Witness Statement Ref. No. 341/3

**NAME OF CHILD: Raychel Ferguson Governance**

**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
20.8.13 – WS341/2

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

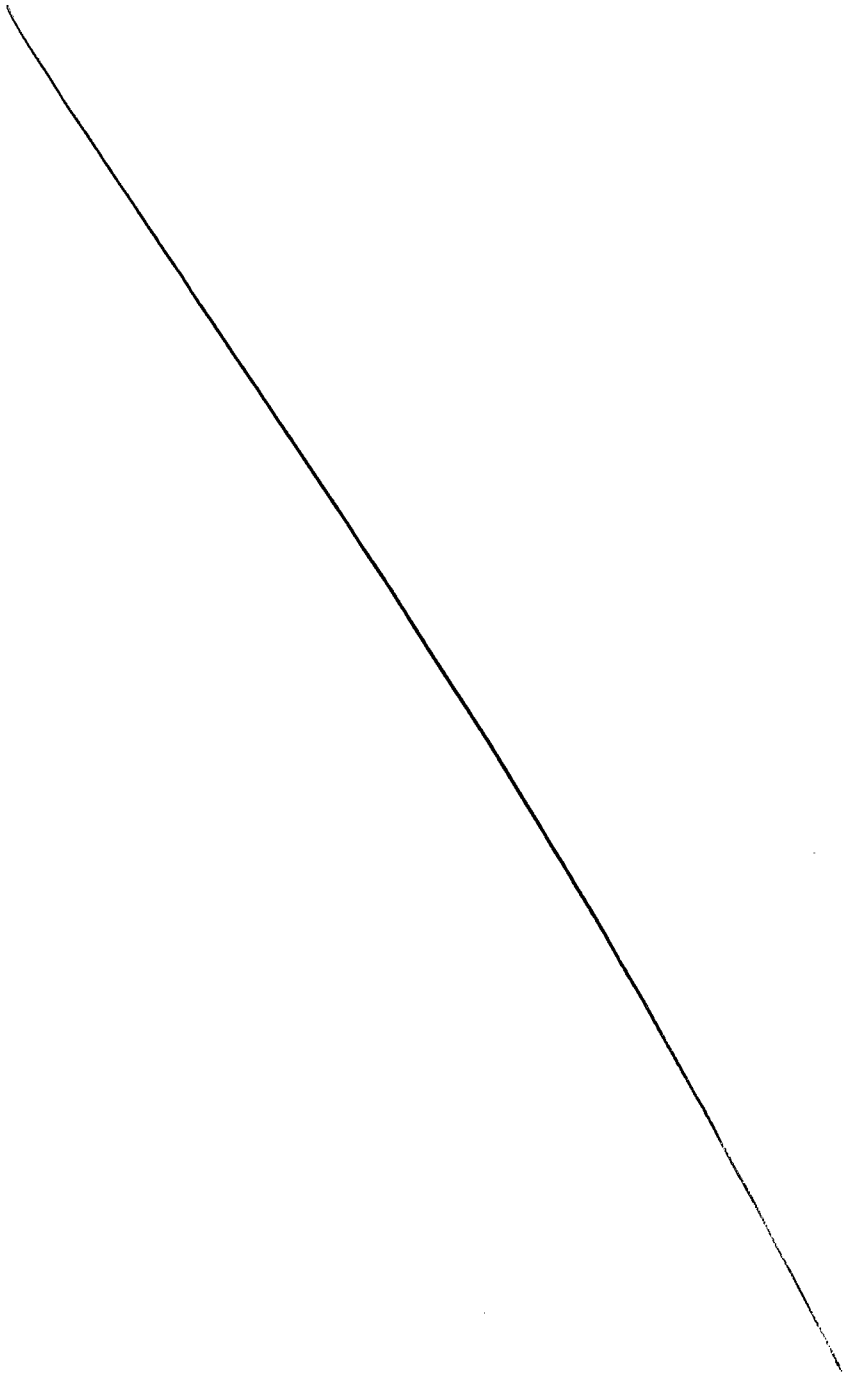
| Ref: | Date: | |
|---|---|---|
| | | |

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

I am grateful to the Chairman for the opportunity granted to allow me to correct and amplify the evidence given during the Inquiry Hearing on 30th August 2013.

1.
I note that during Dr. Carson's evidence on 30th August 2013 that on page 7 lines 18-23 Senior Counsel to the Inquiry questions Dr. Carson on my role but reverses my responsibility by describing it as "the individual within the Trust who's charged with looking after cases that were referred to the Coroner" whereas my role was to look after cases which the Coroner referred to the Trust. The Coroner was advised of many deaths by clinicians but only a small proportion ended up with the Coroner asking the Trust to assist him by obtaining witness statements. Dr. Carson does not describe the process by which he expected clinicians to report Coroner referred deaths to me, but believes their failure to do so may have been in relation to my part-time role as opposed to Dr. Murnaghan's full-time position as Director of Medical Administration. Dr. Murnaghan's post involved responsibility for the Medical Personnel Department, Risk Management, Management of all the paramedical services in the Trust including physiotherapists, physiological measurement technicians, dieticians, and speech therapists etc, the Regional Medical Physics Service, as well as the responsibilities which were eventually devolved to me. When Dr. Murnaghan left early in 1998, his duties were re-allocated within the Trust with Dr. Carson personally taking over management of cases referred by the Coroner and litigation work. When I was appointed on 1st January 1999 Dr. Carson initially devolved only the Coroner work for me to deal with. Dr. Carson had managed the Coroner's work from the same offices that I took over and the office staff advise me that there was no system in place by which deaths referred by clinicians to the Coroner were also reported to Dr. Murnaghan, or to Dr. Carson during the period when he was responsible, or later to me. I do not believe clinicians were expected to undertake such dual reporting as Dr. Carson recollects. Later from 1st April 1999 Dr. Carson devolved to me the Litigation work. My sessional commitment to this work was adequate to fulfill this role and I believe I quickly developed the visibility in these matters which Dr. Murnaghan had had. The priority in my duties was the Coroner's work because it was Court driven whereas the litigation work was less time-pressured being driven by the Plaintiff's solicitor until the Pre-action Protocol in recent years made it Court driven, so there was greater impetus to fulfill Coroner related duties. By the time of my retirement from the post in 2012 after 12 years there had been no change made by the Trust to instigate reporting of Coroner informed deaths to me or the Litigation Management Office. (see APW WS 341/1 Q1a)

2.
From transcript pages 57-60 Mr. Quinn initiates reference to my involvement in the Claire Roberts' case. In my email to Dr. Sands of 7th June 2005 (139-106-001) I refer in paragraph 2, lines 3 and 4 to "standard fluid therapy" in inverted commas when referring to 0.18 N saline. The Chairman on page 60 lines 5 and 6 of the Dr. Carson transcript expresses curiosity as to why I have placed the wording in inverted commas. I can explain that this was because that was how Dr. Sands had described Claire's maintenance fluid in his draft witness statement which I quote in line one of my paragraph. By use of the inverted commas I was seeking to dis-associate myself from describing the fluid in those terms when referring to its then current use. I was alluding to the fact that the fluid was not intrinsically a dangerous fluid and could still be obtained from the pharmacy if required, although it would require to be monitored adequately. I was well aware by 2005 that 0.18 N saline had ceased to be the routine maintenance fluid. The exchange with Dr. Carson on the matter could have been avoided if I had been asked to explain the inverted commas when giving my evidence on 12th December 2012 when the sentence was already under close scrutiny and the inverted commas were written into the oral transcript (page 155 line 23).



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

**Signed:** A P Wallby **Dated:** 18th October 2013