Witness Statement Ref. No. 157/2

NAME OF CHILD: Claire Roberts

Name: Robert Taylor

Title: Dr.

Present position and institution:

Consultant Paediatric Anaesthetist- Royal Belfast Hospital for Sick Children ("RBHSC")

Previous position and institution:
[As at the time of the child's death]
Consultant Paediatric Anaesthetist - Royal Belfast Hospital for Sick Children ("RBHSC")

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between October 1996 - August 2012]

1997-8, Provision of Paediatric Surgical services Working Party
30/9/1997, Regional working group on the care of Acutely ill Child; Sub-group on Paediatric Intensive Care
1997-9, Local Advisory Paramedic Steering Committee
1997-8, EH&SSB Working Party on Meningococcal Disease
1999-2005, Sick Child Liaison Group
2001-2, Hyponatraemia Working Party
2002, Paediatric Long-term Ventilation Working Party
2003-4, Neonatal/Paediatric Interhospital Transport Working Party
2003-5, Chairman, Clinical Audit Committee, RGH Trust
2008-10, End-of life Working Party. General Medical Council, London
2002-12, Clinical Ethics Committee, RGH Trust then Belfast HSC Trust
2007-12, Clinical Ethics Committee, NI Hospice

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

WS-157/1 20th December 2011 Witness Statement to the Inquiry (Claire Roberts)

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

Ref:	Date:	
093-038	17/10/2006	Transcript of PSNI interviews
WS-157/1	20/12/2011	Inquiry Witness Statement

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 and/or medical qualifications;

No changes

(b) Your job, role and functions;

No changes

(c) Your responsibilities and accountability.

No changes

(2) Please specify all investigations in relation to the treatment and death of Claire Roberts.

I refer to her clinical notes.

090-030 Bacteriology/Virology Results

090-031 Biochemistry results

090-032 Haematology results

090-033 Radiology results

090-034 Tympanograms

090-035 EEG reports

090-036 Bacteriology results

090-045 Diagnosis of Brain Stem Death Sheet

(3) Please state when you were first asked to make a statement in relation to the case of Claire Roberts, by whom and for what purpose?

WS-157/1. 20/12/2011. Witness Statement to the Inquiry (Claire Roberts)

(4) What attempts did you make to:

(a) Identify all hyponatraemia deaths at the RBHSC (Royal Belfast Hospital for Sick children) for the purposes of analysis for the Northern Ireland Working Group on Hyponatraemia in Children?

I agreed to put together a draft powerpoint presentation, that ultimately included a bar chart of the cases of hyponatraemia admitted to PICU 1991-2001. The PICU secretary acquired the information for me for this bar chart from the PICU computer records. These records were distinct from those administered by the Clinical Coding department. The data was entered on an Ad Hoc basis by busy clinicians for internal use. The PICU database was not supported by the Trust IT department. I did not complete the data analysis and this draft powerpoint presentation was not used. This draft presentation (07-051-101) was emailed to Dr Paul Darragh and I do not believe it was tabled or taken forward by the Hyponatraemia Working

Group.

The death referred to in 1997 was [redacted] who had been admitted with a [redacted] The death referred to in 2001 was Raychel Ferguson.

(b) **How many of these deaths did you analyse for the same?**

I didn't analyse any deaths. I presented the data that the PICU secretary provided for me in a bar chart.

(c) **Did you make any investigations into the Claire Roberts case in connection with the Northern Ireland Working Group on Hyponatraemia in Children?**

No

(d) **Did the RBHSC/Trust's statistical database permit any identification of Claire Roberts' case with hyponatraemia?**

No. The RBHSC/Trust's statistical database (PAS) was not very useful for the purposes of clinical audit as it did not contain sufficient or sufficiently accurate information. There was a PICU computer database developed in the 1980's that was used for clinical audit. This was not supported by the Trust IT department. Data was entered and accessed on an "Ad Hoc" basis by the doctors and PICU secretary.

I do not think Claire Roberts was identified on the PICU computer database.

