McCarthy, Miriam

From: McCarthy, Miriam
Sent: 14 November 2004 17:32
To: 'j.jenkins[redacted]
Subject: RE: CONFIDENTIAL MESSAGE FOR DR McCARTHY

John,

I am happy to discuss and will call you tomorrow. I have collated a file of papers that were used in formulating the guidance and will get a copy for you--it mostly consists of e-mail correspondence.

I also have notes of 'phone calls that confirm when I was made aware of each death.

Will talk tomorrow

miriam

-----Original Message-----
[redacted]
mailto:j.jenkins@[redacted]
ent: 12 November 2004 8:56
To: Miriam McCarthy
Subject: CONFIDENTIAL MESSAGE FOR DR McCARTHY

Miriam

I have tried to detail my understanding of some of the issues and will be grateful if you can confirm whether you are aware of any factual inaccuracy in the following. If not I intend to send it to the Medical Protection Society (as part of a longer letter) as soon as possible to seek their advice. Can you also confirm whether the names or details of any of the children who had died were discussed at the Working Group, and if so which ones? I will be grateful for copies of any minutes, emails or other documents relating to the working group that you are able to obtain.

I will be grateful for an early response as I need to let the MPS know as soon as possible. I will be in Castle Blds on Thursday and Friday for meetings if it would be useful to discuss.

.any thanks

John

"Ulster Television broadcast a programme in their "Insight" series on 21 October 2004 entitled "When Hospitals Kill". This was the follow-up to a programme which had been broadcast on 25 March 2004. Both programmes related to the deaths of children from hyponatraemia in Northern Ireland. Dr Campbell had been interviewed for the first programme, following which the reporter (Mr Trevor Birney) contacted me as he had heard that I had been involved in a Working Group set up by Dr Campbell to consider the issue of hyponatraemia and to prepare guidelines which were subsequently issued by her to the Health Service in Northern Ireland. I have not myself had any direct involvement in the clinical care of any of the 3 children. I agreed to meet with Mr Birney and did so in my office initially to try to explain to him the nature of the condition of hyponatraemia and the work which had been done in Northern Ireland to produce guidelines and reduce the risk of future occurrence of death from this condition. Following this initial meeting he asked me to agree to be interviewed for a programme and I agreed on the specific understanding that I would not discuss issues relating to individual children, but rather relating to the condition of hyponatraemia and what had been done locally. This interview took place in Antrim Hospital on 26 May 2004. I was surprised and disappointed to see, when the programme was broadcast recently, that the only part of this interview which Mr Birney chose to use was one clip of a few seconds in which he described me as "Dr Campbell's Advisor on the issue of fluid

DHSSPS

management and a leading figure on the Working Group set up to look at the whole issue of hyponatraemia". In the context of a discussion of the work undertaken by the Working Group I made the comment that it was after 2 children had died that we recognised that we needed to look at this, and that Dr Campbell (Chief Medical Officer) had set up a Working Group which met first in September 2001. He then asked me who were the 2 children and I replied that they were Lucy Crawford and Rachel Ferguson. This reflected my understanding that part of the impetus for establishing the Working Group was that the Department had become aware of the death of Rachel Ferguson in Altnagelvin Hospital in 2001, and that the other child had been Lucy Crawford (who had died in April 2000). This understanding was based on a statement made by Dr Campbell during the programme in March 2004 that her Department had become aware of Lucy Crawford's death around the date of Rachel Ferguson's in June 2001.

In fact I have subsequently been informed by Dr Campbell that her Department were not aware of the death of Lucy Crawford at that time but that the second child was Adam Strain who had died some years previously in Belfast. I had had no involvement in or knowledge of the care of that child or any subsequent proceedings, and so assumed that the 2 children were the 2 who had subsequently (in 2002) became known to me as I was asked by the Trusts involved to prepare legal reports in respect of civil litigation by the families, and later by the Coroner to appear as an expert witness at Inquests.

Mr Birney then went on to imply that Dr Campbell had been inconsistent in her interview in March 2004 in saying that she learnt of the event of Lucy's death in June 2001, but later revising this to March 2003. He then stated that I had said that Dr Campbell told me about this death in September 2001. This is incorrect. My statement during the interview in relation to the names of the 2 children was based on my own understanding from Dr Campbell's interview, and not to any direct communication from Dr Campbell. I only became aware of the identity of Lucy Crawford subsequently."

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Dr J G Jenkins
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