Witness Statement Ref. No.	080/2

DEPARTMENTAL AND GENERAL GOVERNANCE

Name: Miriam McCarthy .

Title: Dr.

Present position and institution:

Previous position and institution (2000/01):

Senior Medical Officer, Department of Health, Social Services and Public Safety

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement of 6th July 2005]

See attached resume

Previous Statements, Depositions and Reports:
[Identify by date and title all those since your Witness Statement of 6th July 2005]

WS-080/1 –06-07-05

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	Date:	
WS-080/1	06.07.05	Witness Statement to the Inquiry

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

N.B. In answering the below questions, and where appropriate, please detail the circumstances throughout your appointment as Senior Medical Officer, including any changes that may have occurred during that period.

ROLE AS SENIOR MEDICAL OFFICER

(1) State the dates on which:

(a) You became Senior Medical Officer

Ans: I became a SMO in October 1998.

(b) You ceased to hold that position.

Ans: I ceased to hold position in April 2006.

(2) Describe your career history prior to becoming Senior Medical Officer.

Ans: Resume attached.

(3) Describe your career history since ceasing to be Senior Medical Officer.

Ans: Resume attached.

(4) Please explain the Role of Senior Medical Officer and the responsibilities the role entailed.

Ans: The role of a senior medical officer (SMO) was to provide support to senior officers within Medical and Allied Branch and to provide professional (i.e. medical) advice to the Minister and also to policy colleagues within the then Department of Health and Social Services.

(a) If the duties/responsibilities changed while you were in the post, please give details of the changes and when they occurred.

Ans: As senior medical officer my role initially focused on health promotion and disease prevention including chairing the Teenage Parenthood Working Group. Over the period of my time as SMO my responsibilities changed to areas predominately associated with the strategic direction of hospital services, for example, strategic changes arising from Developing Better Services, service modernisation in the Southwest of Northern Ireland and the Review of Pathology Services in Northern Ireland.

(5) Identify to whom you were accountable in carrying out the duties of Senior Medical Officer.

Ans: Ultimately I was accountable to the Chief Medical Officer. For some areas of work my immediate accountable officer was either a Principal Medical Officer or Deputy Chief Medical Officer.

(6) In particular, please explain your responsibilities as Senior Medical Officer in regard to the quality of care provided to patients by hospitals, including any responsibilities to ensure that Trusts exercised their statutory duty to provide quality care.

Ans: As a SMO I did not have any specific responsibility to ensure Trusts exercised their statutory duty to provide quality care. Rather, my responsibility focused on working with policy colleagues to identify the strategic direction for particular service areas and the standards that may be appropriate to apply in Northern Ireland hospitals.

(a) Please explain how those responsibilities were fulfilled.

Ans: I fulfilled my responsibilities through active participation in service reviews, and being part of the decision making process that developed recommendations for service development or service improvement.

FORMATION OF THE WORKING GROUP

(7) What was the system by which medical issues requiring guidelines came to the attention of the Department?

Ans: Medical issues requiring Guidance may have come to the attention of the Department through a number of routes including:

- *Service advice or Guidance developed in other parts of the UK which may have been considered for application in Northern Ireland.*
- *Specific service issues that may have indicated the need for guidance or a care pathway to improve quality of care/patient outcomes.*
- *Case specific issues that identified the potential of regional learning and may have required guidance to be disseminated to facilitate such learning.*

(a) To what extent was the process by which the Hyponatraemia Guidelines were formulated an example of that system in practice?

Ans: The Hyponatraemia Guidance was drafted as a response to the knowledge of a single case in which there was a mortality associated with hyponatraemia.

(b) Please explain when, where and by whom it was decided that guidelines for hyponatraemia would be provided by the Department.

Ans: I was asked by Dr Darragh to convene the Working Group and was advised that this was at the CMO's request. I was not aware of further detail on how the decision to develop guidance or establish a Group was determined.

(8) You stated at **Ref: WS-080/1, p.2** that Dr. Paul Darragh asked you on 14th August 2001 to convene a working group to produce guidance on the prevention of hyponatraemia in children. As you are aware, this Group met for the first time on 26th September 2001 **(Ref: 007-048-094)**.

(a) Please explain why you were asked to convene the Working Group, and what this role entailed.

Ans: I was asked to be a member of the Working Group established to develop guidance on the prevention of hyponatraemia. My role was not explicitly detailed at this juncture, but in the first instance I was asked to convene the Group.

(b) What exactly led to the establishment of the working party which prepared the hyponatraemia guidelines? Was it only the report of Raychel's death or was it also information about other events?

Ans: My understanding was that the Working Group was established as a direct consequence of the death of Raychel Ferguson.

(9) You stated at **Ref: WS-080/1, p.2** that *"my role as Senior Medical Officer did not focus on discovering why the children died. Rather, I was involved in action to prevent further cases of hyponatraemia."*

(a) Please explain why one of the purposes of the working group was not to discover *"why the children died"*.

Ans: The role of the Working Group was to develop guidance that would help prevent any further cases of serious/fatal hyponatraemia. It was not the role of the CMO or the Department to investigate the deaths of individuals. Other arrangements were in place by which the cause of death of an individual could be considered, i.e. medical post mortems, coroner's cases, etc.

(i) Please explain whether any consideration was given to an investigation of *"why the children died"*. If not, explain why.

Ans: The Working Group did not give consideration to "why the children died". Rather, its role was to develop clear and concise advice on: the risks of hyponatraemia; the children most at risk; how it could be prevented; and the essential monitoring.

(ii) Please explain the assumption(s) the Working Group was working under as to *"why the children died"*.

Ans: When the Working Group was established I was aware of one death (Raychel Ferguson) and the assumption of the Working Group was that her death was associated with and may have been caused by hyponatraemia.

(b) Please explain why one of the purposes of the working group was not to discover why the Department had not been made aware of the deaths earlier.

Ans: The Working Group was not established to investigate why the Department had or had not been made aware of individual cases of hyponatraemia. This was a 'task and finish' group established only to develop guidance on the prevention of hyponatraemia.

(i) Please explain whether any consideration was given to an investigation of why the Department had not been made aware of the deaths earlier. If not, explain why.

Ans: I am not in a position to answer this.

(10) What were the respective roles of yourself and Dr. Paul Darragh in regard to the Working Group that was to produce hyponatraemia guidance:

(a) Between 2001 and 2002

Ans: Dr Darragh chaired the Working Group. Following the initial meeting, I had the responsibility of working with a subgroup of clinicians to draft the guidance, ensuring that the views of clinicians were appropriately reflected and the final version was agreed by working group members.

(b) After the expiry of Dr. Darragh's secondment to DHSSPS in 2002?

Ans: After March 2002, when the guidance was issued, the Working Group ceased to exist.

(11) How did you / the Department identify the clinicians who would form the membership of the Working Group? For example, were they selected, did they volunteer etc.

Ans: My recollection is that in determining Working Group membership, clinicians from relevant speciality areas were identified, giving due account to appropriate geographic distribution.

(a) Please explain why no nursing representatives were invited.

Ans: I don't recall any discussion about nursing representation on the group.

(12) What discussions (in person / by telephone / by letter / by e-mail) took place between 14th August 2001 and 26th September 2001 as preparation for the inaugural meeting of the Working Group?

Ans: I do not recall the detail of discussions or communications that took place between 14th August 2001 and 26th September 2001 in preparation for the inaugural meeting of the Working Group. I do however recall Dr Taylor providing a briefing paper on hyponatraemia.

(13) Materials prepared by Dr. Robert Taylor appear to have distributed to other Hospitals prior to the inaugural meeting in September 2001. For example, **Ref: 043-101-223** was received by Sperrin Lakeland Trust on 10th August 2001, and Craigavon Area Hospital had a copy of a similar document by 8th August 2001 – see **Ref: 329-014-004** and **Ref: 329-014-006.**

(a) Please state if you saw this document (**Ref: 043-101-223**) prior to 26th September 2001.

Ans: Yes, I saw this paper (Ref: 043-101-223) prior to 26 September 2001.

