Witness Statement Ref. No. 178/1

NAME OF CHILD: Claire Roberts

Name: Ian Young

Title: Professor

Present position and institution:

Professor of Medicine and Director of The Centre for Public Health, Queen's University Belfast

Associate Medical Director Research and Development and Consultant in Clinical Biochemistry, Belfast Health and Social Care Trust

Previous position and institution:

Senior Lecturer in Clinical Biochemistry, Queen's University Belfast
Consultant Chemical Pathologist, Royal Group of Hospitals, Belfast

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-August 2012]

Chair, GAIN Hyponatraemia in Adults Working Group, 2007-2008.
Chair, BHSCT Hyponatraemia Working Group, 2010 -2012.
Chair, DHSSPS Obesity Prevention Steering Group, 2009 – present.
Chair, DHSSPS Alcohol Advisory Group, 2010 – present.
Member, DOH Scientific Advisory Committee on Nutrition 2010 – present.

Previous Statements, Depositions and Reports:

096-007-039 Statement to the PSNI
091-010-060 4/5/2006 Deposition to the Coroner

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

Ref:	Date:	
096-007-039		Statement to the PSNI
091-010-060	4th May 2006	Deposition to the Coroner

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 provide the following information:

(a) By whom were you employed in 2004-2005, and in what roles and functions;

I was a Joint Appointment Clinical Academic employed by Queen's University Belfast / The Royal Group of Hospitals. In Queen's University Belfast I was Professor of Medicine. In the Royal Group of Hospitals I was a Consultant in Clinical Biochemistry and Director of Research and Development.

(b) Who employed you as a Consultant in Clinical Biochemistry in 2004-2005, and where did you work?

I was a Joint Appointment Clinical Academic employed by Queen's University Belfast / The Royal Group of Hospitals. As a Consultant in Clinical Biochemistry I was based in The Royal Group of Hospitals but in addition participated in an on-call rota covering Belfast City Hospital, Green Park Trust and the Mater Hospital at nights and weekends.

(c) Describe your work commitments at the Royal Group Hospitals' Trust from the date of your appointment to 2004-2005;

From 1992 I was employed on a Clinical Academic Joint Appointment Contract, with Queen's University Belfast as my primary employer. Approximately 50% of my time was spent working for QUB and 50% for the Royal Group of Hospitals' Trust. My main duties in the Trust included:

1) From 1993 to 2005, Lipid clinic (one outpatient clinic per week): clinical care of outpatients with disorders related to lipid metabolism
2) From 1998 (approx) to 2005, Nutrition Support Team (one ward round per week): clinical care of inpatients with nutritional disorders
3) From 1993 to 2005, provision of clinical advice on management of patients with biochemical disorders, both inpatients and outpatients. This included patients with a wide range of biochemical abnormalities, but the majority of the work related to fluid and electrolyte disorders.
4) From 1993 to 2005, work as a member of the Clinical Biochemistry Laboratory Senior Management Team.
5) From 2002 to 2005, Director of Research and Development for the Trust. This was a time commitment of approximately one day per week.

2. In respect of your statement (Ref: 090-052-159) please state:

(a) The date you made this statement;

I do not know the date on which this statement was made, but assume that this must have been in late 2004 / 2005.

(b) Who asked you to make it and how this request was made of you, e.g. in writing or otherwise. If in writing please provide copy of any such request;

I cannot recall who asked me to make this statement or how the request was made. I have no record of any request relating to the statement in writing or otherwise.

(c) **Why was it written on Police headed paper;**

I cannot recall why the statement was written on Police headed paper. However, since I do not have access to such paper the statement must have been typed up by a third party.

(d) **In respect of your comment: *"There was a progressive deterioration in her clinical situation with evidence of status epilepticus"*: what was the evidence of status epilepticus;**

This was based on the clinical opinion of the neurologist recorded in Claire's notes.

(e) ***"I informed Dr. Michael McBride, the Medical Director of the Trust, that in my opinion hyponatraemia might have made a contribution to the development of cerebral oedema in Claire's case".* Were any written advices provided to Dr. McBride? If so please state what they were and provide copy of the same?**

My recollection is that this advice was given verbally by telephone and that no specific written advice was provided to him.

(f) **In respect of (j) did you consider that this may have raised an issue of professional competence?**

I assume that this question refers to the professional competence of the clinical team looking after Claire at the time of her death. While I felt that some aspects of her care were sub-optimal, this was not sufficient to raise any concern about the professional competence of members of the clinical team in my mind. However, I was not asked specifically to comment on this issue at the time, though if I had developed such concerns during my review of the notes I would certainly have raised them with Dr.McBride.

(g) ***"I advised that it would be appropriate to consider discussing the case with the Coroner for an independent external opinion with access to statements from all of the staff involved in Claire's care".* Please state:**

(i) **Why was it appropriate to take the case to the Coroner?**

It was appropriate to take the case to the Coroner because in my opinion hyponatraemia may have contributed to Claire's death and the management of Claire's fluid balance in hospital played a role in the development of the hyponatraemia.

(ii) **Why was an independent external opinion appropriate?**

To provide additional expert advice to the Coroner on the extent to which hyponatraemia and the management of fluid balance may have contributed to Claire's death.

