[redacted]

From: Ian Young[redacted]
Sent: 21 December 2005 18:18
To: [redacted]
Cc: I.Young@[redacted]
Subject: RE: Claire Roberts

[redacted]

Please find below a further statement about Claire Roberts in response to additional information forwarded by the office. I will need to sign this, but would be grateful if you could check it and make sure it is in an appropriate form:

Thank you for your help.

Ian Young

Start as for first paragraph of statement.
In addition to my formal statement
I have been asked to comment on the report by

~~I am writing in response to a memorandum from Mr A P Walby, Associate Medical Director, enclosing copies of reports by~~ Dr R M Bingham and Dr Maconochie and a response from Mr Alan Roberts.

In general, I agree with the conclusions which Dr Bingham has reached. However, I would like to make the following comments:

1) On page 3 of his statement, in paragraph 1, Dr Bingham interprets the written note from Dr Webb to say: 'I note no biochemistry profile'. In my earlier statement, I interpreted this note to mean: 'I note normal biochemistry profile', and having reviewed the chart I continue to interpret the note in this way. There is a biochemistry profile result recorded in the notes prior to Dr Webb's written note, and this seems inconsistent with Dr Bingham's interpretation of the comment.
2) On page 4, paragraph 1, Dr Bingham indicates that it is unlikely that the serum sodium on admission (132mmol/l) was the cause of Claire's presenting symptoms. I think that this is an important point, with whicl I agree. While Claire's sodium was low on admission, the degree of hyponatraemia was relatively minor and was unlikely to be making a significant contribution to her presentation.
3) As indicated by Dr Bingham, urine output from Claire was not measured. Dr Bingham believes that there is sufficient recorded information relating to wet nappies to conclude that urine output was reasonably high. I do not think that it is possible to reach any conclusion as to whether urine output was high or low.
4) Dr Bingham indicates that the intravenous fluid volume recorded in Claire's notes would not be sufficient to account for the fall in her serum sodium. In contrast, I do not think that it is possible to reach any firm conclusion on this matter in the absence of any record of urine volume or urinary sodium concentration. I believe that the changes in Claire's serum sodium are entirely consistent with the recorded intravenous fluid intake when possible urinary losses of water and sodium are taken into account.
5) In his report, Dr Bingham raises the possibility that the serum sodium measurement of 121 mmol/l was wrong. The laboratory measurement of sodium is extremely accurate. Assuming that an appropriate sample was taken (and there is nothing in the notes to suggest that sample collection was difficult), I believe that the possibility of an inaccurate laboratory result is negligibly small.

In addition to the above comments, I would like to make one comment in response to the letter from Mr Alan Roberts dated 29th September '05. Mr Roberts refers to my earlier statement that: 'The practice at that time would be firstly, to restrict fluid intake and secondly to consider administration of fluid with high content of sodium if symptoms

attributable to hyponatraemia were present'. This statement was made in response to a question about the action take when Claire's serum sodium was noted to be 121mmol/l. In my opinion, when Claire was initially admitted her ser sodium of 132mmol/l was unlikely to have made a significant contribution to her presenting symptoms, although serum sodium was slightly below the lower reference limit and therefore in the hyponatraemic range.

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email: I.Young@[redacted]

From: Ian Young [mailto:[redacted]
Sent: 17 May 2005 11:16
To: [redacted]
Cc: I.Young@[redacted]
Subject: Claire Roberts

[redacted]

Please find attached my report on Claire. You may need to put this in the correct format for me to sign. I am happy to make an changes.

Best wishes

Ian Young

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