Witness Statement Ref. No. WS-178/6

NAME OF CHILD: Claire Roberts

Name: Ian S.Young

Title: Professor

Present position and institution:

Professor of Medicine, Queen's University Belfast

Consultant in Clinical Biochemistry, Belfast Health and Social Care Trust

Previous position and institution:
[As at the time of the child's death]

Senior Lecturer in Clinical Biochemistry, Queen's University Belfast

Consultant in Clinical Biochemistry, Royal Group of Hospitals, Belfast

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]

096-007-039 Statement to the PSNI

091-010-060 4/5/2006 Deposition to the Coroner

WS-178-1 - Inquiry Witness Statement (PDF 1.8MB)

WS-178-2 - Supplemental Inquiry Witness Statement (PDF 9MB)

WS-178-3 - Supplemental Inquiry Witness Statement (PDF 1.7MB)

WS-178-5 - Supplemental Inquiry Witness Statement (PDF 10MB)

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
[Please attach additional sheets if more space is required]

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

Signed: **Ian Young** **Dated: 7/1/13**

The purpose of this statement is to respond to several issues which arose in evidence following my appearance at the Inquiry and which are related to my involvement in the governance elements of Claire Robert's case between 2004 and 2006:

1) **Dr.Steen's oral evidence that she recognised that there had been "fluid mismanagement" in Claire's case:**

During her oral evidence on day seventy one, Dr.Steen (page 91 onward) suggested that in 2004, during the meeting with Claire's parents, she came to the view that there had been "fluid mismanagement" in 1996. I was very surprised at this statement. Following this concession, Dr.Steen was asked a series of questions about the information provided to the Roberts family at the 2004 meeting (in which I participated) and subsequently in writing in light of her view that fluid mismanagement had occurred.

In 2004, Dr.Steen did not indicate to me or in any meeting that I attended that she believed that "fluid mismanagement" had occurred in 1996 when judged by the standards prevailing at that time. The first time that I heard her express this view was in oral evidence to the Inquiry on 18th December. This was not a view which I shared or was aware of in 2004.

As discussed previously, in 2004 I was responsible for dealing with hyponatraemia and fluid management in the meeting with Claire's parents, while Dr.Steen dealt with the clinical journey. The difference in emphasis between my position and Dr.Steen's in relation to the role of hyponatraemia has been highlighted – I felt that hyponatraemia and fluid management were more likely to have played a role in Claire's deterioration and death than Dr.Steen.

When I reviewed Claire's clinical notes in 2004, as I have explained in detail in my written submissions and in oral evidence, I came to the view that Claire's fluid management had been in keeping with prevailing standards of 1996. I did not believe that there had been "fluid mismanagement" by these standards. The important relevant aspects of Claire's fluid management were the initial choice of maintenance fluids and the actions taken at 11.30pm in relation to fluid restriction. My views on these two issues have been outlined in detail in my written statements and oral evidence, where I have indicated why I believe that management was in line with 1996 standards.

A related issue was the frequency of blood sampling. In 2004, I believed that the prevailing standard in 1996 was to check electrolytes once every 24 hours in a child on intravenous fluids – therefore I did not believe that the failure to check bloods during the day constituted mismanagement, though it was clear that it would have been better if this had been done. This would have identified hyponatraemia earlier and minimised the contribution which it made to Claire's clinical course. My position on this was reinforced by comments made by the Coroner's expert witness (Dr.Bingham) at the inquest and recorded at 901-006-022: "In practice blood tests every 24 hrs do not happen in relation to patients on intravenous fluids. It is difficult to take blood

samples from children – in Great Ormond Street it is taken from one third of children. Blood samples and urine samples should be taken every 24 hrs".

Having subsequently heard this issue discussed at length by a number of expert witnesses and the medical staff involved in Claire's care in the context of the current Inquiry, I accept that in Claire's case in 1996 a blood sample should have been taken during the day on Tuesday. However, in 2004 I did not believe that the failure to do this constituted "fluid mismanagement" by 1996 standards and at no stage did Dr.Steen suggest this to me.

