

STATEMENT OF WITNESS

STATEMENT OF: IAN YOUNG, CONSULTANT IN CLINICAL BIOCHEMISTRY
Name Rank

AGE OF WITNESS (if over 21 enter "over 21"): OVER 21

NOT SIGNED IN POLICE OFFICER'S PRESENCE

TO BE COMPLETED
WHEN THE
STATEMENT HAS
BEEN WRITTEN

I declare that this statement consisting of 2 pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence in a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have written or stated in it anything which I know to be false or do not believe to be true.

Dated this _____ day of _____

SIGNATURE OF MEMBER by whom
statement was recorded or received

SIGNATURE OF WITNESS

Ian Young

Re: Claire Roberts (deceased) DOB: 10/01/87

I am a registered Consultant in Clinical Biochemistry, and qualified at Queen's University Belfast in 1985 with MB BCH BAO. I am Fellow of the Royal College of Physicians (London), Fellow of the Royal College of Physicians of Ireland and a Fellow of the Royal College of Pathologists.

In addition to my previous statement I have been asked to comment on the reports by I 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 note written not 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 which 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 weanlings 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.

Form 38/36
(Plain)

SIGNATURE OF WITNESS.....

Ian Young

STATEMENT CONTINUATION PAGE

STATEMENT OF: IAN YOUNG CONTINUATION PAGE NO:

- 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 a 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 a high content of sodium, if symptoms attributable to hyponatraemia were present'. This statement was made in response to a question about the action taken when Claire's serum sodium was noted to be 121mmol/l. In my opinion, when Claire was initially admitted her serum 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.

Form 38/36 [a]
(Plain)

SIGNATURE OF STATEMENT MAKER: Ian Young

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