Prof Young [redacted]
Hobbs

[redacted]

APW notes from Dr. Webb's evidence of 28.4.06

While reading through his Statement DW :

Referred to meeting AS in corridor at lunchtime to be told about the case.

Referred to SHO admission note referring to "loose motions 3 days ago"

Referred to history consistent with seizures and significance of nursing note of improvement following rectal diazepam

Referred to history from mother (confirmed by Mr. McCrea as a direct meeting, not telephone) re cousin with GI upset and Claire's loose bowel motions. DW commented that the important aspect from his point of view was not whether it was diarrhoea or loose bowel motions, but that the change in bowel habit was an important pointer to an infection.

Emphasised the significance of the raised WCC which had not seemed of importance to the independent experts. He highlighted the CSF findings (page 9) of the raised red cell/white cell ratio of 75:1 (normal 500:1) which was suggestive of meningitis and confirmatory of their management.

HMC

Discussed formulation of cause of death

DW	Cause of death	1a Cerebral oedema
	caused by	1b Meningoencephalitis
		SIADH
	related conditions	2 Status epilepticus

He would have written the death certificate then and now as above

DW Agreed it would have been appropriate to repeat the Na 121 test level, but treat anyway

DW Asked "should a doctor taking blood have documented where the blood was taken from if not from a normal vein" - yes

Mr. McCrea

Discussion re ADH

DW asked about the repeat blood test (3rd) showing Na 121 (as recorded by HS). No knowledge. 4th was 129, 5th was 152

DW explained that fall in Na could have been exponential not linear.

DW agreed that medical team would have changed fluid management if blood sample had been done on morning of 22nd and had shown a drop in Na

DW asked was there a protocol to manage hyponatraemia. DW didn't think so but it was managed appropriately anyway - HMC interjected that it was only introduced by DHSS in 2002 or 2003.

DW agreed fluid restriction would have commenced earlier with further blood sampling following.

DW asked " At 8.00pm whose responsibility was it to advise the parents of the serious condition. Replied that he was not made aware of it.

Mr. McCrea stated that DW spoke to Mrs. Roberts at 5.00pm. DW had requested hourly observations, but not informed of change until brain dead.

DW agreed that there was on-call neurological cover by him.

DW asked whether at 8.00pm he should have been advised. Reply - Yes

DW asked would he have arranged an immediate blood test. Reply - Probably. Then agreed there would have been an earlier restriction of fluid.

In reply to HMC who asked if the preceding discussion would make DW alter his cause of death formulation DW stated that SIADH was the cause of the hyponatraemia and he would not change it to add hyponatraemia under 1b

Mr. Lavery

Asked DW about urinary output because of nursing note which states

11.00am PU large arrow 1000.

DW considered this to suggest there was indeed adequate urinary output among other recordings.
HMC dismissive because child's bladder only holds 600mls !

DW confirmed that improvement after Diazepam was an indicator of seizure activity.

Adjourned 12.30pm

Discussion after

DW felt that the second reading of 121 after a period of fluid restriction was even greater indication that SIADH was responsible for the fall in Na and would be interested in Prof. Young's view.

Later discussion with HS and AS. Urine output note - "arrow 1000" actually reads "arrow lab"