By 2004, in comparison with 1996, fluid management had changed in a number of respects. If Claire had been managed according to 2004 standards then the contribution of hyponatraemia to her clinical course would have been reduced or possibly avoided altogether. However, she potentially had two other serious conditions (status epilepticus and a viral encephalitis), either of which could have been fatal on its own. My view was that Claire was mismanaged by 2004 standards but not by 1996 standards. This was the information that I attempted to convey to Claire's parents in the meeting and in my answers to their subsequent questions. In 2004 I did not believe that fluid mismanagement had occurred in 1996 according the standards of that time, so I would not have considered saying this to Claire's parents. However, I was keen that the issue of Claire's fluid management and hyponatraemia should be explored further by the Coroner and that the view of independent external experts should be sought as indicated by my recommendation that the case should be referred.

During oral evidence, Counsel to the Inquiry quoted some of Dr.Steen's comments to the inquest in support of her belief that there had been fluid mismanagement (day seventy one, page 97, lines 13 - 16). These were Dr.Steen's comments relating to what she perceived to be a failure to restrict fluids at 11.30pm. The Inquiry is aware from my oral evidence that I believe that Dr.Steen's comments in relation to fluid restriction at 11.30pm at the inquest were wrong and that the planned fluid restriction did in fact occur, as I have demonstrated. I am not aware that my oral evidence on this point has subsequently been challenged.

More importantly, there is a detailed contemporary record of Dr.Steen's evidence at the inquest in the notes made by Dr. John Bruton. From her responses recorded at 096-014-012 it is absolutely clear that at the time of the inquest Dr.Steen did not indicate that she thought there had been "fluid mismanagement" by 1996 standards. Indeed, the coroner summarises her view as indicating that Claire's fluid management had been normal by 1996 standards.

I am unclear why in oral evidence Dr.Steen said that she believed in 2004 that there had been" fluid mismanagement". However, if she did in fact come to the view in 2004 that there had been fluid mismanagement by 1996 standards then a question arises as to why she did not clearly state this to Claire's parents, at the inquest or in meetings or correspondence to which I was party. There are considerable contemporary records from the 2004-6 period including formal statements, emails and other correspondence. I am not aware from any contemporary evidence that this was in fact her view at that time.

In summary, I want the Inquiry to be entirely clear that I did not believe in 2004 that there had been "fluid mismanagement" by 1996 standards in Claire's case, and that I was not aware of Dr.Steen holding such a view at that time. I believed that had the knowledge and standards of 2004 been

applied to Claire's care, then the contribution of hyponatraemia to her clinical course could have been avoided, although I was uncertain if this would have materially altered the outcome. The information which I provided to Claire's parents and to the inquest was entirely in line with these views, which I have expressed throughout my involvement in evidence from 2004 to the present and have justified from my analysis of the clinical records and contemporary medical literature.

If the Inquiry is inclined to criticise the information provided to Claire's parents on the basis of Dr.Steen's oral evidence, then the criticism should be restricted to Dr.Steen alone.

2) Information provided to Claire's parents about the Trust's decision to refer Claire's case to the coroner:

There has been some discussion about the belief of Mr.and Mrs.Roberts that they were being asked to decide if the case should be referred to the Coroner. My recollection is that in the meeting on 7th December we said that Claire's case was going to be referred to the Coroner, but that the Trust wanted to be able to let the Coroner know whether or not Claire's parents supported this decision. I believe that this is clear from the two paragraphs dealing with referral to the Coroner in the minute of the meeting held on 7th December (highlighting is mine):

089-002-004 Paragraph 3:

"Professor Young advised Mr and Mrs Roberts that the Trust wants to be completely open about this case **and therefore will have to approach the Coroner** for advice on the best course of action. The Coroner may suggest in inquest which would be open for public scrutiny, or may suggest referring the case to the ongoing enquiry led by John O'Hara QC."