(b) Please state if you would have expected this information to have been made available to the Department. If so, state by what means you would have expected it to have been sent.

Ans: Before an inaugural meeting of any Group it would normally be expected that the chair would be in receipt of background information, and the material provided by Dr. Taylor was very helpful in informing the Department of the keys issues with regard to hyponatraemia. The Department would have anticipated papers to be sent by post or electronic mail.

(c) Please explain the purpose of this document.

Ans: I understood that the purpose of the document was to provide briefing material to myself and other colleagues in advance of the first meeting of the Working Group.

(d) Please state if this document was discussed by the Working Group.

Ans: I do not recall specific discussion on the document provided by Dr Taylor but the notes of the meeting record that Dr Taylor provided a summary of the issue, including background, detail of those most at risk, and recommendations to prevent hyponatraemia.

(14) Dr. Robert Taylor sent Dr. Paul Darragh a draft PowerPoint presentation by e-mail on 18th September 2001 *"for your consideration in advance of the meeting on the 26th September"*. **(Ref: 007-051-100)** There is a handwritten note on the e-mail stating *"Anne – Please copy to Miriam McCarthy"*.

(a) Please state if you received a copy of Dr. Taylor's draft PowerPoint presentation.

Ans: Yes, I recall receiving a copy of the PowerPoint presentation.

(b) Please state if you would have expected to have received a copy of Dr. Taylor's draft PowerPoint presentation?

Ans: Before an inaugural meeting of any Group it would normally be expected that the chair would be in receipt of background information, and the material provided by Dr. Taylor was very helpful in informing the Department of the prevalence of hyponatraemia in the Royal Belfast Hospital for Sick children (RBHSC).

(c) Please state if you considered these, as requested by Dr. Taylor.

Ans: I recall reading and noting the content of the PowerPoint presentation.

(d) Please explain what use was made of these materials by the Working Group.

Ans: I do not recall the PowerPoint presentation being included in papers for the Working Group but the issues contained in the presentation were discussed at meeting of the Working Group and subsequent meeting of the subgroup.

(e) At **Ref: 007-051-103**, there is a bar chart showing the incidence of hyponatraemia at the RBHSC from 1991 to 2001, including the number of admitted cases and deaths.

(i) Please state if you saw this chart.

(ii) Please state if you recognised any significance in two deaths being recorded on the chart.

(iii) Please describe any investigations you / the Department carried out into the circumstances of the two deaths noted on the chart.

(15) Please explain what steps:

(a) You / the Department

Ans: ***Beyond Dr Taylor's briefing paper advising on the prevalence of hyponatraemia I do not recall formal steps taken by the Department to establish the prevalence of hyponatraemia in children in hospitals in Northern Ireland.***

(b) The Working Group

Ans: ***Beyond Dr Taylor's briefing paper advising on the prevalence of hyponatraemia I do not recall formal steps taken by the Working Group to establish the prevalence of hyponatraemia in children in hospitals in Northern Ireland.***

took to discover how prevalent an issue hyponatraemia in children was in hospitals in Northern Ireland.

(16) In the minutes of the inaugural meeting of the Working Group on 26th September 2001, it is stated that *"Fluid replacement in children is complex and while guidelines are in place for acute management, chronic management is not as well covered."* (**Ref: 007-048-094**).

(a) What guidelines were *"in place for acute management"*?

Ans: ***I cannot recall which Guidance were referenced in the inaugural meeting of the Working Group.***

(b) What other guidelines were available in the area of fluid management?

Ans: ***In 200I, I was not familiar with the Guidance available on fluid management.***

(17) It was also stated in the minutes that *"The Group felt there was a lack of a paediatrician's view, which it was decided was essential."* (**Ref: 007-048-095**).

(a) Why was it felt that there was *"a lack of a paediatrician's view"*?

Ans: ***It was considered by attendees at the inaugural meeting of the Working Group that there was not sufficient representation from paediatricians.***

(b) Why was this considered *"essential"*?

Ans: ***The paediatric role was considered essential because paediatricians were responsible for children in hospital and, in particular, responsible for prescribing of fluids, including IV fluids.***

(c) Were there no paediatricians present? If so, why not?

Ans: ***Dr Jenkins had been invited but was unable to attend. I recollect that it was considered beneficial for a second paediatrician from an acute hospital site to join the Working Group.***

(d) What action was taken to gain *"a paediatrician's view"*?

Ans: ***A paediatrician from an acute hospital, Dr Jarlath McAloon, was invited to join the Working Group.***

(18) Please explain fully the role of the sub-group as compared to the main Working Group.

Ans: The subgroup's role was to draft the detail of the guidance and to share with other working group members as reflected in my previous witness statement (WS-080/1.) The subgroup operated as a 'virtual group' with communication being by email. This was to facilitate more rapid progress in developing the guidance.

(19) Please identify the members of the "sub-group" responsible for drafting the guidance and how those members came to make up the sub-group - for example, were they selected, did they volunteer etc.

Ans: Subgroup members included Jarlath McAloon, Clodagh Loughrey, Dr Peter Crean, Dr John Jenkins and I. My recollection is that members volunteered for this role.

(20) A second meeting of the Working Group took place on 10th October 2001. **(Ref: 007-038-072)**

(a) Please state who attended this meeting.

Ans: Dr John Jenkins, Dr Jarlath McAloon, Dr Peter Crean and myself.

(b) Please state why there is not an attendance sheet of this meeting.

Ans: The subgroup was not expected to undertake its work with formality and therefore an attendance sheet would not have been considered necessary. My notes of the meeting serve to document attendees.

(c) Please state who made the notes at **Ref: 007-038-072.**

Ans: 007-038-072 is my contemporaneous note of the meeting.

(d) Please state why there is not a typed minute of this meeting.

Ans: It was agreed that the most efficient way of developing the guidance was for issues discussed and agreed to be directly incorporated into the guidance, rather than separate notes detailing discussions. This means of working did not therefore result in formal typed minutes of meetings.

(e) Please state why Professor Maurice Savage, as Professor of Paediatrics and President of the Ulster Paediatric Society, was not informed of, or invited to participate on, the original Working Group **(Ref: 007-042-087)**.

Ans: My recollection is that it was not initially considered that the input of a paediatric renal specialist would be required. Subsequently, however Professor Savage was invited to participate in the Group's work.

(i) Please state if he did attend and participate in the second meeting of the Working Group.

Ans: I have no record or recollection of Professor Savage attending the meeting on 10 October.

(ii) Please state if you / the Department considered following Professor Savage's suggestion that the Royal College of Paediatrics and Child Health should scrutinise any guidelines prepared.

Ans: I cannot recall what was considered or agreed in regard to the suggestion that the Royal College of Paediatrics and Child Health scrutinise the Guidance. While the Working Group was conscious of the benefit in having as much professional support as possible for the guidance it was also focused on issuing guidance as quickly as possible.

(f) Please state whether Dr. Jarlath McAloon, Consultant Paediatrician, Antrim Area Hospital was present at this meeting. If so,

(i) Why was he there?

Ans: Dr McAloon was present at the meeting on 10 October, following an invitation to participate in the work of the subgroup.

(ii) Why was he not present at the inaugural meeting on 26th September 2001?

Ans: My recollection is that Dr McAloon was invited to be a member of the Group after the first meeting held on 26 September 2001. He had not been invited to the inaugural meeting but was subsequently invited to ensure input from a paediatrician working in an acute hospital.

(21) Describe the steps you / the Department took to discuss the work of the Working Group and the issues arising with colleagues in the rest of the U.K.

Ans: As detailed in my previous witness statement (Ref: WS-080/1), I wrote to the NPSA in March 2004, advising of experiences in Northern Ireland and the work to develop guidance. In that correspondence I asked the NPSA to consider this as a matter on which they may wish to develop UK wide guidance.

