Friday, 8 November 2013

(9.45 am)

(Delay in proceedings)

(10.35 am)

THE CHAIRMAN: Good morning, ladies and gentlemen. I'm sorry we're sitting late today. As I think you know and some of you have directly experienced, there has a been a lot of traffic disruption because of an accident on the motorway coming out of Belfast, and unfortunately that has involved one of our team, John Stewart, who was due to question Dr Carson this morning. We've had a message on behalf of Mr Stewart, to say he can't now be here today.

I'm sorry, Dr Carson, I can't arrange at such short notice to have another member of the team question you, so we'll see if that can be sorted out for next week. What we will do today -- and I should say thank you to everybody else who's struggled through delays and traffic to get here today; I'm sure it's made things very awkward.

What we'll do this morning is hear from Mr Simpson, Mr Reid will question Mr Simpson, and then we'll have to call a halt to proceedings for today and we'll resume on Monday. After Mr Simpson's evidence, I will say some more things about how I envisage next week proceeding

and then we'll break and the charity coffee morning, which has been arranged, will then take place.

Mr Reid?

MR REID: Thank you, Mr Chairman. If I could call Mr Paul Simpson, please.

MR PAUL SIMPSON (called)

Questions from MR REID

MR REID: Mr Simpson, you have made two witness statements to the inquiry. For reference purposes, they are WS084/1, dated 4 July 2005, and a second statement, WS084/2, dated 7 September 2013. Is that correct?

A. That's correct.

Q. And you wish to adopt those witness statements as your evidence before this inquiry?

A. I do.

Q. Thank you. Just for clarity, have you made any other statements to any other body regarding these events?

A. No.

Q. Thank you. If I can bring up your second witness statement, 084/2, at page 2, please. There's a quick synopsis of some of your career history. What we can see there is, if we look at 1(a)(i), that you became deputy chief executive of the Health and Social Services Executive in February 1991; is that correct?

A. That's correct.

Q. And is it correct to say that the Health and Social Services Executive is what know or what we've been referring to as the Management Executive?

A. Yes. At the time I was appointed, it was known as the Management Executive and then subsequently more often to Health and Social Services Executive, but they're the same organisation.

Q. Then in April 1997, after Mr Gowdy, who was the chief executive of the Management Executive became Permanent Secretary, you became chief executive of the Management Executive?

A. That's correct.

Q. And you were in that position until December 1999?

A. That's right.

Q. Then from January 2000, the Management Executive was subsumed within the department structure; is that right?

A. That's correct, yes.

Q. And you became deputy secretary of the HPSS management group. If I can bring up reference 323-027e-003, please. On the right-hand side there we can see "HPSS management group" with Mr Gowdy as the Permanent Secretary above it, and then you as deputy secretary in charge of that management group; is that right?

A. That's correct, yes.

Q. We can see that in general, the department split into two groups, the planning and resources group on the one hand and the management group on the other hand.

A. That's correct.

Q. With the professional officers, the CMO, CNO and so on, they're a separate entity?

A. Yes.

Q. Then from July 2003, you became deputy secretary of the strategic planning and modernisation group.

A. That's correct .

Q. How did that differ from the management group?

A. Let me just check this for you. Well, I took over as the deputy secretary in the strategic planning and modernisation group, and then had basically five sections reporting to me, which was the modernisation unit, a strategy unit, or development of strategy unit, human resources for the Health Service, a public safety unit. The department had taken on responsibility for public safety on devolution, so public safety there meant basically the Fire Service and the Ambulance Service. And then lastly, information technology. So it was really quite a change from the previous post of HPSS management group, quite a significant change.

Q. If we bring up 323-027d-001, please. It's not coming up, but I think it shows perhaps the further restructure

in 2003, which you have just mentioned. By deputy secretary, let's be clear, it means you're the head of that group, but you're the deputy to the Permanent Secretary; is that correct?

A. That's correct.

Q. Now, if we can bring up Mr Gowdy's witness statement,WS062/2, page 3, please. He's asked to explain the role of the Management Executive and he states:

"It was primarily established to act as the operational arm of the department. It was concerned to oversee and support the establishment and performance of the trusts and other operational health bodies within the HPSS in Northern Ireland. As such, it was charged with ensuring that contemporaneous government policies in relation to health and social care matters, such as the operation of the internal market in healthcare and the delivery of services, were properly implemented."

Is that an accurate description of the role of the Management Executive as far as you're concerned?

A. Yes.

Q. So would it be fair to say that you were in a similar role? Apart from the change in the group in 2003, you were in a similar role from 1997 all the way through to 2006?

