Witness Statement Ref. No. 268/1

NAME OF CHILD: Claire Roberts

Name: Gordon Clarke

Title: Mr.

Present position and institution:

Retired

Previous position and institution:
[As at the time of the child's death]
Directorate Manager, Paediatric Directorate- Royal Belfast Hospital for Sick Children ("RBHSC")

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-August 2012]
Member of Northern Ireland Advisory Committee on Blood Safety commencing August 2012

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]
None

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);
I am not nor have I ever been medically qualified. I no longer have a copy of my CV.

(2) Please describe your career history before you were appointed Directorate Manager;
From 1975, I held a number of administrative & clerical posts at both the Royal Victoria and Musgrave Park hospitals. I was appointed as Business Manager (paediatrics) on or around 1989/90. Around 1994, I do not recall precisely when, I was interviewed and appointed as Directorate Manager for the paediatric directorate, based in RBHSC.

(3) Please provide any and all information regarding your work commitments at the RBHSC from the date of your appointment to 2006;
From memory, I believe there were several distinct elements, for which I reported to the Clinical Director and was responsible to the CEO:

- Day-to-day operational management & support;
- Personnel & resource management;
- Planning and initiating service development.

(4) Please describe the role, function and accountability of your post as at 1996 and 2006, including those individuals to whom you reported, and who reported to you;
Please refer to answer (3) above and to the organisational diagram at page 8.

(5) Was there a written job description for your post in 1996 and/or 2006? If so, please provide copy of the same.
I no longer have a copy of my job description. Please see answer (3) above.

(6) Please identify your predecessor and successor in post;
The post was created through organisational change and so there was no predecessor to me. I ceased working in paediatrics around 2001/2 and I believe Ms Bernie McQuillan succeeded me.

(7) With reference to the Paediatric Directorate's corporate structure as diagrammatically described by Dr. Connor Mulholland (Ref: WS-243/2 p.6) please state:

(a) Whether this structure is correct as at October 1996?
I believe the structure as at 1996 was of "Directorate" rather than "Business" Manager. This is attached in diagrammatic form herewith - page 8.

(b) Please identify all the personnel in the posts in October 1996, in particular Nurse Manager;
Please see diagram attached - page 8

(c) If the diagram is incorrect in any way, please provide an accurate diagram/description.
Please see diagram attached - page 8

(8) Please state whether your role required you to liaise with the Director of Medical Administration;
My only formal liaison with the Director of Medical Administration would have been in the transmission of any letters of complaint citing medical issues or negligence to his office when received by me in the first instance.

(9) Who was responsible, in 1996-1997 for the categorization of cause of deaths within the RBHSC?
This wasn't my function and I am uncertain of whose responsibility it was.

(10) How was the death of Claire Roberts categorised within the RBHSC statistical data in 1996?
I am unaware of how the death was categorised.

(11) Please provide comment on whether the RBHSC revised its statistical database in the light of the new information about the cause of Claire's death after her Inquest in 2006.
I did not work at RBHSC / paediatrics in 2006 and therefore cannot answer.

(12) Did you receive any report of the death of Claire Roberts, and if so please detail all steps taken by you in relation to this matter?
I received no report on the death that I am aware of.

(13) In 1996-1997, were there any arrangements in place in the RBHSC/Trust for the internal appraisal of clinical performance?
There was a site-wide clinical audit process in operation and the paediatric clinicians would have participated in this process.

(14) In 1996-1997, were there any arrangements in place in the RBHSC/Trust for the retention and destruction of clinical records? If so, please provide copy and specify who was responsible for the same?
I think the recommended medical record retention period was 25 years for paediatric patients though I cannot now be certain.

(15) Please state whether you were aware of the case of Adam Strain in 1996 and if so please describe the extent of your knowledge;
I have no recall of knowing about or being involved in the case of Adam Strain.

(16) Please state whether you were aware of or had any engagement with the case of Claire Roberts and if so please provide full details of the same.
I had no recollection of engagement with the case of Claire Roberts

(17) To your knowledge was the death of Claire Roberts discussed informally by the staff of the RBHSC in October 1996?
I have no knowledge of informal discussion of the death among staff at that time.

(18) Please provide full details of any changes made in patient care, particularly in regard to fluid management, between the death of Adam Strain in 1995 and the admission of Claire Roberts, including
I am unaware of any consequential changes to patient care /clinical practice.

(a) The extent to which any changes made resulted from lessons learnt from Adam's death in 1995 and his Inquest in 1996;

(b) The extent to which any such changes had any effect and, if so, what that effect was.

(19) Please state whether any guidelines or conventions existed in 1996 governing post-mortem examinations with specific reference to:
I am unaware of any such guidelines or conventions and cannot answer questions (a - g).

(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?