I also had contact with Dr Ted Sumner, who provided advice on the draft hyponatraemia guidance (Ref: 007-016-032)

I accompanied CMO to a meeting with Sir Cyril Chandler, during which he provided advice on fluid management. The detail and a copy of my handwritten notes are included as part of my previous witness statement (WS-080/1)

(22) Please state if you received a copy of Dr. Taylor's correspondence with the Medicines Control Agency (**Ref: 007-033-060**). As you are aware, Dr. Taylor filed a Yellow Card Report in respect of Solution No.18.

Ans: I did see a copy of Dr Taylor's correspondence

(a) Would you / the Department have expected a Yellow Card Report in relation to any of the other children's deaths given that hyponatraemia *"is a problem that had been present for many years"*? (**Ref: 007-048-094**).

Ans: 'Yellow Card' reporting is normally undertaken by clinicians in response to side effects/adverse events associated with a medicine. It would therefore be a matter of clinical judgement to submit a yellow card regarding a specific intravenous fluid solution.

RESPONSE TO THE GUIDANCE

(23) Please describe the respective responses of the Special Advisory Committees on:

(a) Paediatrics

(b) General Surgery

(c) Anaesthetics

to the draft guidance produced by the Working Group.

Ans: *I cannot recall the detailed responses of the Specialty Advisory Committees, but I have checked the minutes of these meetings and note that the guidance was commended by members of SAC Paediatrics and SAC Surgery. This matter was also included on the agenda of SAC Anaesthetic (October 2001) but the views of members are not detailed*

(24) Please describe any obstacles and/or difficulties the Working Group or sub-group faced in developing the guidelines that were published in March 2002. Please include any differences of opinion from individuals or specialties as to the content of the guidance, and any procedures/protocols that made development more difficult.

Ans: *The greatest challenge for the Working Group was developing the Guidance in a short time frame. This was deemed to be essential to ensure that clinical staff were well informed of the issues and future cases of serious or fatal hyponatraemia were avoided.*

I recall no difficulties arising that made the development of the guidance problematic. Rather, subgroup members were committed and exceptionally helpful, providing detailed advice and responding to draft material very promptly. They exchanged views and had candid discussions on both the content and presentation of key messages and, in doing so, ensured that the final document was clear, concise, accurate and easy to follow. Specific issues on which there was discussion or debate are reflected in email correspondence November 2001- January 2002.

One specific challenge was determining the scope of guidance, i.e. whether detail on specific fluids should be included in the guidance, and, if so, the strength of evidence on which advice would be based. My recollection is that this was discussed in detail and on a number of occasions. It was agreed that the priority was to focus on the steps necessary to prevent hyponatraemia and to monitor fluids and electrolytes. Members of the Working Group articulated a view that, while some fluids may have a stronger association with hyponatraemia, it could develop with the administration of any fluid (IV or oral).

(25) Please describe the response in the initial period following publication of the Guidance in March 2002. In particular, please identify if you / the Department faced any difficulties / opposition to any element of the Guidance. If so, please identify the areas of difficulty / opposition.

Ans: *My recollection is that the Guidance was well received and I do not recall any difficulties or opposition to any element of the Guidance. The CMO's covering letter to the Guidance highlighted the importance of the matter particularly in the context of two deaths known to the Department at that time (Adam Strain & Raychel Ferguson).*

Copies of the Guidance were requested from clinicians in the UK and in Canada.

(26) In the letter of Dr. Henrietta Campbell, Chief Medical Officer dated 25th March 2002 (**Ref: 007-001-001**), she states:

"The Guidance is designed to provide general advice and does not specify particular fluid choices. Fluid protocols should be developed locally to complement the Guidance and provide more specific direction to junior staff. [...]. It will be important to audit compliance with the guidance and locally developed protocols and to learn from clinical experiences."

(a) How did the Department intend to ensure that the locally developed fluid protocols would reflect the Guidance?

Ans: My recollection is that the Department expected Trusts to ensure that the locally developed fluids protocols reflected the Hyponatraemia Guidance.

(b) Who was intended to *"audit compliance with the guidance"*?

(i) The Department and Trusts together

(ii) The Department alone

(iii) The Trusts alone

(iv) Other organisations?

Ans: I do not recall that there was explicit agreement in March 2002 regarding who would audit compliance with the Hyponatraemia Guidance.

(c) Who was intended to *"audit compliance"* with the *"locally developed protocols"*?

(i) The Department and Trusts together

(ii) The Department alone

(iii) The Trusts alone

(iv) Other organisations?

Ans: I do not recall that there was explicit agreement in March 2002 regarding who would audit compliance with locally developed protocols.

(27) Dr. Jarlath McAloon conducted a Regional Audit in 2003-2004 to examine adherence to the DHSSPS hyponatraemia guidance (**Ref: 007-054-114**).

(a) Why was a Regional Audit conducted?

Ans: The regional audit was undertaken, in keeping with CMO's intention and expectation as articulated when the Guidance was issued in March 2002.

(b) What was its purpose / remit?

Ans: I do not recall seeing a formal Terms of Reference for the audit but I understood its purpose was to examine the adherence to the Hyponatraemia Guidance in paediatric units across Northern Ireland.

(c) In particular, why was Dr. McAloon asked to conduct the audit?

Ans: ***I cannot recall why Dr McAloon was the individual asked to conduct the regional audit.***

(d) What was he asked to do?

Ans: ***I cannot recall precisely what was requested of Dr McAloon but understood that what was required was an assessment of adherence to the Hyponatraemia Guidance.***

(e) What action was taken by you / the Department in relation to the results of this audit?

Ans: ***I cannot recall what action was taken in relation to the findings of the audit. By the time the audit results were available, my duties had changed and my recollection is that my colleague, Dr Willis, was more closely involved in this matter.***

DEATHS OF ADAM, CLAIRE, LUCY & CONOR

(28) In the minutes of the inaugural meeting of the Working Group on 26th September 2001, it is stated that *"Dr. Taylor informed the meeting about the background, incidence of cases seen in RBHSC and patients who are particularly at risk of hyponatraemia. This is a problem that had been present for many years."* (**Ref: 007-048-094**).

(a) Please explain what Dr. Taylor discussed at that time regarding the *"incidence of cases seen in RBHSC"*. In particular, state if he discussed the deaths of Adam, Claire or Lucy.

Ans: ***I recall Dr Taylor highlighting one death, that of Raychel Ferguson. I also recall Dr Taylor advising attendees of the increased identification of cases of hyponatraemia in the RBHSC, including 2 cases resulting in fatality.***

(b) Please state if Adam, Claire or Lucy's cases were discussed at the meetings of:

(i) 26th September 2001
(ii) 10th October 2001.

Ans: ***I do not recall any discussions of Adam, Claire or Lucy's cases at meetings held 26th September or 10th October 2001.***

(c) Please describe the knowledge of the Department in relation to the statement that *"This [hyponatraemia] is a problem that had been present for many years."*

Ans: ***My recollection is that in 2001 the Department was not aware that "hyponatraemia is a problem that had been present for many years". Rather I understood it was a matter that had just been brought to the attention of the CMO in the summer of 2001.***

(29) At **Ref: WS-080/1, p.2,** you state that you became aware of Adam Strain's death in December 2001 through a conversation with the Coroner and that he subsequently forwarded the medical report on Adam Strain. Please describe your reaction to discovering another death in which hyponatraemia was identified as a cause of death, and what action you took as a response.

Ans: ***When made aware of Adam Strain's death, this reinforced my view that guidance was necessary and that it should be finalised and issued at the earliest opportunity.***

(30) Likewise, at **Ref: WS-080/1, p.2,** you state that you became aware of Lucy Crawford's death in March 2003 through a further conversation with the Coroner. Please describe your reaction to discovering another death in which hyponatraemia was identified as a cause of death, and what action you took as a response.

Ans: When in March 2003 I was made aware of Lucy's death, I recall noting that it was unusual for a death to be reported to the coroner almost 3 years after the death. I informed the CMO of my telephone call from the coroner

(31) How and when did you first become aware of the death of Claire Roberts?

Ans: I became aware of the death of Claire Roberts when her death was included in the remit of the Hyponatraemia Inquiry.

(32) How and when did you first become aware of the death of Conor Mitchell?

