Witness Statement Ref. No. 091/1

NAME OF CHILD: Adam Strain

Name: Mr John Leckey

Title: H.M. Coroner for Greater Belfast

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-December 2004]

None relevant to the Inquiry.

Particular areas of interest
[Please attach additional sheets if more space is required]

1. **Describe in detail the reason for your understanding that following your inquest into the death of Adam Strain changes would be made in the future management of cases such as Adam's.**

My understanding was that so far as the Royal Belfast Hospital for Sick Children was concerned, the hospital would "learn" from what happened to Adam. As far as I can recall no specific commitment was given in relation to the future fluid management of children. I sensed that not everyone agreed with the views of Dr Sumner.

2. **Give details of the mechanism you believed to be in place in 1995/1996 for the dissemination of expert opinions obtained by you for your assistance at inquests to the medical profession.**

None that I was aware of. There was discussion at the inquest as to how the views of Dr Sumner could be disseminated amongst the medical profession in Northern Ireland. The consensus was that there was no effective means of doing so other than through the medical literature. Dr Sumner mentioned that at that time he was the editor of the Journal of Paediatric Anaesthesia and he undertook to arrange for Professor Arieff, who is an acknowledged international expert on hyper/hyponatraemia, to write an editorial on the issues. I cannot recall anyone (myself included) querying whether the Chief Medical Officer had any "educational" role. The position then and now is that there is no formal interface between coroners and Chief Medical Officers.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

I had assumed that the Royal Belfast Hospital for Sick Children would have circulated other hospitals in Northern Ireland with details of the evidence given at the inquest and, possibly, some "best practice" guidelines. Children are not always treated in a paediatric unit and, in the event of surgery, the anaesthetist may not be a paediatric anaesthetist.

Signed: [signature] **Dated:** 15/7/05