(20) What was the origin of the pro-forma consent form (Ref: 090-054-185) used for the limited post-mortem presented to Mr. Roberts for signature?
Unknown

(21) Please specify all meetings, discussions, reviews and audits which took place touching on the death of Claire Roberts; identifying those who attended the meetings, where such meetings took place and whether a note was taken of the same.
I have no knowledge or recollection of any such meetings

(22) Please describe what arrangements were in place to ensure the accuracy and quality of information provided to the hospital pathologist for post-mortem by treating clinicians, including:
I have no knowledge of the arrangements and cannot answer questions (a - f) below.

(a) How the treating clinicians prepared and obtained the information for the autopsy summary that was provided to the pathologist;

(b) The extent to which those treating clinicians were trained on how to prepare and provide such information to the pathologist;

(c) Existence of guidelines, procedures or practices governing the information provided by the treating clinicians to the pathologist to establish an accurate cause of death;

(d) How the cause of death was established and agreed;

(e) Whether communications between Claire's treating clinicians and the pathologist were appropriate for establishing an independent view as to the cause of Claire's death;

(f) Whether communications between Claire's treating clinicians and the pathologist complied with any guidelines, procedures or practices governing such provision of information.

(23) Please describe what procedures were in place in 1996 governing post-mortem examinations.
Post-mortem examinations were not managed through my office and I have no knowledge of the procedures employed at that time.

(24) Please describe what procedures were in place in 1996 governing the report of a death such as Claire's to the Coroner?
Unknown

(25) Please describe what arrangements were in place to ensure information was provided to the DHSSPS and the medical/nursing community in general with regard to the death of Claire in 1996 and following her Inquest in 2006, with particular regard to:
I have no recollection of the arrangements for the dissemination of information among DHSSPS, medical & nursing staff in relation to this death either pre or post inquest. I cannot answer questions (a-e) below.

(a) The process by which any information was disseminated within the RBHSC and the wider medical community;

(b) When, by who and to whom the information was disseminated;

(c) Whether such dissemination followed the procedures and practices in place at the time;

(d) The extent to which any inadequacies in dissemination constituted a systems error;

(e) The extent to which any inadequacies in dissemination constituted a human error.

(26) Please describe what steps the RBHSC/Trust took in the period following the death of Adam Strain in 1995 up to the admission of Claire Roberts to exercise internal control in relation to clinical care.
I believe this would have fallen under the clinical audit process

(27) In 1996, what arrangements did the RBHSC/Trust have in place for ensuring that systematic medical and/or clinical audits took place within the RBHSC?
I believe this would have fallen under the clinical audit process

(28) If the RBHSC/Trust had no system in place for conducting medical and/or clinical audits in 1996, please clarify whether the RBHSC/Trust had any other system in place for quality assuring the safe provision of clinical care?
I am unaware of any other system.

(29) Was there any procedure or system in place in 1996 to audit the quality, clarity and completeness of clinical case notes?
RBHSC participated in a site-wide medical records committee.

(30) Was there a system of independent external scrutiny in place to review patterns of performance in the RBHSC, and if so please provide details of the same?
Paediatric directorate participated, inter-alia, in the King's Fund Organisational Audit process.

(31) Please particularise all steps taken by the Trust/ RBHSC to investigate the unexpected death of Claire Roberts.
I am unaware of any such.

(32) In 1996, did the RBHSC/Trust have guidance, policy or procedures in place which governed the issue of clinical record keeping? If so, please describe its main features or provide copy.

I believe this would have come under the auspices of the site wide medical records committee.

(33) Were there any procedures in place in 1996 for communication with next of kin when aspects of care had not gone to plan and the outcome was not a positive one for the patient?
Unknown

(34) In 1996, did the RBHSC/Trust have guidance, policy or procedures in place governing issues arising out of a serious untoward incident or an adverse incident? If so, please provide copy or describe the same.
I believe there may have been a pro-forma for untoward incidents but I cannot recall or describe the detail or process involved. I had no involvement in the creation, formatting or detail of the form which, from memory, were held at ward level by ward managers/ sisters.

(35) Did the RBHSC/Trust take any steps, whether by way of an internal investigation or otherwise, to establish whether lessons could be learned from the death of Claire Roberts, if so what were they? If not, why not?
I have no knowledge of any such investigation.

(36) 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 the initials of Dr. McKaigue? If so why was this note made?
Unknown

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

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

(37) Were you aware of the RBHSC's engagement with the Kings Fund Organisational Audit in 1996? If so how did it affect the advices given to you or others in respect of:
Yes. I have no recall of specific recommendations regarding RBHSC or paediatrics. However, the recommendations from the process would have been managed centrally. Issues would have been addresses to the satisfaction of King's Fund to enable accreditation.

