Witness Statement Ref. No 273/1

NAME OF CHILD: Claire Roberts

Name: George Murnaghan

Title: Dr.

Present position and institution: Retired

Previous position and institution:
[As at the time of the child's death]
Director of Medical Administration – Royal Group 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]

Witness Statement 015/1
Witness Statement 015/2

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

Ref:	Date:	
WS-015/1	30th June 2005	Witness Statement to the Inquiry (Adam Strain)
WS-015/2		Witness Statement to the Inquiry (Adam Strain)
093-025	25th May 2012	PSNI Statement
	2nd May 2006	

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 1998 in respect of the following:

(a) Your professional and/or medical qualifications;

None

(b) Your job, role and functions;

As in previous witness statement.

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

As (b) above.

(d) Your predecessor and successor in post.

None.

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

(a) The date this Office was established;

I do not know – this would have been after I retired

(b) Why this Office was established;

I do not know – this would have been after I retired

(c) How and in what ways this Office differed from the Directorate of Medical Administration/ Risk and Litigation Management;

I do not know – this would have been after I retired

(d) The remit, authority and responsibilities of the Litigation Management Office.

I do not know – this would have been after I retired

(3) Was there a heightened awareness amongst healthcare professionals in the RBHSC/Trust in 1996 as to hyponatraemia, sodium levels, fluid administration, cerebral oedema and SIADH?

Yes, I believe there was leading up to and following Adam Strain's Inquest.

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

(a) After the death of Adam Strain;

Yes, I believe this was discussed at Audit meetings.

(b) After the death of Claire Roberts.

I do not know. I did not know of Claire's death.

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

When I received this statement request.

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

Not involved.

(7) Was the death of Claire Roberts reported to you in 1996, and if so by whom? If not, why not?

No, it seems that Claire's death was not deemed reportable by clinical staff at the time.

(8) 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?

See answer at (7)

(9) Please specify all meetings, discussions, reviews, neuroscience grand rounds 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 was not involved in these nor was anything brought to my attention.

(10) Were you seen or consulted by any clinician/nurse regarding any aspect of the treatment, care and death of Claire Roberts in 1996-1997? If so please provide all details of the same.

No.

(11) Please specify all steps you took in relation to the case of Claire Roberts.

None.

(12) Was the Arieff et al paper BMJ 1992, (Ref: 011-011-074) circulated in the RBHSC in 1996

amongst:

(a) Paediatric Clinicians;

(b) Anaesthetists;

(c) Nurses?

I do not know. This would have been a function of Directorate Team and probably circulated after the unfortunate death of Adam Strain.

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

(a) Record keeping;

(b) Drug prescription and administration?

As this death took place in RBHSC I was not aware of any such audit taking place.

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

I have only recently become aware of Claire's death so I am unable to answer this question as at 1996

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

See answer to (14)

(16) 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?

Where there ever was a possibility that medical care and treatment would have contributed to a death I would have expected that to be a cause of an investigation.

(17) Please state whether you reviewed the clinical notes and records of Claire Roberts in 1996-1997, and if so please state when and for what purpose.

No.

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

(a) Mr. William McKee;

(b) Dr. Peter Crean;

(c) Dr. Joseph Gaston;

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

(e) **Mr. A.P. Walby;**

(f) **Mr. George Brangam;**

(g) **Nurse Manager, Paediatric Directorate;**

(h) **Miss Elizabeth Duffin.**

I do not know as I was not involved and Claire's death did not come to my notice.

(19) **Please state whether your advice was sought in relation to referral of Claire Robert's death to the Coroner in 1996-1997? If so please state what advice you provided and to whom.**

No.

(20) **Please state whether your advice was sought in 1996-1997 in relation to the decision that there should be a restricted, 'brain only' post mortem on Claire Roberts? If so please state what advice you provided and to whom.**

No- not within my role or responsibility.

(21) **Please whether you provided any other advice whatever in respect of the case of Claire Roberts and if so include details of the same.**

No- please see my response at (6) above.