Ans: My recollection is that I became aware of the death of Conor Mitchell shortly before the inquest into his death was due to be heard.

(a) What did you / the Department regard as the implications of Conor's death for the successful implementation of the guidelines?

Ans: My recollection is that Conor's death emphasised the need for hyponatraemia guidance to apply to children wherever they are cared for in hospital (i.e. within paediatric or other settings).

(33) What discussions did you / the Department have with:

(a) Colleagues in the DHSSPS

(b) Colleagues in other hospitals

regarding the failure to inform the Department of Adam / Claire / Lucy's deaths.

Ans: I do not recall discussions with Departmental colleagues or with colleagues in any hospital on the failure to inform the Department of Adam/Claire/Lucy's death.

CREST MEETINGS

(34) You attended a meeting of CREST on 8th November 2001 (**Ref: 075-066-210**). The minutes record your involvement as follows:

"Dr. Stewart reported that the Department had approached CREST regarding the dissemination and 'kite marking' of guidelines on the Prevention of Hyponatraemia in Children Receiving Intravenous Fluids. He introduced Dr. McCarthy, DHSSPS, who stated that the problem had come to the attention of the Department through clinicians, who reported an increase in the condition and felt in need of urgent guidance." **(Ref: 075-066-213).**

(a) Please explain what you meant by clinicians having *"reported an increase in the condition"*.

Ans: My recollection is that this referred to input from clinicians who were members of the Working Group, in which the number of cases of hyponatraemia in the RBHSC was discussed. While the majority of such cases were treated and not associated with

mortality, two were reported in children who had died. The reference to 'an increase in the condition' refers to the total of cases identified, both those resulting in morbidity and those associated with mortality.

(35) You also attended a meeting of CREST on 27th February 2002 (**Ref: 075-073-276**). The minutes record your involvement as follows:

"Dr. McCarthy, Senior Medical Officer, DHSSPS, reported that some months ago, the Department had been approached by Paediatricians, expressing concerns over an increase in the condition of Hyponatraemia and had felt in need of urgent guidance.." (**Ref: 075-073-276**).

(a) Please explain what you meant by paediatricians having *"express[ed] concerns over an increase in the condition of Hyponatraemia"*.

Ans: I have answered this question in respect of Q 34 and the same answer applies.

DISSEMINATION OF INFORMATION

(36) Please explain your role and responsibilities in the dissemination of information / guidelines / policies to Trusts and Hospitals. In particular:

(a) How were new guidelines / practices which were developed elsewhere in the U.K. considered and adapted for use in Northern Ireland?

Ans: As a SMO I did not have any overarching role or responsibility in the dissemination of information/Guidance/policies to Trusts and Hospitals.

However within specific areas of work I may have been involved in issuing guidance and in considering UK guidance and the potential benefit of adopting, or adapting such guidance for application in Northern Ireland. I recall that when issuing guidance the Department would normally include relevant training bodies in a circulation list.

(b) How does new guidance find its way into medical training, at undergraduate and postgraduate level?

Ans: How such guidance would then find its way into medical training would be a matter for the relevant university and, for post graduate training, for the Northern Ireland Medical and Dental Training Agency (NIMDTA).

(c) How were issues that required the production of guidelines / policies flagged up to you or the Department by Trusts and Hospitals?

(i) The quality of care provided to patients

(ii) Ensuring that Trusts exercised their statutory duty to provide quality care

(iii) The implementation of guidelines / practices

Ans: I recollect that there were a range of mechanisms by which issues requiring guidance could be identified. These included letters to the CMO or policy colleagues, or discussion at Speciality Advisory Committees.

(37) How is it decided that an issue is one which can be handled by, or is limited to, a local hospital as opposed to something that is of regional significance?

Ans: My recollection is that this was decided on the basis of a judgement on the relevance of the issue to a single hospital or to all such facilities.

(38) Were there communications between the Chief Medical Officer and her team and any other parts of the Department about the performance of trusts in any of the following matters:

(a) Patient safety and care

(b) Quality of care

(c) Clinical governance

(d) Clinical complaints

(e) Clinical audit?

Ans: I would not have been closely involved in communication between CMO and other parts of the Department on these matters.

(39) If there were communications of the kind mentioned:

(a) Identify those with whom the CMO's team communicated.

(b) Please give examples of the matters which were the subject of the communications
(c) Were there established systems/forums in the Department for such communications?

Ans: In light of my response to Q38, I am unable to provide the further detail required in response to this question.

(40) What did you / the Department consider to be the role of the RBHSC in the dissemination of lessons learned / guidelines / protocols?

Ans: My recollection is that the Department considered all paediatric units to play a major role in the dissemination of Guidance as requested by the CMO in her covering letter to the Guidance.

(a) What would you have liked the RBHSC's role to have been?

Ans: I understood that the role of the RBHSC would be pivotal, as the regional children's hospital.

(b) The 2002 Guidelines state at **Ref: 006-054-438:** *"In the event of problems that cannot be resolved locally, help should be sought from Consultant Paediatricians / Anaesthetists at the PICU, RBHSC"*

(i) How did the Department decide that the RBHSC was going to take that role?

Ans: This matter was not decided by the Department. Rather, it was suggested by Working Group members who recognised that, in complex cases, the clinicians in the PICU in RBHSC were best placed to provide the necessary expert advice.

(ii) What was the kind of role the Department expected the RBHSC to have generally?

Ans: I do not recollect that the Department had explicit expectations for clinicians in the RBHSC, but was content that, in light of their expertise, they would be a source of advice for clinicians across Northern Ireland.

(41) Would you have expected the deaths of:

(a) Adam Strain

(b) Claire Roberts

(c) Lucy Crawford

to have been reported to you or the Department under the informal system? If so,

(i) To whom in the Department would it be reported?

(ii) What action, if any, would you have expected the Department to take?

Ans: Within the systems and procedures in place from 1997-2000 I cannot recall the specific expectations of the Department in regard to any informal system of reporting of deaths. In my role as advisor within the Medical & Allied branch, I would not have had responsibility for or been involved in discussions on this matter. Any response to this question would be speculative. I was not working in the Department between 1992 and 1997.

(42) Would you have expected the Department to have been informed of the statement produced by the RBHSC following the Inquest of Adam Strain? **(Ref: 011-014-107a)** If so,

(a) To whom in the Department would it be reported?

(b) What action, if any, would you have expected the Department to take?

Ans: I have answered this question in respect of Q 41 and the same answer applies.

(43) Would you have expected:

(a) The death of Adam Strain

(b) The statement produced by the RBHSC at Adam's Inquest (Ref: **011-014-107a**)

(c) Claire Roberts

(d) Lucy Crawford

to have been raised at a Special Advisory Committee (particularly the SAC on Anaesthetics in relation to (b))?

Ans: I have answered this question in respect of Q 41 and the same answer applies.

(44) You have told the Inquiry (**Ref: WS-080/1, p.2**) that you first became aware of the death of Lucy Crawford in March 2003. Arising from that;

(a) Please confirm whether you / the Department were made aware by the Sperrin Lakeland Trust during the period 2000-2002 of any untoward deaths occurring following treatment in the Trust's hospitals?

Ans: I was not aware of any communication between Sperrin Lakeland Trust and the Department regarding untoward deaths during the period 2000-2002.

(b) Would you have expected the Sperrin Lakeland Trust to have made you or the Department aware of the untoward and unexplained death of a seventeen month old child following treatment at the Erne Hospital? Please give reasons for your answer.

Ans: In the absence of a formal reporting mechanism in 2000, my understanding was that the Department would not necessarily have expected the Sperrin Lakeland Trust to have made officials aware of an unexplained death.

(45) What do you consider to have been the main impetus behind the creation of a formal adverse incident reporting system from 2002?

Ans: My understanding is that the adverse reporting system established in 2002 was in keeping with similar measures in other parts of the UK and the impetus was to establish a system by which through the reporting of rare events, patterns may be identified and regional learning taken forward.

(46) Why was a formal approach not adopted for adverse incident reporting prior to 2002?