A. No, I think that would not be correct.

Q. If you can explain why it wasn't.

A. From 1997 to 2000, chief executive of the Management Executive had a particular set of responsibilities. They changed then with the abolition of the executive in 2000. For example, from that point on, until 2003, I no longer had responsibility, for example, for finance or, for that matter, IT. There were a number of things that were dropped and it was a smaller role. Then from 2003, as I've explained, until I finished in the department with the strategic planning modernisation group, again it changed. So there were really three quite different roles from 1997 through to 2006 when I left the department.

Q. In terms of that, as Mr Gowdy says there, the overseeing and supporting in the establishment of performance of trusts and other health bodies, to what extent were you involved in that between 1997 and 2006?

A. Principally, I think I say in my witness statement, principally my relationship was with the boards rather than with the trusts. The trusts -- basically, our take on all of this in the Management Executive was that we held the trusts to account through their relationship with the boards. So my principal relationship was with the boards.

Q. Okay.

A. Sorry, I should maybe go on. That doesn't mean to say I didn't have interactions with the trusts, I did, but not in the sense of a formal accountability. Mostly my involvement with trusts during that period would have been in relation to financial performance, capital investment proposals, issues of that kind.

Q. Yes. During that period of time you were leaving the trusts, as far as they could be, to be autonomous bodies?

A. Yes. There was an issue for us, really, even from the time that I was deputy chief and then succeeded John Hunter or Clive Gowdy as chief, that it was important not to undermine the authority of boards in relation to the trusts. If it appeared as if we were holding the trusts and the boards equally to account, we'd have two lines up to the department, that would have made it more difficult for the boards to get what they wanted from the trusts. So we always tried to maintain that pressure of making the trusts report to the boards and then we held the boards to account.

Q. Are you saying that you were concerned that by the department intervening too much in what trusts were doing, it would undermine the boards --

A. Yes.

Q. -- who were the primary body who the trusts were accountable to?

A. Indeed.

Q. Have you been here on other days this week during witnesses giving evidence?

A. Yes, I was present for Mr Gowdy's evidence on Wednesday and for Dr Campbell's evidence yesterday.

Q. Have you had the opportunity to see the evidence as well of Mr Hunter, the predecessor?

A. Yes, I've read through his transcript.

Q. And Mr Elliott as well, the permanent secretary before Mr Gowdy?

A. Yes.

Q. So this week we've traversed the issues with your Permanent Secretary, your CMO and your predecessor.

A. Yes.

Q. You have heard there evidence. Is there anything in particular you would disagree with in the evidence that they've given?

A. No, there wouldn't be. Maybe, chairman, one point for information. When I took over as chief executive in April 1997, there was a slight change in the scope of the role of the executive, and that was that from that point on, the executive was not responsible for health estates, which meant that we were not directly

responsible for the adverse incident reporting centre that was in health estates. From the point that Mr Gowdy became Permanent Secretary, health estates reported directly to him.

Q. And those were the adverse incidents in relation to plant or medical equipment --

A. Exactly.

Q. -- and so on. If I can bring up witness statement 084/2, your witness statement, at page 4, please. Just starting at the bottom of that page, I think this is perhaps setting out what you have just been saying.

A. Yes.

Q. In that there was a Management Executive circular in 1993, accountability framework for trusts, and you say:

"This set out the general light touch approach determined by ministers for the monitoring of trusts by the department. There is nothing in the circular which specifically requires trusts to account for clinical standards or safety."

Is that right?

A. Yes.

Q. If we turn over the page to page 5, please. You state:

"The intervention by the Management Executive in the affairs of a trust --

And is this directly from the circular?

A. Yes.

Q. "... should be exceptional in line with the principles of maximum delegation. It may be judged necessary in certain circumstances, for example items of concern relating to patient or client care."

If I can ask you about that. Can you give any example, without giving specific details, of when the Management Executive did intervene in items of concern relating to patient or client care?

A. I really can't in relation to my time. I can't recall anything specifically related to individual patient and client care, no.

Q. Can you think of any circumstance in which the Management Executive would have intervened in the -- that would have satisfied that criteria?

A. Yes. Obviously, the cases, the tragic deaths that this inquiry is related to, looking back I certainly would have thought that those would have been the kind of instances that should have been brought to the attention of the department. Maybe not necessarily directly to the Management Executive, but at least certainly through the professional medical network.

Q. In order to find out about, say, the certain circumstances like those items of concern, where would the Management Executive have gotten that information

from?

A. It was very much a reactive situation. We didn't -- there was no system in place by which we would have been asking trusts to, in a sense, check down a list of things and, if it met certain criteria, report it. It was very much on the basis of an assumption on our part that the trusts would know themselves if there were instances which affected patient care, that they should let us -- so we were relying very much on their judgment to let us know if things were going wrong.

Q. Would it be a two-way thing? Firstly, that you were reliant on the trusts self-reporting items of concern to you?

A. Yes.

Q. And secondly that you were reliant on the boards having a system for holding the trusts to account for checking if there were items of concern?

