepsy started. I accept that in the clinical records it is also recorded that the seizures started at 6 months. As the clinicians involved from the referring GP onwards believed Claire was suffering further seizure activity I do not think my statement was misleading the Coroner. Dr. MacFaul is wrong to state that there is no record of consideration being given to fluid overload with low sodium fluid (090-022-056). Dr. MacFaul is wrong in stating that Claire's fluid management was not altered. The management was altered in that there was an intention to reduce fluids to 2/3 of present value (090-022-056). Dr. MacFaul is correct to note that there was no mention of a potential or actual overdose of Midazolam but neither was there of the error in phenytoin prescription. These were both discovered later by the Inquiry which paradoxically if known about at the time of my referral of the case to the Coroner might have had the effect to diminish judgment on the effect of the hyponatraemia rather than make it greater.

My letter to the Coroner was not a substantive report but a referral to the Coroner of a case which he needed to consider whether to investigate. The effect was as I intended in that the Coroner decided to investigate the death. I expected the Coroner to obtain an independent expert report from a paediatrician whereupon I agree that the drug prescription errors ought to have been identified from a detailed examination of the notes. The Coroner's letter to me dated 21st December 2004 indicated he was looking for a paediatrician to report for him but as the Inquiry have not released HM Coroner's file on the Claire Roberts' case so other than the letters to me dated 4th January 2005 and 18th April 2005 from HM Coroner I cannot follow the pathway as to how a paediatric anaesthetist and a consultant in paediatric A/E medicine but without a paediatric neurologist came to report instead. Dr. Steen advised in her email of 11th January 2005 10:47 that she believed a paediatric neurologist was the most suitable person to report however as noted in my email of 12th January 2005 08:39 I replied that I had suggested to HM Coroner that a paediatrician should report however he had decided otherwise. I believe this indicates it was discussed on the telephone with Mr. Leckey although I do not have a record of the date but his records may well record this.

2.)

The Chairman at the Hearing on 24th September 2012 (page 130 lines 15-17) referred to the Trust Inquest file on Claire Roberts and a file containing papers arising out of media interest in hyponatraemia. He expressed concern that the first time he had been made aware of these was in my statement to the Inquiry of 6th September 2012.

The Chairman in his letter of 26th September 2005 to the Chief Executive of the RGH Trust requested the Trust to provide specific documentation in relation to Claire Roberts in order to decide whether he

should add her case to the work the Inquiry was undertaking. The Trust provided this under my covering letter to the Chairman of 6th October 2005 and the Chief Executive's letter to the Chairman of 12th October 2005 in which he asked to be advised if the Trust could assist him further. I am not aware of the Inquiry later asking for the Trust's closed Inquest file as it had done in the cases of Adam Strain and Raychel Ferguson, although the Inquiry could be expected to have known that a similar file was going to be prepared in the run-up to Claire's Inquest. The Inquiry adopted a different approach to that which it used in the cases of Adam Strain and Raychel Ferguson. It posted on its website the material it had asked for from the RGH Trust and the material Mr. Leckey had extracted from his Coroner's file. I do not know whether the Coroner was later asked for his complete file either as in the cases of Adam Strain and Raychel Ferguson. Although the Trust prepared its closed Inquest file with pagination and indexation in July 2008 in case it was ever asked for it, it was not until the Progress Hearing on 27th June 2012 (pages 16 and 17) that Inquest files in relation to Claire Roberts were requested by Mr. Quinn and the Trust then forwarded its Inquest file to DLS. I had expected by the time I submitted my witness statement in September 2012 that the Inquest file would have been provided to the Inquiry by DLS. There was no attempt to conceal the file, and for instance when information such as detail about the Trust meeting the Roberts family was requested previously by the Inquiry this was openly provided drawing on all available sources including the Trust Inquest file as needed.

The Litigation Management Office file which covered its responses to the media's interest in hyponatraemia was referred to because it was necessary in order to answer question 40 in my witness statement to the Inquiry. I am not aware of any request by the Inquiry to the Trust before this question to me which would have related to this material.