Ans: This would have been outside my responsibilities and I am not in a position to comment.

(47) Prior to 2002, what would you / the Department have expected Trusts / Hospitals to have done (if anything) in regard to informing you when cases involving deaths due to possible medical mismanagement were involved in:

(a) Formal complaint procedures

(b) Coroner's Inquests

(c) Medical negligence actions

Ans: I have answered this question in respect of Q 46 and the same answer applies.

(48) The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis Q.C. was published on Wednesday 6th February 2013. One of its key recommendations was that of 'openness and candour', namely that: *"Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful."*

(a) What were your / the Department's expectations of how the Trusts dealt with the deaths of Adam / Claire / Raychel / Lucy, and how did their actions meet or fail to meet your expectations?

Ans: I have answered this question in respect of Q 46 and the same answer applies

(b) What were your / the Department's expectations in situations where the Trust(s) withheld relevant documents on grounds of privilege?

Ans: *It is not possible for me to answer this question which I interpret as being one about the legal implications of actions*

(c) What were your / the Department's expectations in situations where the Trust(s) did not make public acceptance of liability in medical negligence actions?

Ans: *It is not possible for me to answer this question which I interpret as being one about the legal implications of actions*

(49) In relation to the Specialty Advisory Committee (SACs):

(a) Please describe their purpose.

Ans: *My understanding was that the SACs provided a forum for discussion with the CMO on strategic issues, service provision and workforce planning.*

(b) Please state when they were created

Ans: *I do not know when SACs were created.*

(c) Please explain why they were created

Ans: *I do not know the rationale for the creation of SACs.*

(d) Please state whether you agree with the evidence of Dr. Elaine Hicks, Consultant Paediatric Neurologist, RBHSC at the Oral Hearings (**Transcript, 7th June 2013, p.22**) where she stated in relation to SACs:

"I think many of us were not convinced that it was as effective as it might have been."

Ans: *I am not in a position to comment on Dr Hicks' evidence. I attended a range of SACs as a medical secretary and was aware that they provided a useful forum for discussion. I was also aware that there was a view among Departmental colleagues and SAC members that the frequency of meetings (most were annual) meant the meetings were not designed to facilitate a response to the wide range of issues arising between meetings and for which alternative mechanisms were needed.*

(50) In relation to the "CMO update":

(a) Please describe its purpose.

Ans: *The CMO Update's purpose was to provide a regular communication with the medical profession on key matters of importance.*

(b) Please state when it was started.

Ans: *I note from records that the CMO update was established in 1994 and subsequently issued on a quarterly basis.*

(c) Please explain why it was started

Ans: *I was not working in the Department in 1994 and cannot comment on this.*

(d) Please explain who produced it and who decided its contents

Ans: My recollection is that the CMO update was produced by a SMO or medical officer in Medical and Allied branch, with administrative support.

(e) Please explain what preceded it in terms of provision of information.

Ans: I am not aware of what preceded the CMO update prior to 1994.

MEDIA INTERVIEWS 2003/04

The Inquiry has been given several transcripts of interviews Dr. Campbell gave as Chief Medical Officer to the media in the aftermath of Lucy and Raychel's deaths:

- 17th February 2003 – UTV **(Ref: 069A-033-078)**
- 17th March 2004 – BBC Radio Ulster Evening Extra **(Ref: 034-151-407)**
- 25th March 2004 – UTV's "The Issue"**(Ref: 006-037-375)**
- 25th May 2004 – The Impartial Reporter **(Ref: 034-142-372)**

At the time, you were providing briefing papers and lines to take for the Minister(s) for Health, Social Services and Public Safety, which you were also sending to Dr. Campbell (e.g. **Ref: 006-039-389 and 004-003-011**). The Inquiry would be grateful if you could address the following comments made by Dr. Campbell:

(51) What system did you / the Department have for researching to prepare briefing papers and lines?

Ans: When providing briefing I normally provided a summary of the relevant events and timeline. I would also, where relevant, provide background information on the matter in question, the frequency with which it may occur and its implications. When preparing submissions for the Minister, these would normally have been approved by CMO, or one of her deputies prior to being forwarded to the Minister.

Information provided in briefing papers was normally sourced from papers received from Trusts, commissioners, the coroner or other relevant parties.

For background information I would typically have extracted information from medical text books, e.g. Kumar and Clark or similar.

(52) What research did you do to prepare these particular papers?

Ans: For the particular papers cited I cannot recall the details of source papers but recollect that I drew information from the summary findings of the inquest, information from the post mortem and information presented in the hyponatraemia guidance.

(53) *"Of course it happens occasionally in very ill patients but we have never before seen it in a healthy child."* **(Ref: 069A-033-078)**

(a) Please state whether you agreed with this statement in 2003.

Ans: *I agree with Dr Campbell's comment that 'it happens occasionally in very ill patients'*

In regard to the second part of the sentence I am not entirely sure to what the term 'we' applies. Assuming it is the Department, yes I agree that the Department may not have been aware of fatal hyponatraemia occurring in a previously healthy child.

(b) Please explain whether you and Dr. Campbell discussed this opinion, either before or after the interview.

Ans: *It would have been normal practice for Dr Campbell to discuss with myself and other colleagues the relevant issues prior to any media interview and to specifically cover the key messages and how they were best articulated for the particular audience.*

My recollection is that the matter in question was discussed with Dr Campbell before media interviews. I cannot, however recall the detail or date of discussions on this particular matter.

(54) Dr. Campbell commented that Adam Strain's case was *"an entirely different clinical situation"* **(Ref: 069A-033-078)** to that of Raychel Ferguson.

(a) Please state whether you agreed with this statement in 2003.

Ans: *I agree with Dr Campbell's comment. When Departmental colleagues and myself became aware of the children whose deaths were associated with hyponatraemia we were aware that the clinical circumstances of each case were different. In particular we were aware that Adam Strain's case had aspects not shared in all the other cases – most notably he was a child with chronic renal disease, admitted for an elective procedure. My understanding was that other cases, (particularly Lucy Crawford and Raychel Ferguson) occurred in children previously well, admitted with an acute episode of illness.*

(b) Please explain whether you and Dr. Campbell discussed this opinion, either before or after the interview.

Ans: *My recollection is that the matter in question was discussed with Dr Campbell before media interviews. I cannot, however recall the detail or date of discussions on this particular matter.*

(55) *"It happens very rarely, but it has happened before. We didn't know that but we have now been able to put in place measures to help prevent it happening again."* **(Ref: 069A-033-079)**

(a) Please state whether you agreed with this statement in 2003.

Ans: *I agree with this statement. The measures initiated by CMO to develop and publish guidance did ensure that concise and accessible advice was available to all clinicians caring for children who required prescribed fluids. I understand this to be a major step in helping prevent any further cases of serious hyponatraemia.*

(b) Please explain whether you and Dr. Campbell discussed this opinion, either before or after the interview.

Ans: ***The impact of introducing the guidance and its role in preventing further cases of serious hyponatraemia was discussed on a number of occasions. This included discussion during the development of the guidance and subsequently after its publication when the CMO took steps to audit its use.***

(56) *"What we have recognised in the Health Service in the whole of the U.K. over recent years, is that by putting information together from every quarter of the U.K., that we can learn from the rare event, the untoward events. [...] Northern Ireland [...] is too small a place to effectively learn those lessons from rare events, so therefore we need to be part of a bigger picture."* **(Ref: 069A-033-079)**

(a) Please explain what has been done since June 2001 to put information together *"from every quarter of the U.K."*

Ans: ***I was not directly involved in measures to ensure that Northern Ireland learned "from every quarter of the UK". I understand, however, that, among other things, participation in UK audits – such as the Congenital Cardiac Audit Database (CCAD), the Cardiac Surgery National Audit, the National Joint Registry and a number of national cancer audits, we have been able to learn of service improvements and identify patterns in disease, morbidity and mortality.***

(b) Please explain whether you agreed, in 2004, with Dr. Campbell's statement that *"Northern Ireland [...] is too small a place to effectively learn those lessons from rare events"* in the context of the deaths under investigation by the Inquiry.