A. Yes, that's right.

Q. So with this concept of trust autonomy, if trusts were inadequately going about their functions, would that have been an issue for the department to sort out or for the boards to sort out in your opinion?

A. I think it would depend very much on what the circumstances were, what were the actual events that were causing the problem. I mean, certainly in terms of

the Management Executive's principal interest, it would have been if trusts were, for example, not meeting targets set out for them in the management plans or if there were issues to do with financial performance. Those were the sorts of things that I would have been paying attention to.

Q. We've said there's two things. First of all, the trust reporting to you, which is reliant on the trusts identifying the problem and passing it up to you. The second is that the boards hold the trusts to account. How do the department -- what system did the department have for checking that the boards were holding trusts to account?

A. In the annual accountability reviews that we had with boards, we would have come to each of those meetings with an agenda. That agenda would have been generated very much by what was in the management plan at any given point in time, and we would be asking the boards fairly systematically, going through the targets and objectives set in the management plan, what has happened. And we would be expecting the boards to tell us in relation to each of the trusts with whom they were purchasing services whether or not those trusts were meeting those. So that's basically how we were doing it.

Q. So you had those annual accountability reviews with the boards each year. Did you have annual accountability reviews with trusts each year?
A. No.
Q. In some of the witness statements and some of the evidence that's been given to the inquiry, accountability reviews to the trusts began at some time. When do you recall those reviews beginning?
A. Not in my time. I have to say, certainly not when I was either deputy chief executive or chief executive, through to that period. And also when I was in the management group until 2003, no, we didn't have any kind of formal accountability reviews with trusts. I think perhaps it may have started some time after that, but I really can't recall, I wasn't involved.
Q. So up to 2003 you don't recall any accountability reviews with trusts?
A. No.
Q. And I think, to be fair, your evidence chimes with that of Mr Hunter on Monday, where he said that he personally relied on the boards holding the trusts to account.
A. Yes, and that's very much the tenor of that survey(?) which we talked about, the initial survey(?) in 1993.
Q. Did the Management Executive have any other -- apart from the accountability reviews on the annual basis, did

they have any other systems or functions for holding the boards to account?
A. No, it was principally through the accountability reviews, backed up by a management information system, which would have fed to us through the boards how they were performing on the various things we were asking them to do.
Q. You've said that you would have expected each of the children's deaths that the inquiry is concerned about to have been informed to the Management Executive and to the department. Does the fact that they weren't, with the exception of Raychel, show the fact that there was a lack of a system?
A. Undoubtedly it does show that, yes.
Q. And why was such a system not in place in your opinion? Why wasn't there a system for notification of serious adverse incidents such as that in place from the trusts to the Management Executive or the department?
A. I think at the time -- I mean, if I could say the culture very much at the time was one of assuming that clinicians were principally responsible for the care of their patients. We had no particular reason to think that that was not happening, that the clinicians were not in fact doing that properly. So I have to say that with the benefit of hindsight, that was an error, that

was a mistake, we should not have been relying on that because we have evidence in front of us that that kind of reporting did not happen.
Q. Is it your evidence almost that too much deference was given to the clinicians or the autonomous nature of the trusts?
A. I would have to say so, yes.
Q. If I can ask you -- if we go back one page, back to page 4, we see at the bottom at question 9 you were asked about Mr William McKee's comment as the former chief executive of the Royal Group of Hospitals. He told the inquiry that in 1993/94 and subsequently for many years he as chief executive of the Royal Group was specifically not held responsible for clinical safety, clinical quality, clinical matters, and that the board of the trust had no such responsibility either, and that the trust only became responsible for clinical quality in 2003 when the circular was issued.
A. Mm-hm.
Q. And subsequently the statutory duty of quality. What is your opinion of Mr McKee's evidence on that point?
A. Well, I frankly have found it baffling. I really can't understand why Mr McKee would have thought -- leaving aside for the moment his personal position as chief executive within an organisation and his personal

accountability, I can't understand why he would ever have thought that his organisation corporately was not responsible for clinical safety since that's the principal purpose of its creation. So I found that very difficult to comprehend.
Q. If we look at -- you have said leaving aside for the moment his personal opinion as chief executive. If we do look at his personal position and the position of the board of the trust, is it your evidence that they did have responsibility prior to the 2003 circular or that they didn't?
A. Oh, they undoubtedly did, they must have had. Even at the most basic level of an employer employing staff, doing things, there is a responsibility on the part of any organisation employing staff to take responsibility for the actions of its employees.
Q. In terms then of the 2003 circular and the introduction of the statutory duty of quality, do you consider other than enshrining in statute that responsibility, that there was actually any difference from the position before the circular to the position after the circular?
A. No, in the sense that I don't think that there was a point in time before which there was no accountability and a point in time when there was. I think this is simply enshrining in law what could and should have been

understood to have been the case anyway.