3.)
Dr Steen in her evidence on 17th October 2012 stated on page 15 starting on line 24 that "...the litigation team had been trying for years to try and have a clearer picture of what had been happening that morning. I think a lot of the searches went on the ward diaries." I on behalf of the litigation management office had always accepted what Dr. Steen had repeatedly said (in terms) that she had been on Allen ward on the morning of 22nd October 1996 and had known about Claire but could not explain why she had not taken her ward round as usual. There was therefore no searching I thought necessary. It would not be expected that the Trust should be able to identify the movements of a consultant not performing their routine duty.
The search for the ward round diary was only initiated as a result of a request by the Inquiry on 6th April 2012 (HW-0008-12) following receipt of Angela Pollock's witness statement (WS225/1, Q12). The ward round diary (as opposed to the ward diary) would have assisted about required tests in the way she indicated however I would not have expected either diary to contain information about the movements of a consultant and they were not looked for with that purpose.
On page 16 starting at line 9, Dr. Steen stated "I was not aware that the IT system could be interrogated to identify which patients were admitted on a certain day, and I'm not sure the Trust did either..." This knowledge was certainly known to me and the litigation management office and I believe Dr. Steen may have forgotten what most consultants would know that the hospital had computer analysis available for its PAS. An example would be that a Clinical Director would for management purposes be able to supply each consultant in their Directorate periodically with a breakdown of the ward bed occupancy and length of stay which had occurred under their name. This is produced by an aggregate of individual patient PAS computer entries.
Dr. Steen then went on to confirm that the IT Dept. produced the Allen ward bed occupancy figure during Claire's admission. This listing of 8 patients (by name) was forwarded by Mrs. Angela Pollock to me in March 2012 having been produced for her by the IT Dept. It later turned out to only have been a list of those patients who were admitted on 21st October 1996 (including Claire) and did not include

those already in the ward. DLS letter to the Inquiry of 6th April 2012 (BPC-104-12) (drafted from information provided to me by Mrs. Pollock) was therefore wrong in the total number of patients actually in the ward for which I apologise. Dr. Steen's statement at line 22 in relation to Mrs. Pollock's knowledge is therefore in error I believe, and her comments in lines 24-25 and page 17 line 1 regarding an opportunity do not then follow.
On page 17 line 17 when Senior Counsel was asking about 'management' and its concern and Dr. Steen answered 'yes' she was presumably referring to RBHSC management (ie Mrs. Pollock in her current management role) as I had no means of pursuing the whereabouts of Dr. Steen.
On page 19 line 16 I believe Dr. Steen must have been mistaken about the IT Department's knowledge.
On page 20 starting at line 9, my discussion with Dr. Steen advised her that if I came by any information which pointed to where she was on 22nd October 1996 I would advise her of it, but I did not advise her to wait to see if such information came in because her statement was already overdue. No such information came to me from witness statements.
On page 31 starting at line 12 I am not aware of what PAS interrogation Dr. Steen was referring to. It was not being done on behalf of the litigation management office. Regarding lines 22 and 23 it is not clear in what aspect Dr. Steen felt the IT Dept. did not know what to do.
Regarding page 31 line 25 and page 32 lines 1 and 2, as stated above I knew that PAS could be interrogated by senior authorized staff who had been granted appropriate access to different levels of information.

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

Signed: A.P. Wells **Dated:** 21st November 2012

HER MAJESTY'S CORONER

DISTRICT OF GREATER BELFAST

John L Leckey LL.M.
H.M. Coroner
Coroner's Office
Courthouse
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80 Victoria Street
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Mr Peter Walby FRCS Ed
Associate Medical Director
Litigation Management Office
1st Floor, East Wing
Royal Group of Hospitals
Grosvenor Road
BELFAST BT12 6BA

21st December 2004

Dear Peter,

CLAIRE ROBERTS, DECEASED

I am writing to acknowledge receipt your letter of 16th December.

I am sending a copy of your letter to the parents of Claire with a request that they arrange to meet with me early in the New Year. Also, I am sending a copy to Brian Herron who carried out the limited post-mortem examination and asking for his comments.

