Witness Statement Ref. No. 271/1

NAME OF CHILD: **Claire Roberts**

Name: William McKee

Title: Mr.

Present position and institution:

Previous position and institution:
[As at the time of the child's death]
Chief Executive, Royal Hospitals.

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 specify any changes occurring in the period from November 1995 to October 1996 in respect of the following:

(a) Your professional or other qualifications;

(b) Your job, role and functions;

(c) Your responsibilities and accountability, including to whom and how you reported and who reported to you.

(2) Please detail any changes in clinical and corporate governance in the Royal Group of Hospitals/RBHSC as and between 1995-1997 and 1997-2004 in respect of:

(a) The reporting, investigation, analysis and learning from adverse clinical incidents;

In my letter dated 26 July 2005 to the Inquiry (Reference 45487) I outlined the incident reporting systems in place from 1995 to 2005.

(b) The referral of deaths to the Coroner.

I do not recall any changes in respect of referral of deaths to the Coroner for the periods 1995-97 and 1997-2004.

(3) After the Inquest into the death of Adam Strain, did you give any instruction that the Medical Director and/or Director of Medical Administration should be informed of any future deaths involving hyponatraemia?

I do not recall giving an instruction that the Medical Director and/or the Director of Medical Administration should be informed of deaths involving hyponatraemia or any other cause of death. In his role as Director of Medical Administration, Dr Murnaghan would have been involved in deaths which were referred to the Coroner.

(4) In 1996, what steps were being taken to ensure overall understanding and clarity of lines of responsibility and accountability in clinical care?

In 1996 lines of responsibility and accountability in clinical care was essentially a matter for professional self regulation involving the individual clinician, medical colleagues and the GMC.

(5) In 1996, what steps were being taken to encourage staff to report adverse events so that lessons could be learned?

I refer you to my answer at point 2(a) above.

(6) Please state the policies and procedures for reporting unexpected and/or unexplained deaths to DHSSPSNI and EHSSB?

I refer you to my answer at point 2 (a) above.

(7) Please state the policies and procedures for reporting the Coroner's findings and Verdicts at Inquest to the DHSSPSNI/EHSSB?

I do not recall any specific policy or procedure in relation to reporting the Coroner's findings and Verdicts at Inquest to the DHSSPSNI/EHSSB. In my previous statement I indicated that from January 1999 there was a mechanism in place for sharing learning via the Associate Medical Director, Mr Peter Walby to the DHSSPSNI via the Chief Medical Officer and issues were also flagged up by the HM Coroner to the DHSSPS or the Health Minister. However, I am not aware that this was a formal process such as a Trust, DHSSPS or HM Coroner's policy or a more informal process.

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

I first became aware of the death of Claire Roberts in 2004 as a result of the UTV programme and subsequent communication with the Roberts family via the Medical Director's Office.

(9) 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?

At the time I would not have expected the death of an individual patient to be reported to the Chief Executive unless the Medical Director was concerned about the care management provided by the service area including the performance of a doctor with a potential for referral to GMC or if an independent external clinical review of the case was required or if there was a potential for reputational damage to the organisation. At the time of Claire Roberts' death I would have expected deaths to be reported within the Clinical Directorate structure and discussed at clinical audit meetings, or morbidity and mortality meetings. As outlined in my letter dated 26 July 2005 to the Inquiry (Reference 45487) the reporting of adverse incidents, including deaths, developed over a period of time as clinical governance evolved in the Royal Hospitals Trust and the wider HPSS.

(10) Please provide detail of all investigations into the treatment and death of Claire Roberts.

I do not recall the detail of investigations into the treatment and death of Claire Roberts. It would be my understanding that this was led by the Medical Director, Dr M McBride, when this issue was raised with him in 2004.

(11) Did you cause a search to be made for documentary materials relating to Claire Roberts, if so please specify what was sought, what was found, and where it was found?

I did not personally cause a search for documentary materials relating to Claire Roberts. That would have been managed by the offices of the Medical Director.

(12) Was there any attempt to trace:

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

(b) Minutes of Neuroscience Grand Rounds?

(c) Neuropathologists file?

(d) **Nursing reports, reviews or audits?**

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

I refer to my previous answer at (11).

(13) **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) **Dr. Ian Carson;**

(f) **Nurse Manager in Paediatric Directorate;**

(g) **Miss Elizabeth Duffin;**

(h) **Mr. George Brangam.**

I cannot specify to whom the death of Claire Roberts was reported in 1996, this would have been the responsibility of the clinical staff involved in her care and treatment and for the Paediatric Management team.

(14) **Please state whether you regarded the death of Claire Roberts as 'expected' or 'unexpected'.**

This would have been a matter for professional clinical opinion and Coroner's Inquest.