(a) Communication with patient's parents and record of the same;

(b) Investigation of patient's death;

(c) Review of medical records;

(d) Systematic programme of audit;

(e) Implementation and compliance with published guidance?

(38) When do you believe the following individuals become aware of the death of Claire Roberts:

I am unaware of when other staff members at the Royal hospitals became aware of the death of Claire Roberts.

(a) Dr. George Murnaghan;

(b) Dr. Joseph Gaston;

(c) Dr. Ian Carson;

(d) Mr. A.P. Walby;

(e) Mr. George Brangam;

(f) Miss Elizabeth Duffin.

(39) In respect of the UTV Insight documentary ('When Hospitals Kill'- 21st October 2004) please state:
I did not work at RBHSC in 2004 and cannot therefore comment on any "connection". I cannot answer questions b - k.

(a) Was a connection made between the programme and the case of Claire Roberts either before or after broadcast?
Unknown

(b) If not, why not?

(c) What did the RBHSC learn from the programme?

(d) What requests for information and comment were received from UTV;

(e) What information and comment was given to UTV, specifying by whom, to whom and when;

(f) Please identify those individuals engaged in this process;

(g) Who bore responsibility for this process;

(h) What internal responses were generated by any such requests;

(i) What internal responses were generated by the broadcast of the documentary;

(j) Whether any record or documentation of this process was made, and if so please provide the same;

(k) If same was created, but is now no longer available please state what became of it.

(40) Was there any appraisal of staff performance in the aftermath of Claire's death?
Not of my staff. Appraisal of medical staff would have been the responsibility of either the Clinical Director or the Medical Director.

(41) 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.
Unknown

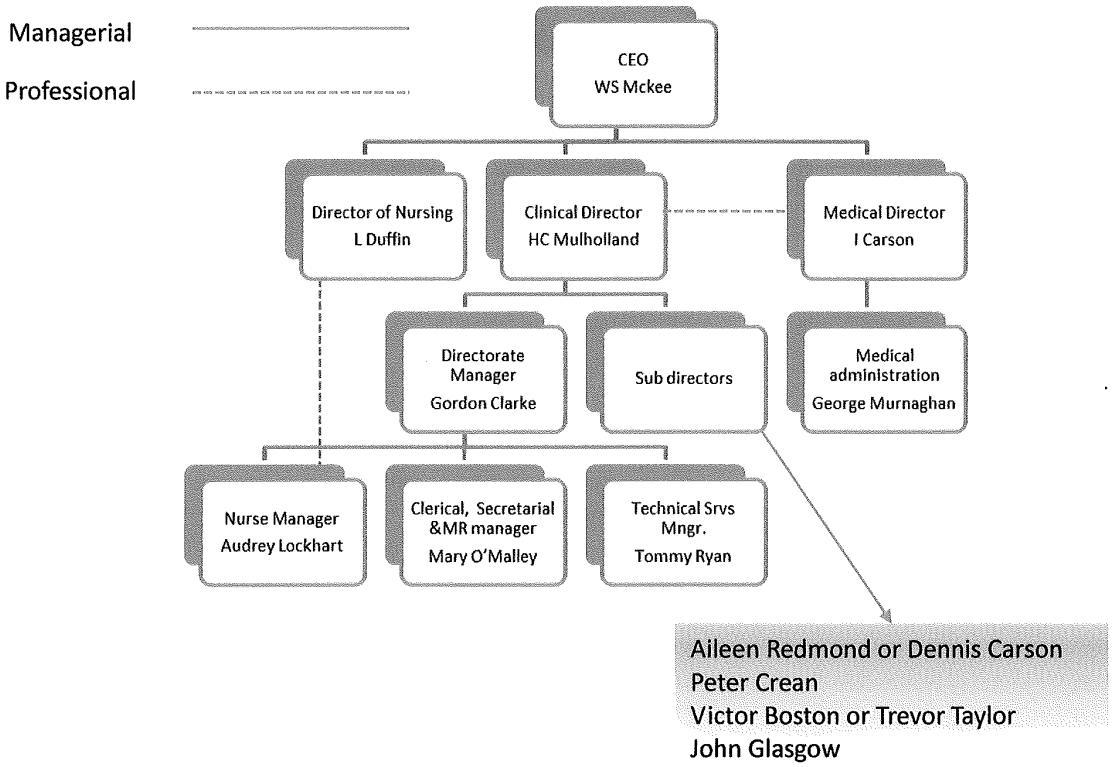
(42) Please describe how the 'culture' within the RBHSC has changed since 1996?
Unknown

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

(44) Please provide any further comments you may wish to make;

Please provide any further documents or materials you may wish to include

Organisational structure at 1996



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

Signed: **Dated: 12th Sept. 2012**