Please advise me if you would be able to obtain for me statements from Dr David Webb, Dr Hearth Steen, Dr A Sands and Professor Ian Young? If you are not please let me know as soon as possible and I would write to each direct.

Finally, I am sending a copy of this letter to Dr Ted Sumner asking him if he is aware of a Consultant Paediatrician at Great Ormond Street Hospital who I could approach for an independent report.

Yours sincerely

29/12/04
OJS

J L LECKEY
HM CORONER FOR GREATER BELFAST

A.49/04/35/J Page: 318.

[redacted] notes. [redacted]
notes with Dr Steen [redacted]
for statement. [redacted]
[redacted] (I think you should go and borrow the notes from Dr Steen [illegible] urgently to copy them. The sooner Dr Bingham report the better I feel. If Dr Steen [illegible] herself let me know and I will speak to her.

[illegible]

ding

Telephone: [redacted]
Fax: [redacted]
E. mail: [redacted]

Mr Peter Walby FRCS Ed
Associate Medical Director
Litigation Management Office
1st Floor, East Wing
Royal Group of Hospitals
Grosvenor Road
BELFAST BT12 6BA

4th January 2005

Dear Peter,

CLAIRE ROBERTS, DECEASED

I refer to my letter of 21st December.

I am writing to advise you that I will be obtaining an independent report from Dr Robert Bingham who is a Consultant Anaesthetist attached to Great Ormond Street Hospital for Children in London. His name was suggested to me by Dr Ted Sumner who advised me that Dr Bingham is past President of the Resuscitation Council and is an expert on fluid management in children. I have informed Dr Bingham that if he sees a need for input from a Consultant Paediatrician I would have no objection to him liaising with one of his colleagues in the hospital.

I should be grateful if you would arrange to forward to Dr Bingham direct all the medical records. His address is c/o Great Ormond Street Hospital for Children NHS Trust, Great Ormond Street, London WC1N 3JH.

In accordance with my normal practice I will provide you and the parents of Claire with a copy of his report as soon as it becomes available.

Yours sincerely

J L LECKEY
HM CORONER FOR GREATER BELFAST

Litigation [illegible]

7/1/05

20/4/05

HER MAJESTY'S CORONER

DISTRICT OF GREATER BELFAST

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Mr Peter Walby FRCS Ed
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BELFAST
BT12 6BA

18th April 2005

Dear Peter,

CLAIRE ROBERTS, DECEASED

I am pleased to be able to report that Dr Bingham of Great Ormond Street Hospital for Children has e-mailed me a copy of his report and I am enclosing a copy of this. (He is forwarding to me a formal signed copy.)

Dr Bingham telephoned me a week or so ago and suggested the desirability of obtaining a report from a Specialist in Paediatric Emergency Medicine. On my behalf he spoke to Dr Ian Maconochie who is a Consultant in Paediatric Accident & Emergency Medicine at St Mary's Hospital London. He is willing to prepare a further report for me and I have now written to him confirming that I wish him to do so. Once I receive a copy of his report I will send a copy to you.

Yours sincerely

J L LECKEY
HM CORONER FOR GREATER BELFAST

Enc

A.49/04/35/J Page: 314

[redacted]

From: [redacted]
Sent: 12 January 2005 08:39
To: Heather Steen
Subject: RE: Re Roberts Case

Heather

You will have my letter now naming Dr Robert Bingham as the Coroner's Expert.

Mr Leckey did not give us the choice: - as I mentioned to you, I said to Mr Leckey that I felt a paediatrician would be more appropriate than a paediatric anaesthetist, but he clearly decided otherwise.

Peter

---Original Message---
From: Heather Steen
Sent: 11 January 2005 10:47
To: [redacted]
Subject: Re Roberts Case

Peter
I was thinking about the Coroners Case Review. Surely the most suitable person to review it is a paediatric neurologist. We should point out thatwe had very limited access to CT Scan in 1996
Heather

12/01/2005