Witness Statement Ref. No. 341/2

NAME OF CHILD: Adam Strain/Claire Roberts/Raychel Ferguson/Lucy Crawford

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

Associate Medical Director; Litigation Management Office – 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]

6.9.12 – WS176/1
21.11.12 – WS176/2
6.12.13 – WS176/3
31.5.13 – WS341/1

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

I am grateful for the opportunity granted to allow me to correct and amplify the transcript of the evidence given at the Hearing on 25th June 2013.

1. In relation to the exchanges between Senior Counsel to the Inquiry and Mr. Leckey running from pages 59-70 there is discussion as to how senior management in the Trust should have become aware of the statement produced by the Trust at the Adam Strain Inquest. At page 63 lines 10-13 and 19-20 there is reference to who in the Trust could authorise such a statement. Senior Counsel then notes at page 65 lines 8-12, 16-25, and page 66 lines 1-6 that Dr. Hicks (paediatric lead), the medical director, and the CEO did not know of the statement at the time. This does not record that the Clinical Director of Anaesthetics (Dr. Joe Gaston) a very senior clinical manager within the Trust actually drew up the draft statement himself as stated in his witness statement WS013/1 Q2, and Dr. Murnaghan, Director of Medical Administration was party to its production at the Inquest in modified form. I believe that these two senior medical managers would have had the authority to act on behalf of the Trust in relation to the Inquest statement. While it is not for me to judge whether Dr. Gaston or Dr. Murnaghan should have done more than they did, Senior Counsel at page 66 lines 10-14 states there seemed to be no governance structure in relation to the commitment to the Coroner, yet Senior Counsel refers to the seminar which was planned but did not occur because of holidays, illness and forgetfulness. The Trust accepted the failure to hold the seminar was inexcusable but it was not because there was no governance structure. Dr. Carson, Dr. Hicks and Dr. Gaston were on Dr. Murnaghan's list of proposed attendees at the seminar. While Dr. Carson may not have known of the statement "at the time" (page 65 line 9 - Senior Counsel) it was presented to the Coroner he is most likely to have known about it shortly afterwards consistent with Dr. Murnaghan's handwritten file note (059-001-001 & 002) and his oral evidence on 25th June 2012, page 209, line 10. When Mr. Leckey was asked who he thought would have had authority within the Trust to make a commitment (page 67 lines 7-19) he answered the medical director or clinical director. The most relevant Clinical Director Dr. Gaston and the Director of Medical Administration Dr. Murnaghan both attended the Inquest, although neither was called to give evidence when Dr. Taylor introduced the Draft Statement C5. Dr. Hicks would have become aware of the statement had the seminar occurred. I believe the Trust is being placed in a poorer light than it should be. There was a failure but it was an administrative one albeit a serious one.

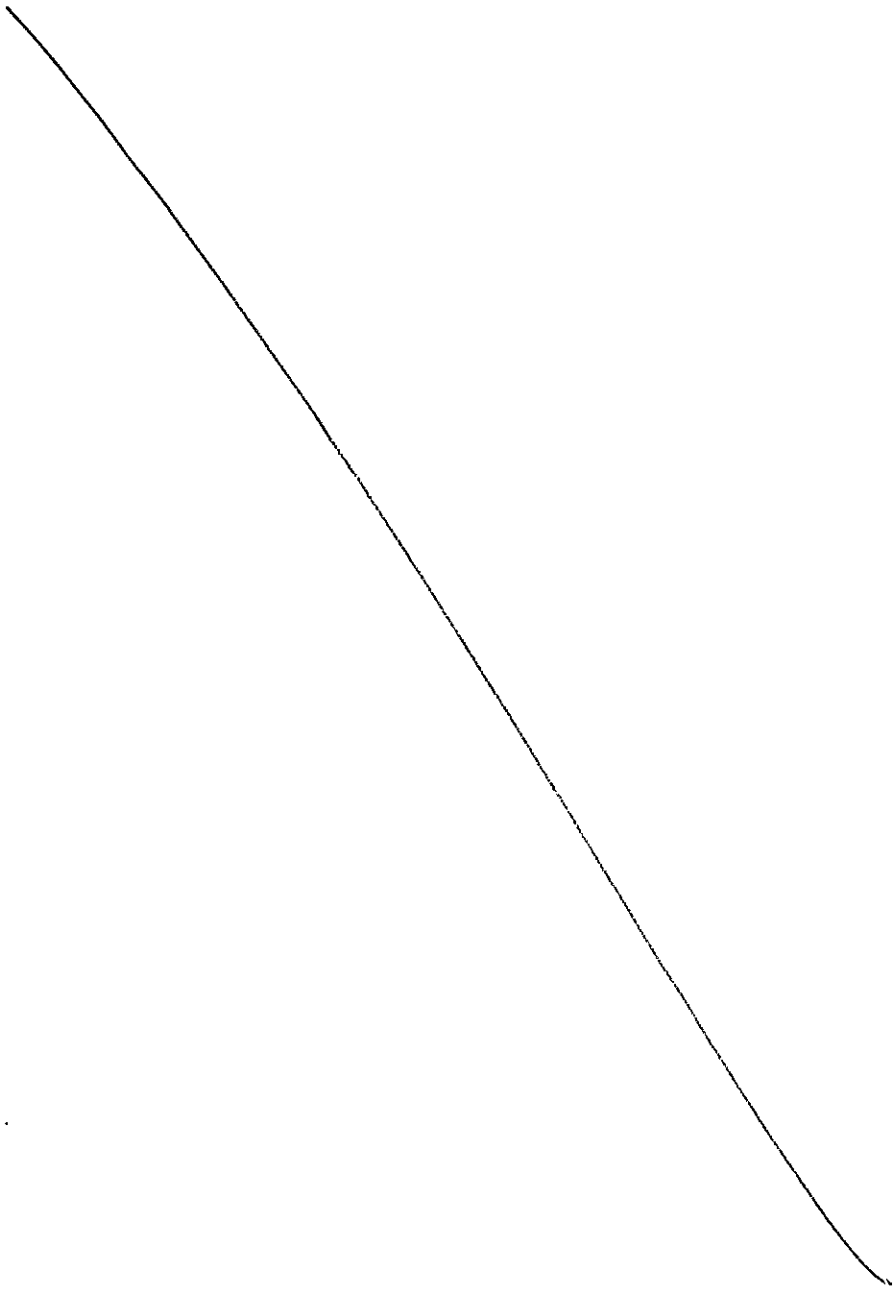
2. Senior Counsel to the Inquiry advises Mr. Leckey on page 95 lines 21 & 22 that I was "in the office of risk management", and on page 96 lines 18 & 19 that witness statements were "being taken by the trust risk manager". This is not correct. I advised the Inquiry during my evidence on 11th December 2012 page 163 lines 10-12 that I was not involved in risk. Mr. Leckey at page 96 line 21 is led to agree with the proposition that involvement of risk management in taking statements "perhaps puts a different colour on things". This scenario did not occur within the Trust while I was working in the Litigation Management Office.