Ans: ***I agree, in part, with Dr Campbell's comment. With the relatively small population in Northern Ireland I understand that for some disease areas we will be too small to learn from rare events – an example is in paediatric cardiac surgery where we contribute to CCAD so that patterns can be identified for the entire population undergoing surgery across the UK.***

However, if I consider this matter in regard to more commonly occurring events I do not agree with Dr Campbell's comment. For these events, there is the opportunity to learn from the Northern Ireland position and this premise underpinned the establishment of the Serious Adverse Incident (SAI) reporting system within Northern Ireland.

(57) *"What we know now is that the fluids which were given to Lucy were the ones that were being used in ordinary custom and practice throughout the whole of the NHS except for one or two practitioners who'd begun to recognise this issue of hyponatraemia where the body goes through this abnormal response in just a very few cases and you being to get oedema or swelling of the brain."* **(Ref: 034-151-407)**

(a) Please state whether you agreed with this statement in 2004.

Ans: ***I agree with the comments that the fluids prescribed to Lucy were those 'used in ordinary custom and practice...' I recall that the fluids administered to Lucy were being used across the health service – and continued to be used widely until the NPSA published guidance in 2004.***

In regard to Dr Campbell's comment 'where the body goes through this abnormal response in just a very few cases', I agree that such events are rare, but I would not agree with the terminology 'abnormal reaction'.

My understanding was that this was not necessarily an 'abnormal reaction'. Rather, I understood that increased ADH secretion was a physiological response to stress, such as infection or surgery, and could therefore be considered as a child's anticipated response to such stress. This was emphasised in the guidance which advised that "stress, pain and nausea are all potent stimulators of ADH which inhibits water excretion".

Notwithstanding the above, I recognise that this is a complex matter and that I do not have expertise in this area. The evidence of one of the Inquiry's expert witnesses, Dr Jupp, stressed the complexity of hyponatraemia, suggesting that there may be some factors that can make one child more susceptible and vulnerable while another child of the same age and same situation may not have had reacted in the same manner.

In this, as in many interviews, the CMO would have had the challenging role of translating a complex matter into user-friendly accessible language. For particularly complicated matters, this has the potential consequence that the level of technical detail provided simply cannot reflect all of the relevant facts about the matter in question.

(b) Please explain whether you and Dr. Campbell discussed this opinion, either before or after the interview.

Ans: I recall this particular matter being discussed with Dr Campbell and other Departmental colleagues in advance of the interviews on 17th March and 25th March.

(58) *"On speaking with Sperrin Lakeland Trust it's quite clear that they did not realise at the time, nor would they have been expected to, that there were implications for the wider service from the case."* **(Ref: 034-151-408)**

(a) Please explain whether you agreed, in 2004, with Dr. Campbell's statement that Sperrin Lakeland Trust would not have been expected to realise that there were implications for wider service from Lucy's case.

Ans: Yes I agree with Dr Campbell's comment. At the time of Lucy's death there was no formal mechanism by which Trusts could readily report matters that could potentially have implications for the wider service

(59) *"This new and emerging problem of hyponatraemia or retention of fluids in a very small number of children"* **(Ref: 034-151-408)**

(a) Please explain whether you agreed, in 2004, with Dr. Campbell's statement that the problem of hyponatraemia or retention of fluids was *"new"* and/or *"emerging"*.

Ans: It was my understanding, based on discussions with the Working Group members, that hyponatraemia, or retention of fluids, reflected a child's physiological response to stresses and as such was unlikely to be new.

However, I agree with Dr Campbell's comments in the context that what was recognised and understood was that awareness and recognition of the risks needed to be improved among clinicians prescribing fluids to children.

(60) *"With Lucy, we saw the first test of what was a very rare occurrence, written up in the medical journals only recently"* **(Ref: 006-037-375)**

(a) Please state whether you agreed with this statement in 2004.

Ans: ***I agree with Dr Campbell's comment to the extent that serious hyponatraemia was rare and the evidence was emerging, as reflected in the Hyponatraemia Guidance issued to Trusts in 2002. I was aware that there had been a number of journal publications on this matter.***

(b) Please explain whether you and Dr. Campbell discussed this opinion, either before or after the interview.

Ans: ***My recollection is that the matter in question was discussed with Dr Campbell before media interviews. I cannot, however recall the detail or date of discussions on this particular matter.***

(61) *"The rarity in these 2 events [the deaths of Lucy and Raychel] was the abnormal reaction which is seen in a very few children to the normal application..."* **(Ref: 006-037-377)**

(a) Please explain if you considered / consider that Lucy and Raychel received a *"normal application"* of IV fluids.

Ans: ***I am not in a position to comment on whether Lucy or Raychel received a "normal application" of IV fluids. The coroner in each case concluded that the fluids received by Lucy and Raychel contributed to their hyponatraemia and subsequent demise.***

(62) *"In the knowledge of the evidence which has been in the medical journals over the past 4 years since Lucy's death, [the coroner's findings are correct], but in the light of what was known in the medical community throughout the whole of the U.K. in the year 2000, when poor Lucy died, there were very few people who would have known what was going wrong, apart from one or two experts who had begun to notice the very abnormal reaction in certain children."* **(Ref: 006-037-378)**

(a) What do you consider *"was known in the medical community throughout the whole of the U.K. in the year 2000"* regarding the dangers of hyponatraemia?

Ans: ***I would not have been familiar with what exactly was known in the medical community in the year 2000. In preparing the Hyponatraemia Guidance, however, working group members confirmed that knowledge and skills relating to paediatric hyponatraemia in children, its prevention and management were not widely available across the health service, hence the urgent need to prepare and disseminate guidance.***

In subsequent work as a member of the NPSA Working Group on hyponatraemia I was made aware that similarly, across the UK, it was considered that the ability to identify, monitor and treat hyponatraemia in children were not sufficiently known in the medical community.

(b) Please explain whether you agreed, in 2004, with Dr. Campbell's statement that *"there were very few people who would have known what was going wrong"*.

Ans: *In light of my response to 62 (a) I would agree with Dr Campbell's comment that too few people would have had the knowledge to fully understand what 'what was going wrong'.*

(63) *"The coroner and I together, both recognise that these 2 tragic deaths [Lucy and Raychel's] brought together as a pattern, then allowed us, to put two and two together and to recognise that there were some strange but rather unique features afoot which needed to be taken into..."* **(Ref: 006-037-378)**

(a) Please explain whether you consider / considered that Lucy and Raychel's cases shared *"strange but rather unique features"*.

Ans: *I am not entirely sure what was meant by 'strange and unique' and it is therefore difficult for me to comment on this.*

The CMO requested the development of Hyponatraemia Guidance in 2001, following the death of Raychel Ferguson. Subsequent knowledge of other deaths, including those of Adam Strain and Lucy Crawford, confirmed the need for guidance, which had been disseminated to Trusts before Lucy's death was known to the Department.

My recollection is that the clinical circumstances of each of these cases was consistent with the type of cases cited in the guidance, which included specific reference to post-operative circumstances, and vomiting and diarrhoea. Therefore, while serious hyponatraemia is rare, I would not necessarily have described the circumstances as 'strange and unique'

(b) Please explain if you recognised any pattern between the deaths of Raychel Ferguson and Adam Strain.

Ans: *At the time the Hyponatraemia Guidance was in preparation and Working Group members were aware of the deaths of Raychel Ferguson and Adam Strain, I recall recognising some common factors – including operative intervention, aspects of the monitoring, fluid requirement and fluid type. It would not, however, have been my role to make any formal assessment of patterns between the deaths of Raychel Ferguson and Adam Strain.*

(64) *"Going back to the year 2000, it would not have been unusual for a doctor or a group of experts not to have recognised what happened to Lucy. It is easier to do that in the knowledge of what has been presented to us through the medical journals in the last 4 years."* **(Ref: 006-037-379)**

(a) Please state whether you agreed with this statement in 2004.

