KNOWLEDGE OF CLINICIANS ON THE CMO'S WORKING GROUP
First meeting on 26th September 2001[1] – Guidelines provided on 26th March 2002

	ADAM	CLAIRE	LUCY	RAYCHEL
Robert Taylor[2] *Consultant Paediatric Anaesthetist, RBHSC*	Anaesthetist in Adam's surgery. Discussed hyponatraemia guidelines at Sick Children Liaison Group meeting on 26.06.2001 (Ref: WS-008/1, p.15)	Examined Claire in PICU (Ref: WS-157/1 p.2)	Chaired RBHSC audit (mortality) meeting at which Lucy's death was listed (Ref: 061-038-123)	Copied into Dr. Carson's email to the CMO of 30.07.2001 referring to 5-6 deaths over a 10-year period of children with seizures (Ref: 021-056-135). Reported Raychel's case to the Medicines Control Agency on 25.09. 2001 (Ref: WS-008/1, p.18)[3]
Peter Crean[4] *Consultant Paediatric Anaesthetist, RBHSC*	Knew about fluid issues in Adam's case & approved the draft statement recommendations (Ref: 060-014-025)	Named Consultant on Claire's Case Note Discharge Summary (Ref: 090-009-011)	Treated Lucy when she was transferred to the RBHSC (Ref: 013-021-071)	Had overall responsibility for Raychel's care after she was transferred to RBHSC (Ref: 012-032-159) Attended meeting of Paediatric Anaesthetic Group on 26.11.2001 where Raychel was discussed (Ref: WS-038/1, p.14)
Clodagh Loughrey *Chemical Pathologist, BCH*	Coroner informed her of Adam's case on 29.11.2001 (Ref: 007-025-048)			Contacted by Dr. Herron between 13.06 & 03.09.2001 (Ref: WS-041/1, p.3). Sent Raychel's papers by Dr. Herron on 03.09. 2001 for an opinion on the cause of the profound hyponatraemia (Ref: 012-063g-322)

1 Dr. Taylor "*informed the meeting about the background, incidence of cases seen in RBHSC*" – Ref: 007-048-094

2 Member of Department's Working Group (1997-1999) reporting on 'Paediatric Surgical Services in Northern Ireland' – Ref: 306-079-001. He founded the Sick Children Liaison Group in 2000 - Ref: 093-035-110n. See Minutes of the 26.06.2001 meeting - Ref: WS-008/1, p.15

3 Dr. Taylor informed MCA that he was conducting an "audit" of children admitted to PICU, with initial results indicating "*at least 2 other deaths attributable to the use of 0.18NaCl/4% Glucose*" – Ref: 012-071e-412

4 Established the Paediatric Anaesthetic Group in 1999 (Ref: WS-038/3 p.3)

Geoff Nesbitt[5] *Consultant Anaesthetist, Altnagelvin, Clinical Director*	May have known about Adam's death before the meeting (Ref: 095-011-059a)			Attended Raychel following her collapse & participated in the 12.06.2001 Review meeting[6]
John Jenkins[7] *Consultant Paediatrician, Antrim & Senior Lecturer in Child Health, QUB*			Provided Report on Lucy's case dated 07.03. 2002 (Ref: 013-011-037)	Received Dr. Taylor's letter to Dr. McAloon on 02.10.2001 referring to hyponatraemia and a paediatric death (Ref: WS-059/2, p.16)[8]
G Marshall[9] *Consultant Surgeon, Erne*				
David Lowry *Obstetrician & gynaecologist, Clinical Director, Craigavon*				Attended meeting of Paediatric Anaesthetic Group on 26.11.2001 where Raychel was discussed (Ref: WS-038/1, p.14)
Elizabeth McElkerney[10] *Nurse & Directorate Manager, Women & Child Health, Ulster*				

[5] Around mid-June 2001 *"I requested that any data on hyponatraemia or incidence of this is Northern Ireland would be helpful and Dr. Taylor … agreed to send me these details"* – Ref: WS-035/1, p.3. Shortly after Raychel's death he also learned from RBHSC about a death there in "1997" – Ref: 023-010-015

[6] Gave evidence of a conversation with Dr. Chisakuta mid-June 2001 re: change in use of Solution no. 18 in RBHSC following *"several deaths"* and Craigavon also trying to change - Ref: 022-102-317

[7] Present at CREST meeting of 08.11.2001 when Dr. McCarthy reports that the 'hyponatraemia problem' has come to the *"attention if the Department through clinician, who reported an increase in the condition and felt in need of urgent guidance"* – Ref: 075-066-213

[8] Dr. Taylor's letter also stated that he had *"audited our incidence of admissions to PICU with hyponatraemia"*

[9] The Medical Director, Dr. Kelly, notifies all consultant paediatricians and staff grades on 21.06.2001 of the circumstances of Raychel's death due to hyponatraemia that was discussed at a Medical Directors' meeting on 18.06.2001 – Ref: 022-025a-068. The *"Medical Directors present were able to report a number of near misses around the province … It also appears that the [RBHSC] … no longer uses No 18 solution post surgery or for rehydration"* – Ref: 036a-055-141. Dr. Fulton (the Medical Director At Altnagelvin) agrees with Dr. Kelly's account referring to *"several anaesthetists present … said they had heard of similar situations though it was not clear if there had been fatalities"* – Ref: 160-143-002

[10] Member of Department's Working Group (1997-1999) reporting on 'Paediatric Surgical Services in Northern Ireland' – Ref: 306-079-001