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| AD-0556-13 | HYP B04/2 | 15th April 2013 |

Ms A Dillon
Solicitor to the Inquiry
Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast
BT1 4GB



Dear Madam,

**RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS-CLAIRE ROBERTS**

I refer to the above and your letter of 11th April 2013.

I now enclose Professor Young's comments on the Clarification Note referred to in your aforementioned letter.

I trust that this is in order.

Yours Sincerely

Joanna Bolton
Solicitor Consultant

IS Young 15/4/13

I have been asked if I wish to comment on a letter and Clarification Note ref. AD-0556-13 and dated 11th April 2013. The Clarification Note deals with two issues: "Claire Roberts Timeline of Events" 310-001-001 and Restriction of Fluids after 23.30.

**1) Claire Roberts Timeline of Events (310-001-001)**

I saw this document for the first time on the monitor during the course of my oral evidence on 10th December 2012. When the document was introduced to me, Mr Quinn indicated that the purple line represented the midazolam infusion (p144, lines 17-18), which was confirmed by the Chairman (p147, lines 4-5). The Chairman also indicated that the only cumulative total on the Timeline was the dark blue line (p149, line 2). I then stated that the purple line did not make sense as an indicator of midazolam (p148, lines 8-15).

Having now had an opportunity to review the timeline along with the explanation provided in the Clarification Note, it is clear to me that the purple line represents the cumulative total volume of infused medication rather than just midazolam. I agree, therefore, that the timeline is correct based on the fluid balance chart, drug prescription sheets and nursing notes.

**2) Restriction of fluids after 23.30**

This section of the Clarification Note indicates that the Inquiry has updated its "Schedule of IV and Medication Input" at 310-015-001. There are two new versions – one which is described as "based solely on the Fluid Balance Chart" (310-015-002) with administration of Phenytoin between 23.00 and 00.00 and one "based additionally on the evidence of Dr.Stewart on 6th November 2012" (310-015-003). This is described in the Clarification Note as having the administration of Phenytoin between 23.30 and 00.00.

Before considering the two new versions which have been sent to me, I wish to comment on one aspect of all three documents which I think is misleading. Each row is assigned a time, which is the end of the hour during which fluids were administered. For instance, the first row in each table (22.00) deals with fluids administered between 21.00 and 22.00 and recorded at the end of that hour. A problem arises with the third row in each table (00.00) which deals with the fluids administered between 23.00 and 00.00. This is indicated in the first column as being on 23th October, when in fact it deals with fluids administered on 22nd October.

I think that all three versions would be clearer if the rows were labelled with the hour in question. For instance, the first row would become 21.00 – 22.00, the second row 22.00 – 23.00 etc. In addition, the third row (currently 00.00) would be more easily understood if allocated to the day of 22nd October rather than 23rd October as at present.

I now wish to comment on the two new versions which have been sent to me (310-015-002 and 310-015-003).

a) 310-015-002 shows the administration of Phenytoin between 23.00 and 00.00. I do not think it is correct to say that this is based "solely on the Fluid Balance Chart." The administration of Phenytoin between 23.00 and 00.00 is also indicated in the Nursing Notes

at 090-40-138. 310-015-002 would be more accurately described as "based on the fluid balance chart and nursing notes" and reference to the corroborating evidence of the Nursing Notes should be made in the footnote.

The final paragraph of the Clarification Note indicates agreement with my submission that there was a restriction of fluids to 2/3 following the discovery of the sodium result at 23.30 if it is accepted phenytoin was administered between 23.00 and 00.00.

I would like to highlight in this regard that until the oral evidence of Dr.Stewart to the Inquiry on 6th November 2012 there was no suggestion that the time of Phenytoin administration recorded on the Fluid Balance Chart and the Nursing notes was incorrect. Inquiry experts, reviewing the clinical records, accepted that Phenytoin was administered between 23.00 and 00.00 (for example, Dr. Aronson at 237-002-011 and Dr.MacFaul at 238-002-199 and 238-002-200). Therefore, it follows that the information which I provided to Claire's parents and the inquest with regard to fluid restriction after 23.30 was correct based on the records and information available at that time and any assertion to the contrary is mistaken.

b) 310-015-003 is an alternative version of the "Schedule of IV and Medication Input" based on the oral evidence of Dr.Stewart to the Inquiry on 6th November 2012. In relation to this, I would like to highlight an error on the second page of the Clarification Note, which states that 310-015-003 assumes that Phenytoin administration occurred between 23.30 and 00.00. On inspection, 310-015-003 in fact assumes Phenytoin administration between 23.30 and 00.30, as indicated by Dr. Stewart in his oral evidence. The Clarification Note therefore needs to be amended in this respect .

Furthermore there is a mathematical error on 310-015-003. The fourth row (01.00) includes a total fluid per hour of 77.5. This value is the sum of Phenytoin (55) and Midazolam (2.5), and should therefore be 57.5.

There is nothing in the contemporary records to indicate administration of Phenytoin between 23.30 and 00.30. Dr.Stewart did not make any note to this effect at the time of Claire's admission and the suggestion that the Nursing Notes and Fluid Balance Chart are incorrect emerged for the first time during his oral evidence to the Inquiry.

Dr.Stewart's oral evidence is in conflict with the Fluid Balance Chart and Nursing Notes. If the Chairman determines that Dr.Stewart's oral evidence is correct and both the Fluid Balance Chart and Nursing Notes are inaccurate in this regard, then I agree that fluid restriction to 2/3 following the discovery of the sodium result at 23.30 did not take place. However, I wish to highlight that when I provided information to Claire's parents in 2004 and the Inquest in 2006 there was no challenge to the timing of the Phenytoin administration recorded in the clinical notes. This emerged for the first time when Dr.Stewart gave oral evidence to the Inquiry.

Ian Young

15/04/13