Witness Statement Ref. No. 076/1

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Name: Paul Darragh

Title: Dr.

Present position and department/employer:

Consultant in Public Health Medicine, Eastern Health and Social Services Board.

Length of time in post: From 1997

Previous position and department/employer in 1995:

Joint Appointment. Department of Public Health Medicine, Eastern Health and Social Services, Board and the Queen's University of Belfast.

Previous position and department/employer in 2000:

Eastern Health and Social Services Board, but seconded to DHSS&PS as Deputy Chief Medical Officer ("DCMO") in latter part of 2000 until August 2002.

Previous position and department/employer in 2001:

Eastern Health and Social Services Board, but seconded to DHSS&PS as DCMO.

Membership of Professionals Bodies:

Fellow of the Royal College of Physicians (FRCP) UK and Ireland.
Fellow of the Faculty of Public Health Medicine (FFPHM) UK and Ireland.

Particular areas of interest
[Please attach additional sheets if more space is required]

(i) How and when did you first become aware of the deaths of Adam, Lucy and Raychel?

I became aware of Raychel's death on 2nd July 2001 when it was discussed at the meeting of Directors of Public Health (075-081-323). Subsequently, during the production of the Guidelines, I became aware that there was the possibility of another case associated with Royal Belfast Hospital for Sick Children ("RBHSC") but this child (Adam) suffered from other health problems. With respect to Lucy I only became aware of this early in 2004 through the media.

(ii) Describe in detail the steps you took:
(1) to discover why the children died;
(2) why the DHSSPS was not made aware of the deaths at an earlier stage; and
(3) to ensure that lessons would be learned for the future.

I was informed of the diagnosis of hyponatraemia at the CMO/DPH meeting and CMO subsequently asked me to chair the working group. The purpose of the working group was not to discover why the children had died or why the Department had not been made aware of the deaths earlier, but to produce Regional Guidance on the prevention of Hyponatraemia. It was agreed a small sub-group would undertake the drafting of the guidelines, which would be presented to Special Advisory Committee General Surgery, Special Advisory Committee Paediatrics and Special Advisory Committee Anaesthetics in the first instance for further comment.

Particular areas of interest (Cont'd)

(iii) **Give details of your colleagues within the DHSSPS with whom you discussed the steps to be taken in response to the deaths of Adam, Lucy and Raychel to include the reasons why and when they were contacted by you and the outcome of your discussions.**

The issues surrounding the establishment of the Hyponatraemia Working Group were discussed only with Dr H Campbell (Chief Medical Officer) and Dr M McCartney (Senior Medical Officer). The purpose was to discuss the mechanism of conducting the Working Group. The timing of this process was 21 August 2001 for the invitation of personnel to attend the first meeting (007-050-099), so discussions with CMO/Dr McCartney were around that time.

(iv) **Describe in detail your role, if any, in the preparation of guidance in respect of hyponatraemia in children, to include details of colleagues in Northern Ireland and in the rest of the UK with whom you discussed the content of such guidance.**

The group consisted of myself (chair); Dr B Taylor, RBHSC; Dr D Lowry, (Craigavon Hospital); Dr G Nesbitt, Altnagelvin Hospital; Mr G Marshall, Erne Hospital; Mr B McCallion, RBHSC; Dr F Kennedy, Northern Health and Social Services Board, Dr C Loughrey, Belfast City Hospital; Ms E McElkerney, Ulster Hospital Dundonald; Dr P Crean, RBHSC; Dr M McCarthy, DHSS&PS; and secretary to the group, Dr Mark, DHSS&PS.

I chaired the above group at a meeting on 26 September 2001 the minute of the meeting is 007-048-094. I had no direct contact with colleagues outside N Ireland on this matter. However, Dr Taylor undertook on behalf of the group to make contact with the Committee on Safety of Medicines who act as a national resource for problems associated with medications.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

Though I convened the initial meeting and subsequently raised the proposed guidelines at some of the Special Advisory Committees I did not complete the process as my period of Secondment expired. Dr M McCarthy took the lead role in completing the process through the activities of the sub-committee.

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

Signed: Paul Darragh. **Dated: 29.6.05**