(iii) **Were statements taken from all staff?**

I did not take or seek statements from all staff and have no knowledge of others taking such statements.

3. **In respect of your review of the Claire Robert's case, please state:**

(a) **What specifically was asked of you by Dr. McBride; please provide full details of the**

same;

Dr.McBride asked me to review the case and advise him whether in my opinion hyponatraemia may have contributed to Claire's death.

(b) What were you told was the purpose of your review?

The purpose of my review was to provide an independent assessment of the case and to advise Dr.McBride on whether hyponatraemia may have contributed to Claire's death. This was to inform his decision on whether to refer the case to the Coroner.

(c) Did you receive any other specific instructions in relation to this review and, if so, please include full details of the same;

I did not receive any other specific instructions that I can recall.

(d) Did you keep any documents or records relating to your review of the Claire Roberts case? If so please provide the same;

I did not keep any documents or records in relation to my review of the case.

(e) Did you take any notes of your interviews with Drs. Steen and Sands, and if so please provide the same;

I cannot recall whether or not I took any notes at the time of any discussions with Drs.Steen and Sands. However, I do not have any relevant notes in my possession.

(f) Did you attempt to interview Drs. Webb, McKaigue or members of the nursing staff?

No. I recall speaking to Dr.Webb on the phone, but this was to inform him that the case was to be referred to the coroner and did not constitute an interview.

(g) Why did you speak to Dr. Nichola Rooney in respect of the formulation of your opinion?

Dr.McBride asked me to speak with Dr.Rooney who was helping to liaise with Claire's family. Any discussion with Dr.Rooney in relation to the formulation of my opinion was to clarify matters of fact relating to meetings which she had attended. She did not influence the formulation of my opinion.

(h) Did you seek or receive any further documents?

I believe that the only documents which I sought were Claire's clinical notes. I have no recollection of receiving any further documents, other than correspondence from the Roberts family.

(i) At the time of your review, were you aware of the Adam Strain case?

Yes, but not in any detail.

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

I did not give this any consideration and am not aware that it was considered by others.

(k) Did you have the opportunity to view the UTV Insight programme (22nd October 2004)

before meeting Mr. and Mrs. Roberts?

No

(l) **Did you keep a file or record relating to this work, including:**

(i) **Correspondence;** No

(ii) **Attendance notes;** No

(iii) **Telephone memoranda;** No

(iv) **Internal communications;** No

(v) **Emails;** I retained emails at the time but these have subsequently been lost.

(vi) **Reviews and opinions?** No

(m) **Did you make any note or memorandum of the meeting with Mr. and Mrs. Roberts 7th December 2004? If so please provide the same.**

I did not keep any note or memorandum of the meeting so far as I can recall.

(n) **Were you supplied with any document prepared by Dr. Steen relating to Claire's treatment?**

I have no recollection of such a document.

(o) **In respect to your reply (Ref: 089-006-012) to those additional queries raised by Mr. and Mrs. Roberts subsequent to the 7th December 2004 meeting, please state:**

(i) **Was it reduced to writing?**

I think (though I cannot be certain) that I commented via email.

(ii) **If so to who was it sent, and please provide copy.**

I think (though I cannot be certain) that it was sent to Dr. Nicola Rooney. I do not have a copy.

(p) **In relation to the minute of the meeting held on 7th December 2004 (Ref: 089-002-002), please state:**

(i) **Why you chose not to correct inaccuracies occurring in Dr. Steen's exposition?**

I am unclear about the meaning of this question - please specify the inaccuracies to which you refer.

(ii) **How, if you were "involved in the case purely as an independent advisor", you were able to reiterate "that the Trust would not proceed with any action until they [Mr. and Mrs. Roberts] decide how they wish the matter to proceed"?**

In this context, "independent advisor" refers to my independence from the team who had been involved in Claire's clinical care and the fact that I had no prior knowledge of the case. I had been advised by Dr. McBride during our discussion that he wanted to know the wishes of Mr. And Mrs. Roberts before making a final decision on whether to refer the case to the Coroner.

(iii) **To whom did you report with regard to this meeting?**

I do not recall reporting to anyone with regard to this meeting. I would have made reference to the meeting in a subsequent conversation with Dr. McBride about the overall situation, but this would not have included a detailed report on the meeting.

(iv) **Did you liaise with Mr. Walby in respect of the response to the Claire Roberts case?**

I liaised with Mr. Walby only after the case was referred to the Coroner and prior to the hearing.

(r) **In respect of your review of the case notes of Claire Roberts, did you form any other views in respect of shortcomings or deficiencies you may have noted in the following areas:**

As indicated above, the purpose of my review was to determine whether hyponatraemia may have contributed to Claire's death and not to reach any conclusions about possible shortcomings or deficiencies in her care. Therefore, I did not fully consider all aspects the quality of care which was provided. However, I did form views about some aspects of her care during my review of the case and I refer to these below.

(i) **Drug prescription and administration;** No views formed.

(ii) **The recording of CNS observations;** No views formed.

