

An Roinn

Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhespsor.gov.uk

From:

Dr Miriam McCarthy

Date:

26 January 2005

To:

Neil Magowan

CC:

INQUIRY INTO HYPONATRAEMIA – RELATED DEATHS

Your e-mail correspondence of 17 January refers. I am responding on behalf of Medical and Allied.

- 1. I confirm that all records and papers held by Medical and Allied Branch relating to the deaths of Adam Strain, Lucy Crawford and Raychel Ferguson have been forwarded to Mr Gowdy.
- 2. Individuals within Medical and Allied who were involved in matters relating to the deaths of Adam, Lucy and Raÿchel are as follows:
 - Dr Henrietta Campbell Chief Medical Officer

Dr Henrietta Campbell provided Ministerial advice, press briefings and interviews. She also established the Hyponatraemia Working Group, responsible for the production of guidance on the prevention of hyponatraemia, following the death of Raychel Ferguson.

• Dr Paul Darragh - Deputy Chief Medical Officer 2000-2002, currently Consultant in Public Health Medicine, EHSSB

Dr Darragh chaired the first meeting of the Hyponatraemia Working Group in September 2001.

• Dr Ian Carson – Deputy Chief Medical Officer 2002-current. Advisor to Chief Medical Officer 2000-2002.

Dr Carson provided input on Ministerial briefing and press statements.

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• Dr Miriam McCarthy - Senior Medical Officer

Dr McCarthy drafted Ministerial briefings, submissions and statements. She chaired the Hyponatraemia Working Group (following the first meeting) and drafted the guidance on the prevention of hyponatraemia in children (published March 2003).

• Dr Margaret Mark - Medical officer

Dr Mock attended the first meeting of the Hyponatraemia Working Group and drafted minutes of the meeting. She had no other involvement in matters relating to the deaths of Adam, Lucy or Raychel.

3. The following individuals were members of the Hyponatraemia Working Group or were consulted for advice during the preparation of guidance. In this capacity they provided advice on the formulation of the guidance on the prevention of hyponatraemia in children, but were not involved in matters directly relating to the death of Adam, Raychel or Lucy:

Dr B Taylor	Consultant	RBHSC
Dr P Crean	Consultant	RBHSC
Dr D Lowry	Consultant	CAH
Dr J Nesbitt	Consultant	Altnagelvin Hospital
Mr B McCallion	Consultant	RBHSC
Dr C Loughrey	Consultant	BCH
Dr J Jenkins	Consultant	Antrim Area Hospital
Ms E McElkerney	Directorate Manager	r kitti r ki ou i iospita.
,	of Child Health	Ulster Hospital
Dr E Summer	Consultant	Great Ormond Street
	(retired)	Hospital, London

In addition the following individuals were consulted in 2004 when the guidance was reviewed:

DR MIRIAM McCARTHY Senior Medical Officer

DHSSPS

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