089-002-005 Second last paragraph:

"Professor Young added that he would be happy to meet with Mr and Mrs Roberts again and reiterated that the Trust would not proceed with any action until they decided how they wish the matter to proceed."

I understand now that this may not have been completely clear to Claire's parents. However, I believe that we did our best to explain the process that the Trust intended to follow. For the avoidance of doubt, the message which I intended to convey to Claire's parents was that the Trust was duty bound to report the matter to the Coroner but the Trust also wished to be able to inform the Coroner at the same time that the family did or did not wish the matter to be reported to him. I certainly did not mean to convey to Claire's parents that the Trust's duty to report the matter was in some way conditional upon their consent being obtained.

3) Use of the word hyponatraemia in the meeting with the Roberts family on 7th December:

In oral evidence on day 66, page 88-89, I was asked about our failure to use the word "hyponatraemia" in our meeting with the Roberts family. This was because the word "hyponatraemia" is missing from the note of the meeting. However, it has now become clear to me that we may in fact have used the term "hyponatraemia" in the meeting, although it is not in the

note. This is based on the fact that Mr.Roberts refers to hyponatraemia in his questions submitted following the meeting and in addition on his statement to the Coroner at 089-012-086 of which I have now become aware:

> At a meeting on 7 December 2004 with medical staff from the Belfast Royal Hospital Professor Young stated that hyponatraemia (falling sodium) may have contributed to swelling of Claire's brain and therefore ultimately to her death.

4) I wish to make the following specific comments in response to the evidence given by Dr.Steen on day 71:

P92 line 23: – "U&E done at 27 hours." The repeat sample was taken at approximately 25 hours after admission

P93 lines 4-7: – The query was the extent to which hyponatraemia had contributed to her condition, not fluid mismanagement.

P93 lines 17-21: - I did not believe that there had been fluid mismanagement by the standards of 1996. This was not discussed. Therefore, I did not consider saying this to Claire's parents at any stage.

P93 line 23 – P94 line 3: This was definitely not my view (that "fluid mismanagement" had occurred by 1996 standards). I did not indicate this to the medical director or attempt to indicate it to Mr and Mrs.Roberts.

P95 line 21 – P96 line 2: We indicated at the meeting on 7 December that in 2004 bloods would have been repeated earlier (089-002-004 paragraph 4). As discussed above, when we met Mr.and Mrs.Roberts in 2004 I did not believe that this was an established standard of care in 1996.

P96 lines 17 – 24: If Dr.Steen realised this, then she could have raised the issue at the time. However, she did not. I certainly did not realise this.

P97 lines 4 – 9: At no stage previously on 2004 – 2006 did Dr.Steen express this view to me and it was not a view which I held in 2004.

P98 lines 11-12: The implication of the question is that the views expressed by Dr.Steen in response to oral questions were shared by other clinicians at the time. Dr.Steen did not articulate these views at any time to my knowledge in 2004 – 6 and for the reasons discussed above they were not views shared by me.

P99 line 23 – P100 line 4: Dr.Steen did not state at any stage in 2004 or 2006 that this was her view.

P106 lines 3-5: The objective of the reply was to answer questions concisely, clearly and accurately. I was not aware of any discussion about making concessions, and there was certainly no agreement among clinicians to which I was party.

P109 lines 18-22: I believe that I am likely to have provided the wording in response to this question, which fits with my opinion at the time as discussed above. Since I was not aware of the

views that Dr.Steen expressed during oral evidence to the Inquiry, the wording makes complete sense in light of my opinion in 2004.

P110 lines 23 – 25. In 2004, I was unsure whether removing the contribution of the hyponatraemia would have made any difference to Claire's clinical outcome. This would have depended on the severity and significance of the status epilepticus and viral encephalitis, which I was not in a position to judge. This explains the wording of the answer which I provided, and my recommendation that the case go to the Coroner where I anticipated that independent experts in these conditions would give an opinion.