(e) **Did you seek information from colleagues as to hyponatraemia cases in the RBHSC within the preceding 10 years to assist in the work of the Northern Ireland Working Group on Hyponatraemia in Children?**

Yes, I did discuss the hyponatraemia deaths with other colleagues. I can not recall what information was discussed. At this time in 2001 we were aware of Lucy and Raychel's deaths.

(5) **Please state whether in 1996 you considered that hyponatraemia was a condition that was:**

(a) **Preventable?**

Yes

(b) **Treatable?**

Yes

(6) **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:**

I do not believe I informed the following individuals of Claire's death.

(a) **Dr. Elaine Hicks;**

(b) **Dr. Peter Crean**

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

(d) **Dr. George Murnaghan;**

(e) **Dr. Joseph Gaston;**

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

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

(h) **Miss Elizabeth Duffin;**

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

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

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

I have no recollection of any informal discussion of Claire's death with RBHSC staff.

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

I can not recall how I regarded her death

(10) **Please state if any advice was sought from the Coroner's office in respect of referral.**

I did not discuss Claire's death with the Coroner's Office as I was not present at the time of her death and I do not know if any advice was sought.

(11) **Please state whether any advice was sought from you, or whether you had any input into the causes of the death included on the death certificate of Claire Roberts, and if so what advice you gave?**

I do not think any advice was sought from me or that I had any input into Claire's cause of death included on her death certificate.

(12) **Please state whether the advice of the Director of Medical Administration, Dr. George Murnaghan, was sought in relation to referral of Claire Robert's death to the Coroner in 1996.**

I had no involvement in her referral to the Coroner and I do not think I sought the advice of Dr Murnaghan in this matter.

(13) **Did you accept the Coroner's findings:**

(a) **In the case of Adam Strain (Ref: 011-016-114)?**

At the time (1996) I did not agree with the Coroner's findings that dilutional hyponatraemia caused his death.

(b) **In the case of Claire Roberts (Ref: 091-002-002)?**

Yes, when I read it in 2012

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

(a) **Paediatric Clinicians;**

I do not think it was circulated. It is not usual practice to circulate research papers amongst staff.

(b) **Anaesthetists?**

The paediatric anaesthetists were aware of this paper in 1996. It was not circulated.

(15) **Was there a heightened awareness amongst clinicians in the RBHSC in 1996 as to hyponatraemia, sodium levels, fluid administration, cerebral oedema and SIADH?**

I do not recall the awareness levels of these matters amongst other clinicians in 1996. The Paediatric Anaesthetists did have a heightened awareness of these matters in relation to Adam's death and the subsequent "Draft Guidelines".

(16) **Please state whether your opinion was sought as to whether or not a full or restricted post-mortem examination of Claire Roberts should be requested, and if so what advice you gave.**

I do not think my opinion was sought.

(17) **What, in 1996, did you understand the purpose of an Autopsy Report to be?**

I would have understood the purpose of an Autopsy Report to be to contain the post-mortem findings and a cause(s) of death. This would be used to inform the relatives and clinicians.

(18) **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;**

I have no recollection of consent guidelines from 1996. It would have been usual practice to ask for the parent's permission to proceed with a post-mortem.

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

I have no recollection of any such guidelines from 1996. It would have been usual practice to ask for the parent's permission to proceed with a limited post-mortem.

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

I have no recollection of any such guidelines from 1996 of when authorisation for same could be given.

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

I have no recollection of any such guidelines from 1996. It was my usual practice to give parents information and options for the decision on a limited post-mortem.

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

the Coroner be notified;

I have no recollection of any such guidelines from 1996. The doctor would be required to inform the Coroner of certain deaths. The parents would not be asked for their views in these circumstances. If a case was referred to the Coroner the parents would not be permitted to refuse a Coroners post-mortem or investigation.

(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;**

I have no recollection of any such guidelines from 1996. Parents would usually be asked for their views on this. There would be no option for a limited post-mortem if it was a Coroners case.

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

I have no recollection of specific guidelines from 1996. The autopsy report would usually be shared with the parents and GP.