(15) **What steps were taken in 1996 to ensure that lessons learned from audit and inquests were translated into changes in clinical practice?**

I cannot provide the detail of steps taken in 1996 to ensure lessons learned from audit and inquests were translated into clinical practice. In my earlier statement to the Inquiry (WS 06/1) I indicated that the Director of Medical Administration had responsibility for the dissemination of internal learning from Inquests until 1999 and this area would be better addressed by Dr Murnaghan. Clinical audit was in place within the Royal Hospitals Trust from around 1993 and there was an Audit Committee and a Medical Audit department to facilitate audit. This area would best be referred to Dr Murnaghan, Dr Gaston or Dr Mulholland.

(16) **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 am unable to confirm if the input of the Director of Medical Administration was sought specifically in relation to the death of Claire Roberts.

(17) **In 1996, what arrangements were in place to monitor deaths to identify areas of concern?**

I am not aware of any formal arrangement in 1996 by which deaths were monitored to identify

areas of concern. It is my understanding that morbidity and mortality was discussed at clinical audit meetings to identify learning.

(18) In 1996, what systems were in place to identify and manage the poorly performing clinician?

I am not aware of any formal systems in place to manage poorly performing clinicians in 1996. The review of complaints, incidents and claims and clinical audit would have informed clinical management of any potential concerns. There were no formal 'Whistleblowing Policies' within healthcare at that time. The medical profession were self-regulated and the GMC has statutory responsibility for overseeing self-regulation and members of the profession have a moral, ethical and professional responsibility for their own practice and that of their colleagues. From 1997 the Medical Director, Dr I Carson was leading on the implementation of "Medical Excellence" in the Royal Hospitals Trust and this area should be referred to Dr Carson and Dr Murnaghan.

In 2000 a consultation document was issued "Confidence in the future for patients and for doctors". This was a consultation document on the prevention, recognition and management of poor performance of doctors in NI. Before then there was no guidance available to the Trust or any other employer to assist in the management of poorly performing clinicians.

(19) Describe the monitoring of litigation in 1996 in order to utilise the information to improve clinical practice and policies.

I cannot recall how litigation was monitored to improve practice in 1996. This area should be referred to the Director of Medical Administration.

(20) In relation to the Litigation Management Office kindly advise:

(a) The date this Office was established;

I cannot recollect the date this Office was established.

(b) Why the Directorate of Risk and Litigation Management/ Directorate of Risk and Legal Administration was superseded by the Litigation Management Office?

I cannot recall the detail of any restructuring of this service.

(c) The identity of the Directors of the Litigation Management Office;

I cannot recall the detail of this.

(d) The remit, authority and responsibilities of the Litigation Management Office between 1996-2006;

I cannot provide this information. This should be referred to Dr G Murnaghan and Mr Peter Walby.

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

I cannot provide this information. This should be referred to Dr G Murnaghan and Mr Peter Walby.

(f) Whether the Litigation Management Office analysed information from litigation for the

purposes of distilling lessons to be learned;

I cannot provide this information. This should be referred to Mr Peter Walby

(g) If not who did?

I cannot provide this information. This should be referred to Mr Peter Walby

(h) If so, what steps were taken to share these lessons;

I cannot provide this information. This should be referred to Mr Peter Walby

(i) Whether there was any external scrutiny of these processes?

In 1996 there was no requirement for external scrutiny and no guidance.

(21) In 1996, what systems were in place to monitor the quality of clinical care?

The only system that I can recall that is relevant to this matter is the internal process of clinical audit. There was no regional guidance or support for clinical audit in 1996.

(22) Were minutes of the Paediatric Audit Committee/ Mortality meetings sent to the Medical Records Committee and/or the Audit Department of the Royal Group of Hospitals?

I cannot provide this information.

(23) 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?

In 1996 as this area was the responsibility of the Director of Medical Administration I would not have expected nursing staff to mount an investigation into the death of Claire Roberts. I would expect that nursing staff would co operate with any such investigation including the provision of statements if required. Statements would have been statements of fact and I am not conversant with the detail of this case and cannot comment if nursing staff would have been required to provide this.

(24) Was there any appraisal of staff performance in the aftermath of Claire's death?

I refer to my answer at (18) above.

(25) In respect of Circular ET 5/90 (as amended) January 1991 (Ref: WS-061/2 p.321) please state:

(a) What arrangements were in place to ensure the maintenance of an effective reporting system of untoward incidents;

(b) What mechanisms were put in place to determine whether a case met the criteria for reporting;

(c) What mechanisms were put in place to assess whether there might have been a suggestion that there had been a failure in professional standards of care and treatment;

(d) What mechanisms were put in place to assess whether an incident might give rise to

publicity in the press or media?

I cannot recall the detail of the arrangements or mechanisms in place to ensure reporting of untoward incidents in respect of Circular ET 5/90. It was custom and practice that external guidance was circulated through the Chief Executive's Office to the relevant Director(s) for action as required. This would include the monitoring of such action.

(26) In respect of Directive PEL (93)36, Annex B, Paragraph 3 *"If a patient dies unexpectedly the clinician in charge of the case must report the death immediately to the Coroner"* (Ref:WS-062/1 p.18) please state:

I cannot provide the detail in relation to the dissemination of this Circular. It was custom and practice that external guidance was circulated through the Chief Executive's Office to the relevant Director(s) for action as required. This would include the monitoring of such action.