(iii) **The record of fluid balance and management;** Choice and rate of administration of fluids to Claire was in line with common practice at the time of her admission, though not in line with practice at the time of my review. There was an accurate record of fluid intake but not of fluid output. Monitoring of serum electrolytes did not occur with sufficient frequency given the severity of Claire's clinical condition. Once severe hyponatraemia was identified, management of fluid balance was appropriate but Claire may already have suffered significant adverse consequences as a result of this.

(iv) **Access to CT/EEG scan facilities;** No views formed.

(v) **Referral of patients to PICU;** No views formed.

(vi) **Responsibility of and attendance by the named consultant;** No views formed.

(vii) **Record keeping;** Record keeping was generally adequate though in a few places unclear.

(viii) **Communication with family and record thereof;** Communication with the family at the time of Claire's death seemed to have been reasonably good. However, some aspects of Claire's condition may not have been discussed at the time (such as hyponatraemia). I thought that this was likely to be a consequence of the complexity of her medical problems and a failure to recognise the full significance of the hyponatraemia at the time. More recently (following the television programme and the contact made by Mr.and Mrs. Roberts with the Trust) communication had become more formal.

(ix) **Process for referral of deaths to Coroner;** No views formed.

(x) **Process relating to restricted hospital autopsies;** No views formed.

(xi) **Sharing information with next of kin;** No views formed.

(xii) **Learning from adverse clinical incidents.** No views formed.

4. **In respect of Medical Director, Dr. Michael McBride's letter of 17th December 2004 to Mr. and Mrs. Roberts (Ref: 089-005-010)** ***"as you have been informed by Professor Ian Young of the Queen's University Belfast, our medical case note review has suggested that there may have been a care management problem in relation to hyponatraemia and this may have significantly contributed to Claire's deterioration and death. In such circumstances it is necessary for the Trust to report the case to the Coroner for further investigation"*****, please state:**

(a) **What was the** ***"care management problem"*** **of which you informed Mr. and Mrs. Roberts?**

The "care management problem" which I referred to was the possible role of hyponatraemia in Claire's deterioration and subsequent death, and the way in which the management of her fluid balance and monitoring of serum electrolytes contributed to the development of the hyponatraemia.

(b) **In those circumstances why did you inform Mr. and Mrs. Roberts that** ***"the Trust, in the meantime, would not contact the Coroner until Mr. and Mrs. Roberts decided what they wished to do"*** **(Ref: 089-002-004)?**

A considerable period of time had elapsed since Claire's death and a referral to the Coroner after such a long period would be an unusual occurrence. In these circumstances, it would be desirable to be aware of the wishes of the family before discussing the case with the Coroner. However, this did not necessarily mean that the wishes of the family would be followed in relation to the referral, rather that Dr. McBride would be aware of the family's wishes before making a decision about a referral. I agreed with this approach and felt that it was appropriate.

(c) **Did you take part in any further investigation in the hospital after the referral to the Coroner?**

No

5. **Please state whether the advice of Mr. A.P. Walby was sought in respect of referral to the Coroner?**

Mr. Walby's advice was not sought by me. I do not know whether anyone else sought his advice on this issue.

6. **Please state whether you would have expected the death of Claire Roberts' death to have been referred to the Coroner in 1996 and if so why?**

I would have expected any death in which a care management problem made a significant contribution to a death to be referred to the Coroner in 1996. However, I do not believe that the clinical staff recognised that such a problem existed at the time of Claire's death, and that this explains why a referral to the Coroner did not take place at that time.

7. **Please state whether there were any guidelines or conventions governing the referral of deaths to the Coroner in 1996?**

In 1996 my role in the hospital would not have required me to make referrals to the Coroner, so I have no knowledge of this issue.

8. **Please state whether any guidelines or conventions existed in 1996 governing post-mortem**

examinations with specific reference to:

In 1996 my role in the hospital would not have required me to have any involvement with a decision to request a post mortem, so I have no knowledge of the issues below.

(a) **Whether you think it would have been appropriate to have requested a post mortem examination of Claire without limitation or restriction;**

(b) **When consent was required for a post-mortem examination;**

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

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

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

(f) **Whether parents of the deceased child should be asked for their views on whether or not the Coroner be notified;**

(g) **Whether parents of the deceased child should be asked for their views on whether a full or restricted post-mortem should be carried out;**

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

9. **Please state whether you would have expected nursing staff to mount an investigation into the death of Claire Roberts in 1996 and whether you would have expected statements to have been obtained from the nurses in respect of same?**

I would not have expected nursing staff to mount or conduct such an investigation, or for statements to have been obtained from them. Claire's death was perceived to be a consequence of a severe illness and no unusual features requiring a special investigation were considered to be present.

10. **If there was a possibility that medical care and treatment might have contributed to a death would you have expected an investigation to have been undertaken:**

(a) **In 1996;**

Yes

(b) **In 2004?**

Yes – processes for this would have been more structured and formal in 2004.

11. **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 have any knowledge of this area.

12. **Please provide any further comments you may wish to make;**

I have no additional comments.

13. Please provide any further documents or materials you may wish to include.

No further material to include.

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

Signed: Ian Young Ian Young Dated: 14/9/12