(19) **What was the origin of the pro-forma consent form used for the limited post-mortem presented to Mr. Roberts for signature (Ref: 090-054-185)?**

I do not know what the origin of this consent form was.

(20) **Please specify all meetings, discussions, reviews 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 do not have any recollection of any meeting regarding Claire Roberts.

(21) **Please provide information detailing those meetings which took place:**

(a) **Before the Autopsy report became available;**

I refer to above answer (20).

(b) **After the Autopsy report became available.**

I refer to above answer (20). I don't know if there were any meetings after the Autopsy Report became available.

(22) **Did the Pathologist attend the meeting(s), and if so please identify who the Pathologist was?**

I refer to the above answer (20). It would be usual to invite the Pathologist to attend the Mortality meetings when there was a post-mortem.

(23) **Was any learning gained from any such meetings? If so what?**

I do not have any information on Claire's meetings or what learning was gained.

(24) **Please state whether you played any role in mortality meetings/discussions? If so what was that role?**

I would have been responsible for chairing the Mortality meetings after I took over the role of Audit Co-ordinator in December 1996. For the Mortality section of the Audit Meeting the PICU secretary would contact the relevant Consultant(s) and organise the dates of the Audit Meeting and when they would be available to present the case and ensure that the medical notes were available.

(25) **As part of your duties as Audit Co-ordinator in the Paediatric Directorate did you:**

(a) **Arrange mortality meetings/audit?**

The PICU secretary organised the mortality meetings. I would have chaired the Clinical Audit meeting.

(b) **Arrange for minutes to be taken of the same?**

The mortality meeting was not minuted, so that clinicians could speak openly. This arrangement was in place before I took over the role of Audit Coordinator. I would arrange for the Clinical Audit presentations to be minuted.

(c) **Submit those minutes to the RBHSC/ Trust Medical Records Committee and/or Audit Committee?**

The PICU secretary would type the minutes of the Audit presentations and submit them to The Clinical Audit Committee, from 10th December 1996 to 9th January 2003

(d) **What was the process for the selection of cases for discussion at mortality meetings?**

The death of every child was selected for presentation at the mortality meeting. The PICU secretary would contact the relevant Consultant(s) and organise the dates of the Audit Meeting when they would be available to present the case and ensure that the medical notes were available.

(e) **Is it possible that Claire Roberts' case could have been discussed / presented at a mortality meeting before the receipt of the Autopsy report?**

Yes it is possible, but the usual practice would have been to wait for the Autopsy report.

(26) **How many patients died annually in PICU in 1995 and 1996?**

1995, 26 deaths. 1996, 23 deaths

(27) **Were there any guidelines or conventions in the RBHSC in 1996 regarding the criteria for children being admitted to PICU and, if there was doubt as to admission, whether a PICU consultant would have been asked for advice in relation to the same?**

There were no written guidelines. It would have been usual practice for the Consultant to be informed and attend each PICU admission.

(28) **What responsibility did PICU consultants have in respect of communication with the parents of an admitted child, and what was his/her role in relation to the same?**

The usual practice and responsibility was for the PICU Consultant and the PICU nurse to inform the parents of the child's condition usually with the Paediatrician in attendance as soon as the child had been stabilised.

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

I am not aware of any appraisal of staff performance at this time.

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

I do not think there was any change to training/teaching provided by the RBHSC/Trust at this time.

(31) **With respect to the biochemistry reports (Ref:090-030-094 *et seq*)? sought and received in the course of Claire's treatment, please state:**

(a) **Whether the pro-forma notification report form was subsequently amended to communicate the timing of sample, analysis and report? If so when and upon whose instruction;**

I do not know if the report form was amended.

(b) **Whether any complaints or requests were made in relation to report forms before or after the treatment and death of Claire Roberts?**

I am not aware of any complaints or requests in this matter.

(32) **Please state whether you would have expected nursing staff to commence 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?**

I can not comment on nursing procedures. At the time of Claire's death I do not believe I had the knowledge to lead me to form any view as to whether an Adverse Incident form would be completed.