(a) What steps were taken to ensure the clinicians of the RBHSC were aware of this Directive,

(b) What steps were taken to ensure the clinicians complied with it?

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

I do not know how the death of Claire Roberts was categorised in 1996. This should be referred to the Paediatric Directorate.

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

I cannot answer this question. This should be referred to the Belfast HSC Trust.

(29) 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:

I cannot recall the detail of feedback from the Kings Fund Organisational Audit in 1996.

(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?

(30) Was there any system or process for the audit of referrals to post-mortem and referrals to Coroner? Was this system or process subject to any external scrutiny or review?

I am not aware of any system or process for the audit of referrals to post-mortem or to the Coroner.

(31) In 1996, what steps were being taken to achieve a change in the culture within the Royal Group of Hospitals/RBHSC?

I refer you to my letter dated 26 July 2005 to the Inquiry (Reference 45487).

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

I cannot answer this question. In 1996 this would have been the remit of the Director of Medical Administration and the Clinical Director of Paediatrics.

(33) Under what circumstances would you have reported the death of Claire Roberts to:

(a) The Chief Medical Officer;

(b) The DHSSPSNI;

(c) The EHSSB?

In 1996 this would have been delegated to the Director of Medical Administration in line with extant guidance at the time.

(34) *"every adverse incident, including deaths whether expected or unexpected, provide an opportunity for learning. Medical professionals have used 'morbidity and mortality case conferences' for many years"* **(Ref: WS-077/2 p.21). In respect of this statement please state:**

(a) What learning was derived from Adam Strain's death, Inquest and litigation in respect of fluid management and the dangers of hyponatraemia?

I do not recall the detail of the learning derived from the death of Adam Strain. This should be referred to the Medical Director, the Director of Medical Administration and the Clinical Director for ATICs.

(b) How was Claire Roberts death used as an opportunity for learning?

This should be referred to the Medical Director and Clinical Director for Paediatrics

(35) Do you have access to:

(a) First, second and third Clinical Audit reports to Trust Board;

(b) First and second Health and Safety reports to Trust Board;

If so, please provide copies of the same.

I do not have access to these documents. This should be referred to the Belfast HSC Trust.

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

I was not engaged in the Trust's response to enquiries relating to hyponatraemia after the UTV insight programme.

(37) What plans were made to deal with the anticipated aftermath of the UTV programme?

I cannot recall the detail of plans made to deal with the anticipated aftermath of the UTV programme.

(38) What documentation was generated by the Trust in respect of this programme, including:

(a) Contact with UTV;

(b) Internal response;

(c) External response to the programme;

(d) Please provide copy of the same.

I do not have access to this information. This should be referred to the Belfast HSC Trust.

(39) Was this discussed at Board Level? If so, please provide Minutes of the same.

I do recall the matter being discussed at Trust Board level and I not have access to Trust Board minutes.

(40) Was notification of the issues relating to the death of Claire Roberts regarded by you as sufficient to trigger a review of her case in accordance with the *"Procedure for Investigation and Review of Adverse Incidents"* (Ref:WS-061/1 p.4).

This would have been a matter for the Medical Director to take into consideration. This should be referred to the Associate Medical Director and Medical Director.

(41) In respect of the following statement *"In line with good governance and our commitment to openness and transparency, the Royal Hospitals acknowledges to patients and the public when things go wrong and systematically ascertains what happened, how it happened and why, so that we can do all that is possible to ensure that lessons are learned to prevent a re-occurrence"*(Ref: 302-096-004) please state:

(a) Whether there was a systematic attempt to ascertain what had happened in Claire's case?

(b) Whether this was reduced to writing? If so, please provide copy.

I cannot recall the detail of investigations into the death of Claire Roberts. This should be referred to the Medical Director and Associate Medical Director.

(42) In 1996-1997 was there any review undertaken into the Adam Strain case (whether of death, Inquest or litigation)?

Other than the Inquest into the death of Adam Strain I am unaware of any other review of the case. This should be referred to the Director of Medical Administration.

(43) In the light of the recommendations of the Allitt Inquiry, did you set up any mechanism whereby information relating to patient deaths might be brought speedily to your attention or to that of the Board?

The Allitt Inquiry report, "*Clothier, C. Report of the Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kestevan Hospital during the period February to April 1991.* London, The Stationery Office, DoH 1995" was issued from London. It was not circulated to NI, nor would it have had any authority here. I am not aware of any related regional guidance issued by the DHSS in NI.

(44) 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?**

No, I did not keep a file or record of the work in relation to the case of Claire Roberts.

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

It would be unusual for me not to liaise with Corporate Affairs in relation to a case such as the Claire Roberts case. However, I do not recall the detail of this matter.

(46) Were the deaths of Adam Strain and Claire Roberts raised at any Board Meeting and if so please provide the Minutes of such meetings?

I do recall the matter being discussed at Trust Board level but I do not have access to Trust Board minutes.

(47) 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: William McKee

Dated: 14 September 2012