Ans: *Yes, I agree with Dr Campbell's comment. By 2004, the hyponatraemia guidance had been in place for 2 years in Northern Ireland. It would, therefore have been expected that compliance with the Guidance would have facilitated clinicians in preventing hyponatraemia, and in recognising its signs and symptoms.*

(b) Please explain whether you and Dr. Campbell discussed this opinion, either before or after the interview.

Ans: *The benefits of preparing and disseminating guidance and its impact on increasing awareness of hyponatraemia and improving measures to prevents its occurrence would have been discussed with CMO prior to media interviews.*

(65) Provide any further points and comments that you wish to make, together with any relevant documents.

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

Signed: DM Carlisle

Dated: 26 September 2013.

RESUME

PERSONAL DETAILS

Name: Dr Miriam McCarthy

Home Address: [redacted]

Home Telephone No: [redacted]
Daytime Telephone No:
Mobile:
Email Address:

Date of Birth: [redacted]

PROFESSIONAL REGISTRATION

General Medical Council	Reg No: 2703491, Full Registration	1982

ACADEMIC QUALIFICATIONS

MB BCH BaO with Commendation in Obstetrics and Gynaecology	Queens University, Belfast	June 1981
Master of Public Health	University of Minnesota, School of Public Health	June 1994

PROFESSONAL QUALIFICATIONS

Diploma of the Royal College of Obstetricians And Gynaecologists (DRCOG)	1984
Member of the Royal College of General Practitioners (MRCGP)	1985
Membership of UK Voluntary Register for Public Health Specialists	2005
Membership of the Faculty of Public Health	2005
Fellowship of the Faculty of Public Health	2007

EMPLOYMENT

Consultant, Public Health	Strategic planning and service development in areas of medicines management, cancer services & specialist services	June 2011-
Deputy Secretary Healthcare Policy Group	Policy advisor on primary, secondary and community care	Feb 08 – May 2011
Director of Secondary Care, DHSSPS	Policy advisor on secondary care services	Apr 06 – Feb 08
Senior Medical Officer, DHSSPS	Professional advisor on health services policy and strategy	Oct 98 – Mar 06
Medical Officer, DHSS	Professional advisor on health services and Strategy	Aug 97 – Oct 98
Director of Community Health Initiatives, Hennepin County Minneapolis, USA	Design and delivery of local public health initiatives	Nov 96 – Aug 97
Independent Consultant, Self-employed	Independent consultant, family planning and adolescent health services	June 94 – Oct 96
Medical Officer, DHSS	Professional advisor on health services policy and strategy (including drug utilisation)	Aug 89 – Aug 92
General Practitioner	Principal in General Practice	Jan 86 – July 88
GP Trainee, NIPGMDE	Trainee in General Practice	Aug 84 – Dec 85
Senior House Officer (SHO) Mater Hospital	Obstetrics & Gynaecology rotation	Feb 84 – July 84
Locum Registrar Mater Hospital	Psychiatry rotation	Aug 83 – Jan 84
Senior House Officer (SHO) Whiteabbey	Medicine and care of the Elderly rotation	Feb 83 – July 83
Senior House Officer, Belvoir Park Hospital	Radiotherapy rotation	Aug 82 – Jan 83
Junior House Officer, Whiteabbey Hospital	Medicine & Surgery rotations	Aug 81 – July 82

PUBLICATIONS

McCarthy, M; Wilson-Davis, K; McGavock, H; Relationship between the number of partners in a general practice and the number of different drugs prescribed by that practice. Br J Gen Pract., 1992;42:10-12

McCarthy, M; Jacquart, K; Quam, L; Family Planning, Managed Care and Rural America, Western Journal of Medicine, September 1995 – Supplement to Vol 163, No 3

Jenkins, T; Taylor, B; McCarthy, M; Prevention of hyponatraemia in children receiving fluid therapy, Ulster Medical Journal Vol 72, No 2, pp 69-72, November 2003

Wilson, C; O'Mullan, S; McCarthy, M; Thrombolytic therapy for myocardial infarction facilitated by mobile coronary care. Ulster Medical Journal Vol 73, No 2, pp 77-84, November 2004

CHAIR/LEAD AUTHOR IN MAJOR POLICY& STRATEGY DOCUMENTS

- Joint Chair, Service Framework Board 2008- 2011
- SRO, Strategy on Maternity Services 2011
- Chair, Eyecare Strategy , 2011
- Chair, Policy Framework (Standards) for Long Term Conditions 2011
- Chair, North/ South Feasibility Study 2007 -2009.
- Senior Responsible Officer, Review of Pathology Services 2005- 2007
- Chair, Teenage Parenthood Strategy 2001-2006
- Member, NPSA Hypotonic Fluids Group 2005 – 2006.
- Project manager, Guidance on Management of Gynaecological cancer 2003
- Lead author, Guidance to prevent Hyponatraemia in children receiving IV fluids 2003
- Co-Chair N/S Paediatric Cardiac Group 2005-2011
- Member, Working Group on Paediatric Cardiac Services 2012-2013
- Member, Regional Radiotherapy Programme Board 2011-present
- Chair, Regional Radiotherapy workforce Planning Group
- Chair and member of regional service reviews including Review of Genetics, Cardiac surgery, Review of Cardiology, Review of Neonatology, 2002-2011

PRIZES

Delta Omega Public Health Award	Awarded by the University of Minnesota June 1994.
Stevenson Prize in Public Health	Awarded by the Northern Ireland Affairs Committee, Faculty of Public Health Medicine, 1998.

WORK FOR OTHER ORGANISATIONS IN THE HEALTH SERVICES

Member of a NICE Technology Appraisal Committee 2013-

WORK FOR CHARITIES / SOCIETIES

Council Member of the Ulster Medical Society. 2002-2005

Trustee for *Pennell*, a national charity promoting the health of older women. 1999-2004

Trustee for *Hope for Youth*, a charity promoting life opportunities for youth 2012-

Issued to candidates

Job Specification

Dr Mairs
Dr McCarthy

SB/55/98 2/95

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

SENIOR MEDICAL OFFICERS

5 YEAR FIXED TERM CONTRACT (with the possibility of conversion to permanency)

SALARY: **£39,830 - £62,570(under review)**

This memorandum should be read in conjunction with the enclosed leaflet "Information for Applicants". Completed application forms, which demonstrate the qualities sought, must be returned to Recruitment Service, Northern Ireland Civil Service, Orchard House, 40 Foyle Street, Londonderry, BT48 6AT, to arrive not later than the closing date of Friday 28 August 1998.

CVs will not be accepted in place of completed application forms.

GENERAL BACKGROUND

At present there are two Senior Medical Officer vacancies. The successful candidates will be based at Castle Buildings, Stormont, Belfast. The responsibilities of the Medical and Allied Group within the Department of Health and Social Services (DHSS) are:-

(i) to monitor the state of health of the public in Northern Ireland and to advise Northern Ireland Government Departments on matters relating to the protection and improvement of public health;

(ii) to advise the DHSS on medical matters relating to the Health and Personal Social Services;

(iii) to provide certain medical services for Northern Ireland Government Departments eg Prison Medical Service, Occupational Health Service to NICS, Employment Medical Advisory Service and Medical Referee Service.

Within the Medical and Allied Group, in addition to the Chief Medical Officer (CMO) and the Deputy Chief Medical Officer (DCMO), there are 2 Principal Medical Officers, 10 Senior Medical Officers and 21 Medical Officers.

DUTIES AND RESPONSIBILITIES OF THE POSTS

The postholders will be involved mainly with promoting and improving the health of the public in Northern Ireland, by providing advice to the CMO on formulation, interpretation and implementation of Departmental policy.

The postholders will operate in a complex environment which demands an awareness of current issues in the areas of public health. This information must be interpreted in the light of current policy and legislation, scientific or medical advances and organisational change.

Responsibilities will require the postholders to liaise with many different agencies, embracing Government Departments at NI and UK levels, Health and Social Services Boards, medical and allied professionals, environmental health departments and professionals within the health education sector.