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

(a) **Record keeping;**

Not to my knowledge.

(b) **Drug prescription and administration?**

Not to my knowledge.

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

I was involved in the clinical care of Claire after her first set and before her second set of Brain Stem tests which indicated that she had suffered brain stem death. From reviewing her notes I believed that she was being treated for meningitis and seizures and do not remember if I formed a view of whether there was an iatrogenic contribution to her death.

(35) **If there was a possibility that medical care and treatment might have contributed to a death would you have expected that care and treatment to have been investigated?**

Yes

(36) **In October 1996 were you aware of:**

(a) **Circular ET 5/90 (as amended) January 1991?**

I do not recall this document specifically.

(b) **A Charter for Patients and Clients (Northern Ireland Health and Personal Social Services) March 1982:**

I do not recall this document specifically.

(c) **Directive PEL (93)36?**

I do not recall this document specifically.

(d) **Welfare of Children and Young People in Hospital (HMSO 1991);**

Yes

(e) **The Paediatric Intensive Care Society (UK) Standards document, 1992.**

Yes

(37) **With reference to document 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 the initials of Dr. McKaigue? If so why was this note made?**

It appears that they are his initials, I do not know why the note was made.

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

I do not know

(c) **Who is the *"Dr. Allen"* copied in at the foot of this note, and what was his/her role in relation to this matter?**

I do not know who Dr Allen refers to.

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

I do not know how this was categorised in the statistical data.

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

I have no knowledge of this.

(40) **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 can not recall if I was aware of the RBHSC's engagement with the Kings Fund Organisational Audit in 1996 and have no record of the relevant advices given.

(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?**

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

I do not know when the following individuals became aware of Claire's death.

(a) **Dr. George Murnaghan**

(b) **Dr. Peter Crean**

(c) **Dr. Joseph Gaston**

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

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

(f) **Mr. George Brangam**

(g) **Miss Elizabeth Duffin.**

(42) **Please provide details of any changes in patient care relevant to hyponatraemia between the death of Adam Strain in 1995 and the admission of Claire Roberts, including:**

(a) **Any changes that you made in respect of your own practice;**

I agreed to the "Draft Recommendations" following Adam's Inquest and used dry heparin syringes and a new, more accurate blood gas analyser for measuring sodium.

(b) **How such changes were formulated and disseminated;**

The guidelines were written by Dr Gaston and agreed by the Paediatric Anaesthetists. The new syringes and blood gas analyser were purchased and installed in PICU.

(c) **To what extent any such changes affected or informed your approach to the treatment of Claire Roberts, or her treatment in general.**

My treatment of Claire was related to the management of polyuria and Diabetes Insipidus as a result of her brain stem death. My actions would not have been affected by lessons learnt from Adam.

(43) **With reference to your attendance upon Claire on the morning of the 23rd October 1996, please state the basis upon which you diagnosed polyuria?**

Polyuria diagnosis would have been based on her urine output which was the result of diabetes insipidus which commonly accompanies brain stem death.

(44) **Please state whether you received any training or guidance (including details of the same) in**

respect of:

(a) **The compilation and completion of death certificates;**

This was taught when I was an undergraduate at Queen's Medical School

(b) **Referral of deaths to the Coroner;**

This was taught when I was an undergraduate at Queen's Medical School

(c) **The principles governing post-mortem requests.**

I do not remember receiving any specific training or guidance on this matter. My usual practice would be to discuss such requests with the child's paediatrician and the pathologist and attend the post-mortem if possible.

(45) **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 do not think there was any system for auditing referrals to post-mortem and referrals to the Coroner.

(46) **Did you learn any lessons from the death of Claire Roberts and with hindsight were lessons to be learned from it? If so, what were those lessons?**

I am not aware of any lessons learnt from Claire's death

(47) **Please identify whether any lessons deriving from the case of Claire Roberts were disseminated either before or after the Inquest. If so please state how, where, when and to whom.**

As above answer

(48) **With hindsight could or should anything have been done to heighten awareness of hyponatraemia amongst practising clinicians after the death of Claire Roberts, and if so what?**

I do not feel able to comment on this. I only became aware of the Coroner's verdict in 2012

(49) **Please describe how the 'culture' within the RBHSC has changed since 1996?**

Adverse incident reporting (IR-1 forms) is much more established and these incidents are analysed and presented at audit meetings 2-3 times throughout the year.