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

Standard procedures as set out in the Coroner's guidelines – see my response at (28)(e) below .

(23) **Was there any learning to be had from the case of Claire Roberts with respect to hyponatraemia?**

Not involved, so cannot answer.

(24) **If there was no referral to the Coroner in 1996, and no Inquest, how was such learning to be had?**

See answer to (23).

(25) **Please specify to whom the death of Claire Roberts was reported in 1996-1997:**

(a) **Mr. William McKee;**

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

(c) **Miss Elizabeth Duffin.**

I do not know – was not involved.

(26) **Please specify the date, nature and content of any such reports.**

See answer to (25)

(27) **To your knowledge was the death of Claire Roberts discussed informally by the staff of the RBHSC in October 1996?**

See answer to (25)

(28) **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;.**

A post-mortem examination required consent by the next of kin. However, when the Coroner directed a postmortem examination, the clinician involved would advise the parent/next of kin and explain that their consent was not required

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

The clinician involved together with the next of kin would make this decision based upon the child's clinical history, clinical findings, investigations and the questions to be answered by the postmortem examination

(c) **Authorisation for the same;**

See reply to (b) above

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

See reply to (a) above

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

In certain circumstances, set out below, a death should be notified to the Coroner;
A death in hospital should be reported if:

- there is a question of negligence or misadventure about the treatment of the person who died;

- they died before a provisional diagnosis was made and the general practitioner is not willing to certify the cause; or

- the patient died as the result of the administration of an anaesthetic.

(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;

See answer at 9(b) above

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

Normal practice was to share the findings of an autopsy with the general practitioner and the parents/next of kin of a deceased child

(29) 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 was not involved and therefore cannot answer.

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

See 29(a)

(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?

See 29(a)

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

See 29(a)

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

I do not have access to this information.

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

See answer to (30)

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

Roberts?

See answer to (30)

(33) 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?

I was not involved whatsoever.

(34) Did you 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?

See answer to (33)

(35) Were you contacted by the Trust in respect of the UTV Insight programme (22nd October 2004)? If so please state when, by whom, and with what outcome.

No.

(36) 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?

I was not involved.

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

I was not involved.

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

No.

(39) Did you have any communication with Drs. Steen, Taylor, Webb or McKaigue regarding the death of Claire Roberts in 1996-1997?

No.

(40) Were steps taken in 1996-1997 to monitor information deriving from medical negligence litigation for the purposes of improving clinical practices and policies?

A Medical Risk Management Committee was established at the Royal in about 1995-6 and this was attended by representatives of clinical directorates, the Finance Director and the Trust's legal adviser. Discussions took place, based upon the claims received, the progress of these, the potential liability attaching, and any 'learning issues' that arose. Meetings were held every two months.

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

(a) After the death of Adam Strain;

Yes, as per my previous Statement- WS 015/2 a "feedback session" was planned but unfortunately and regrettably it never took place.

(b) After the death of Claire Roberts.

I was not involved.

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

I was not involved.

(43) In 1996-1998, what steps were taken to achieve a change in the 'learning culture' within the Royal Group of Hospitals/RBHSC?

See response at (40) above

(44) Did you seek the advice of, correspond, communicate or engage Mr. George Brangam in respect of the case of Claire Roberts?

No.

(45) Please state in what circumstances you would have reported a death to the Coroner in 1996-1997?

In 1996-1997 clinicians involved in the direct care of a patient who died, and fulfilled the criteria set out above, reported directly to the Coroner.

(46) Please provide details of any and all contact you had with the Coroner in respect of the case of Claire Roberts

None.

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

I do not know. This was a matter for clinical staff within the RBHSC Directorate.

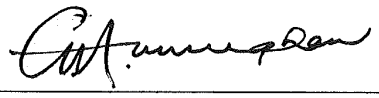
(48) Did any change in the training/teaching provided by the RBHSC/ Trust to clinicians result from Claire's death?

I do not know.

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

None.

(50) Please provide any further documents or materials you may wish to include. None.

Signed:  Dated: 13.09.2012