The CMO and Minister will be heavily dependent on the postholders for providing expert advice and information in the fields of public health, environmental health and communicable diseases. The provision of this information and advice is crucial to the delivery of improvements in the public health in Northern Ireland. Accountability for the impact of the decision, information or advice is to the Department and the Minister but ultimately and also very importantly, to the general public. Professional accountability is directly to the CMO.

The nature of the work will involve the need to make rapid decisions on public health risks, often on the basis of limited or incomplete data. It is essential for the postholders to be up to date on medical and public health issues including recent advances and development work both nationally and internationally.

The postholders are also accountable to the Chief Executive of the Health and Social Services Executive (HSSE) for the quality of the medical advice given to the HSSE.

Sound judgement regarding strategic approaches will be critical to these positions. The relative effect of strategic decisions will vary greatly and will impact upon existing programmes, media campaigns, resources and public awareness.

Where decisions must be made as a matter of urgency, for example as in the case of an outbreak of communicable disease, an environmental emergency, the issue of Hazard Notices or blood safety issues, the postholders must exercise considerable judgement and common sense. Many of the issues will have a high public or media profile and therefore political sensitivity is an essential quality.

In providing advice to the DCMO/CMO on management and policy issues - the postholders must prioritise and ensure that those issues which senior management should be immediately aware of are brought to their attention particularly in sensitive areas concerning public health matters e.g. breast screening, hepatitis, etc.

By their nature the posts will have limited executive authority. Consequently the postholders will depend heavily on the ability to influence a wide range of individuals and bodies including the public and medical professionals as well as colleagues in DHSS, HPSS and

other government departments. A high level of professional and personal credibility is essential for this to happen.

QUALIFICATIONS AND EXPERIENCE

Applicants must:

1. hold or be entitled to hold full registration with the General Medical Council and currently be entitled to practice;

2. have at least 5 years' post full registration experience gained within the last 8 years;

3. be able to demonstrate an understanding of the major public health issues and how they may be tackled;

4. be able to demonstrate an understanding of the major clinical issues facing the Health and Social Services;

5. be able to demonstrate that they meet the competence requirements of the Northern Ireland Senior Civil Service. These are set out at Annex A;

6. possess a full current driving licence which enables the holder to drive in Northern Ireland and have use of a vehicle for official purposes, or have access to a form of transport which will enable the applicant to meet the requirements of the post in full.

Applicants should be aware that after an eligibility sift, should shortlisting be required it may be necessary to apply one or more of the following criteria, in the following order:-

(i) possession of a higher medical qualification (ie membership or fellowship of a Royal College or Faculty);

(ii) the experience at 2 above may be extended incrementally up to 8 years.

APPOINTMENT

The appointment will be made within the Senior Civil Service. Salary will be within the range of £39,830 - £62,570 (From 1 December 1998 £40,420-£63,490) and progression will be mainly determined by performance. The post offers a non-contributory pension scheme.

The appointment will be for a period up to 5 years with the possibility of conversion to a permanent appointment.

As a condition of the appointment for a non civil servant, the successful candidate will be required to agree in writing that, if the appointment is not renewed or made permanent at the end of the fixed term period, he/she will have no right of appeal to the Civil Service Appeal Board and will be excluded from making any claim to an Industrial Tribunal in respect of the

right of an employee under Article 126 of the Employee Rights (NI) Order 1996 not to be unfairly dismissed. Article 240(1) of that Order, permits the exclusion, by agreement; of any such claim where the dismissal consists only of the expiry of the fixed term, without it being renewed or made permanent, in the case of an appointment for a fixed term of one year or more.

The service rendered during the period of appointment will not count for the purpose of eligibility for compensation made by Government Departments analogous to the provisions of the Contracts of Employment and Redundancy Payments Act (NI) 1965.

If a Northern Ireland Civil Servant is successful, their terms of appointment will be governed by paragraph 4.11 of CSC 38/92 which is currently under review.

The normal retirement age for this post is 60.

In addition to the usual public and privilege holidays, there is annual leave allowance of 30 days

Assistance with relocation expenses may be available.

GENERAL

The Department may decide to interview only those applicants who appear from the information available, to be most suitable.

Applicants who wish to learn more about the posts before deciding to apply may telephone Dr Boyle on Belfast (01232) 520713 or Dr Mock on Belfast (01232) 520710.

The Northern Ireland Civil Service is committed to equality of opportunity in employment. **All applications for employment are considered strictly on the basis of merit.**

The Service welcomes applications from all suitably qualified applicants, irrespective of religion, gender, disability or race. As Roman Catholics are currently under-represented at this level in the medical discipline in the Northern Ireland Civil Service applications from the Roman Catholic section of the community would be particularly welcome.

THIS MEMORANDUM SHOULD NOT BE TAKEN AS CONSTITUTING CONDITIONS OF EMPLOYMENT

NORTHERN IRELAND CIVIL SERVICE

SENIOR CIVIL SERVICE COMPETENCIES DEFINITIONS

1 *LEADERSHIP*

Creates and broadcasts a vision for the future, reflecting interpretation of issues in their broad context and analysis of challenges and opportunities the organisation will encounter. Through personal drive and example builds the enthusiasm and commitment in their team to persist with firm strategies, achieve long-term goals, and set the highest standards of integrity and service.

2. *CONCEPTUAL AND STRATEGIC THINKING AND PLANNING*

Identifies all the current and future factors and their pattern of inter-connection which make up the broad picture that must guide strategy development. From grasp of the broad picture articulates strategic options for delivering Government policy, and evaluates them by predicting likely outcomes under possible contingencies. Translates strategy into practical, achievable goals, identifying and focusing upon those areas of action which are key to accomplishing the vision and strategic objectives.

3. *FOCUS ON OUTCOMES*

Takes responsibility for achieving specific, challenging objectives within agreed time scale and budget, and meeting or exceeding required quality standards. Displays drive, energy, determination, resilience and the capacity to mobilise people and resources to greatest effect, towards achieving customer orientated results. Copes well with change and is ready to challenge existing ways of thinking/behaving in a persistent search for ways of improving performance.

4 *MANAGING AND DEVELOPING STAFF*

Manages staff to perform to their potential through agreeing clear expectations, setting challenges which generate their enthusiasm and commitment, promoting their rounded development and giving support when

appropriate. Demonstrates commitment by making effective use of well developed interpersonal skills and spends time in pursuit of these aims.

5. *MANAGING RELATIONSHIPS AND PARTNERSHIPS*

Seeks to collaborate and build networks and partnerships with internal and external individuals/groups. Uses influencing and negotiating skills to secure agreement to work towards objectives of benefit to the collaborating partners, own parts of the organisation, the Service as a whole and the wider society, ensuring clear accountability.

6. *COMMUNICATION*

Perceptive in identifying when and what to communicate. Shows clear recognition that communication is a two way process, demonstrating the capacity to listen and respond to the views, needs, feelings and concerns of others.

7. *MANAGING RESOURCES INNOVATIVELY*

Recognises that gaining maximum value from finite resources requires continuous critical examination of how they are deployed. Shows the ability to break out of established ways of thinking in the search for innovative ways of improving performance. Innovates without compromising on essential standards or putting the organisation under unsustainable pressure.

8. *PERSONAL EFFECTIVENESS*

Displays the confidence, quickness of intellect and grasp of complexity, to be consistently effective in decision making in a fast changing and often ambiguous working environment. Able to manage work pressures well, showing both resilience and tenacity.

Addition and amendment to WS-080-2 - Dr Miriam McCarthy

Please find an addition to my witness statement regarding Q. 14(e)

(i) Yes, I recall seeing the bar chart

(ii) The inclusion of two deaths in the data emphasised the need for evidence to be produced without delay

(iii) The Department did not conduct investigations into the circumstances of the two deaths. My response to 9(a) provides the rationale for this position

My other amendments are as follows:-

Q32 - I became aware of the death of Conor Mitchell on 13 May 2003, and informed the CMO and Dr Carson immediately.

Q57 - Amend last line to read until the NPSA issued a safety alert in 2007