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

I was not aware of this.

(51) **In respect of the practice of Clinical Coding in the RBHSC/ RGH please:**

(a) **State what Clinical Coding system was in use in 1995-1997;**

I do not know. This would be best answered by the Trust

(b) **State what Clinical Coding system was in use in 2001;**

I do not know. This would be best answered by the Trust

(c) **State how such Clinical Coding system was used, by whom and under what guidance/practice;**

This would be best answered by the Trust. As I recall the doctor wrote the diagnosis and Clinical Coders entered the data.

(d) **State who had overall responsibility for Clinical Coding in 1995-1997;**

Mr Danny McWilliams from the Clinical Coding Department. I believe he was the senior person with responsibility.

(e) **Describe the practices and procedures clinicians were expected to follow in relation to Clinical Coding, with particular reference to the accurate coding of deaths;**

I do not have records of such practices and procedures. The doctors would usually provide the clinical diagnosis(es) and the Coding Clerks would be responsible for coding these and entering them on a database.

(f) **State who had overall responsibility for the audit of Clinical Coding information in 1995-1997;**

This would be best answered by the Trust.

(g) **Provide details of any Clinician Awareness sessions in Clinical Coding that were held at the RBSHC during both these periods;**

I remember that Mr Danny McWilliams from the Clinical Coding Department gave several presentations to the Audit meeting. I can not remember all the details of his presentation but recall that there were serious inaccuracies with the coding system. One example was that Central Venous line insertions were coded as Varicose Vein surgery, an unlikely procedure in the RBHSC.

(h) **Describe the process which would have to be followed to retrieve such coded information from the system;**

This would be best answered by the Trust. Doctors were unable to access this data directly but could request some data from the Coding Department.

(i) **If there existed a system for Clinical Coding in the RBHSC/ RGH in 1995-1997, describe how it might have been that the death of Claire Roberts was not picked up on for review prior to the broadcast of the UTV documentary in 2004.**

This would be best answered by the Trust.

(52) **In respect of your presentation dated the 26th September 2001, 'Hyponatraemia in Children, Teaching Aid' (Hyponatraemia Working Party Department of Health 2001- Ref: 077-051-101 *et seq*) please:**

(a) **Who was involved in the production of this presentation, for what purpose and who attended it;**

As in answer 4(a). I agreed to make a draft powerpoint presentation, which ultimately

included a table of the cases of hyponatraemia admitted to PICU 1991-2001. The PICU secretary had acquired the information for this bar chart from the PICU computer records. These records were distinct from those administered by the Clinical Coding department. The data was entered on an Ad Hoc basis by busy clinicians for internal use. The computer database was not supported by the Trust IT department. I did not complete the data analysis and this draft powerpoint presentation was not used. This draft presentation (07-051-101) was emailed to Dr Paul Darragh and I do not believe it was tabled or taken forward by the Hyponatraemia Working Group.

I therefore did not complete the data analysis and this draft powerpoint presentation was never used. The priority of the Working Group was to produce a Guideline for the Prevention of Hyponatraemia in Children.

(b) **State what research was undertaken in relation to the information in this presentation, by whom and using what sources of information;**

I reviewed the various research papers and the PICU secretary retrieved the data for the bar chart from the PICU computer records. I would also refer to my answer in 52(a).