3. Mr Leckey queries how the Trust secured PSNI statement forms (page 95 lines 12 & 13). The HMSO forms pre-printed with "NOT SIGNED IN POLICE OFFICER'S PRESENCE" (eg 139-156-011) were supplied by officers mainly from Grosvenor Road Police Station and also other PSNI police stations. The use of these witness statement proformas by the Trust was known by the Coroner's Office and Mr. Leckey did not question their use prior to his Inquiry evidence at page 96 lines 7-10 (see my evidence of 12th December 2012 page 146 lines 15-19). When a police officer took a statement it would be witnessed by the police officer. If it was obtained by the Trust from the witness as allowed for by the block capital heading (as above) the witnessing section by a police officer was left blank. The Coroner's Office therefore knew the source. I have recently checked with the Trust and the police continue to accept requested witness statements prepared using these forms both for the Coroner and also in criminal cases on behalf of the Director of Public Prosecutions.
   To facilitate the simple creation of a second original copy if the first was lost by the police, the post, or the Coroner's Office as happened on occasions, the Trust scanned in the forms electronically so that an original signed statement could be created again, as per my evidence on 12th December 2012 page 146 lines 3-12.

4. Senior Counsel refers to the involvement of the Trust's management team in "drafting" witness statements (page 96 line 25). The only drafting involvement in statements was that given in the witness statement request letters (eg Dr. Webb's statement request 139-124-004) and related to the identification and qualifications of the witness and not to the substance of the statement itself.

5. Senior Counsel refers to "The 2002 system, which was the old system,..." (page 97 line 1) when referring to drafting or amending statements. The system had not been replaced by any new system by the time I had retired last year.

6. Senior Counsel at page 98 lines 9-14 makes a point about how experts commented that Claire would have benefited from one-to-one nursing which is available in PICU. I am not aware that anyone in the Trust has ever disagreed with that, but it has not been raised in previous evidence to my knowledge. The issue which has been raised was whether it was a mistake not to seek an intensive care bed for Claire. My point made in my witness statement (WS 176/3 page 2) was that if one had been sought it would not have been forthcoming as by 1996 standards an intensive care bed was not likely to be available for those not requiring airway support which Claire did not at the time Dr. Webb left the hospital on 22nd October 1996. I pointed this out verbally on 28th July 2005 to Dr. Webb who agreed. The only purpose therefore in him seeking and having a request rejected would have been to seek to cover himself against an untoward eventuality as did indeed unfortunately occur. It was on this basis that Dr. Webb agreed that it was inappropriate to describe a fruitless seeking as a mistake.
   This is not then laid out clearly by Senior Counsel at page 99 lines 9-14 and Mr. Leckey is not appraised of the significant difference in "seeking" and "obtaining placement" when he makes his comments on wanting medical practitioners to admit their mistakes (lines 20-25).



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

Signed: A P. Wallbank **Dated:** 20th August 2013