(c) **With particular reference to the table headed 'Incidence of Hyponatraemia at RBHSC' (Ref: 007-051-103) please describe:**

(c.i) **Who compiled this table;**

I compiled this bar chart

(c.ii) **How it was compiled;**

It was based on the data retrieved by the PICU secretary

(c.iii) **Where the information contained in the table was obtained from, both in respect of admissions and deaths associated with hyponatraemia for all the years listed;**

From the PICU computer records

(c.iv) **Why there are no hyponatraemia-associated admissions or deaths recorded for 1995 or 1996;**

The data was retrieved by the PICU secretary. I do not know why there are no data for 1995-6

(c.v) **If this information was derived from the Clinical Coding system in place in the RBHSC/ RGH at the time state why the deaths of Adam Strain and Claire Roberts were not classified/identified as being associated with hyponatraemia;**

The data was not derived from the Clinical Coding system

(c.vi) **If this information was derived from the coding system in place in the RBHSC/ RGH at the time state whether the search was undertaken using a primary diagnoses or to include co-morbidities, providing reasons for the same;**

The data was not derived from the Clinical Coding system

(c.vii) **What steps you took, if any, to ensure that Adam and Claire's deaths were coded**

as having involved hyponatraemia once you appreciated that they had not been coded in that way;

Around 2001 the PICU computer records were replaced by a system for a UK and Ireland wide PICU database called PICANET. The computer records prior to 2001 were kept by the PICU secretary but the database used (PCFILE) was no longer available on the PICU computers.

(c.viii) **During the course of your presentation whether you referred to the fact that there were two other deaths associated with hyponatraemia in 1995 and 1996, namely Adam Strain and Claire Roberts. If not, please state why not;**

As in answer 4(a) and 52(a) this was a draft presentation emailed to Dr Paul Darragh. To my recollection it was never tabled at subsequent meetings and never used. It does not appear that Adam or Claire's deaths were part of that data collection. I was not aware that Claire Roberts' death involved hyponatraemia until 2012.

(c.ix) **How were the deaths of Adam and Claire classified for coding purposes and by whom, including where the record for the same was kept, and how such record might be accessed;**

As answered above.

(c.x) **Whether the patient who is recorded in the table as having died from hyponatraemia in 1997 is one of the deaths being investigated by the Inquiry and, if so, which?**

As in answer 4(a) the death referred to in 1997 was [redacted] who had been admitted with [redacted] and the Coroner investigated his death in 1997. I think that the PICU secretary retrieved his name because hyponatraemia was listed among the various diagnoses in the PICU computer records. His death is not being investigated by the Inquiry.

(c.xi) **Whether there are any deaths identified on this table that are not the subject of investigation by the Inquiry?**

As in answer 53(x)

(53) **In respect of the email from Christine Stewart (Press and Public Relations Officer) to Mr. Colm Shannon (DHSSPSNI) (Ref: 023-045-105) please state:**

(a) **What the *"detailed examination of the issues"* in the case of Adam Strain entailed, and your role/involvement in such examination;**

I can not recall the conversation referred to.

(b) **Who was involved in this examination and on what basis;**

I can not recall the conversation referred to.

(c) **What information you were asked to provide by Christine Stewart in relation to this examination of the issues, and what information you did provide in relation to the same;**

I can not recall the conversation referred to.

(d) **Whether you advised Christine Stewart that there were *"no new learning points, and therefore no need to disseminate any information"*? If so please state what you meant by this and on what basis you provided such advice. If not, please provide comment on how Christine Stewart could have come to such a conclusion.**

I can not recall the conversation referred to.

(e) **Whether the death of Claire Roberts was taken into account during this examination of the issues, and in respect of any lessons to be learned and disseminated?**

I can not recall the conversation referred to.

(f) **Whether reference was made to the Clinical Coding system in place in the RBHSC/RGH at the time to ascertain the full extent of admissions and deaths from hyponatraemia in order to inform your views?**

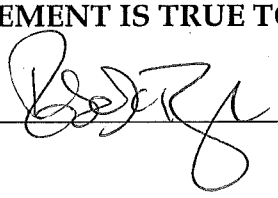
I can not recall the conversation referred to.

(g) **Whether you considered arranging a further presentation in relation to the 'Incidence of Hyponatraemia at RBHSC' to disseminate any such learning points that derived from the Inquest of Claire Roberts.**

I was not aware of the 2006 Inquest of Claire Roberts until 2012.

(54) **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:  **Dated:** 21/9/12