Q. If I can move just to ask you about clinical governance and the introduction and development of clinical governance. You have no doubt heard quite a lot about that issue over the last few days. First of all, as chief executive of the Management Executive and then as deputy secretary of the management group, what did you consider your role as in terms of the development of clinical governance?

A. It was one of a list of things that I would have been looking to to make sure it happened on behalf of ministers. It was a prominent issue for us throughout the period. Having listened to the evidence earlier this week, it's clear to me now, looking back, that there were delays in taking that period from the time that England really took the step forward.

I look back on it now and wonder what were the sorts of reasons behind that. I honestly can't recall at any stage we saw that as a first order issue for us. There were all sorts of other things that were occupying our business. But I do recall that we did have some difficulties because -- just really from the point that the Labour government came into power in May 1997, from that point on, and then coming forward to all the political discussions leading to the Good Friday

agreement in 1998, there was certainly a sense of treading water to some extent with a lot of issues, wondering what should we do, how quickly should we move on certain issues. The direct rule ministers in those last days before devolution generally took an approach of: don't rock the boat.

THE CHAIRMAN: Sort of hands off?

A. Hands off.

THE CHAIRMAN: So that they weren't going to make any decisions, they were going to leave it for the incoming assembly and the executive to make.

A. Yes. I could give you an example of that. Fit For The Future, which was in a sense our kind of opening gambit into how do we change everything in light of the new government, if you read the introduction to Fit For The Future written by the then minister Tony Worthington, it's very clear he was saying, "These are the sorts of things that we think you should do in Northern Ireland because this is what we're doing in England, but really it's very much up to the incoming executive to take its own decisions".

So there was a sense of uncertainty around at that time on the part of officials like myself as to how quickly to proceed in certain things. It's also, I think, worth saying to you that keeping an eye on

what was happening in England with the development of these things, we were very conscious that there were a lot of resources being put in place in England to take all of this forward, things like the creation of NICE and the Commission for Health Improvement, national performance, there's a list of things, which frankly we were not in any case in a position to replicate because we just didn't have the resources to do it at that point.

So there were difficulties in deciding in the political context how quickly to move. There were also practical difficulties in relation to actually gathering together the necessary resources to follow the English lead.

Q. Although you agree it's difficult to ask for the resources if the framework or the idea or the motivation to move something along isn't there in the first place?

A. Yes, although it's also worth maybe just mentioning to the inquiry that during that period from when the Labour government came in in May 1997, we were operating with an extraordinarily tight financial regime. In the last days of the Conservative government, we were operating on a yearly basis with diminishing resources. We were getting negative growth, in other words we were not getting any growth monies at all. And Labour, when they

came in, maintained the Conservative government's approach on spending for health for the two first years. So we were in a situation where we knew there was no prospect of getting any additional resources, so there was a sense of: there's hardly any point in asking because we were just not going to get it.

THE CHAIRMAN: Mr Reid used the phrase a moment ago about whether it's difficult to ask for the resources if the motivation to move something along wasn't there in the first place. Would you quibble with the idea that motivation wasn't there?

A. I wouldn't, really. Motivation, if I can qualify it in the sense of -- was not seen by us at that time as a top priority.

THE CHAIRMAN: When you used that phrase a moment ago, Mr Simpson, about "governance wasn't a first order for us, all sorts of other things were", were those other things issues such as waiting times, waiting lists and what units were staying open, or is there --

A. Those sorts of things and particularly at that time, certainly it was very prominent in my mind, great concern about the pattern of hospital services. We were in a situation where we realised that our hospital services were creaking and they couldn't be sustained, so probably the first order for me throughout that time

was: what do we do about hospital services, do we need to change the structures, do we need to close hospitals, basically, do we need to build new hospitals.

THE CHAIRMAN: That has been a running sore for some time, hasn't it?

A. Indeed it has.

THE CHAIRMAN: And the basic problem is whether we have too many hospital that we can't maintain.

A. Yes.

THE CHAIRMAN: And deciding which ones to close is a political decision.

A. A political decision, and there are all sorts of quality issues built into that obviously as well.

THE CHAIRMAN: Yes. If you close A, where do the patients from A go to?

A. Or equally, if you keep some place open where you have difficulty maintaining staff levels, particularly consultant staff levels, what are the quality issues that arise from that. So we were very concerned about those sorts of things, yes.

MR REID: Would it be fair to say that the top level issues that the department was facing were those that might have the most immediate political or media impact? The development of clinical governance sometimes isn't a headline grabber, would you agree, until something

goes wrong?

A. Yes.

THE CHAIRMAN: Sorry, let me just take you back. There must have been equivalent debates in England about waiting times and waiting lists.

A. Indeed, yes.

THE CHAIRMAN: So we're not different from England and Wales in that area. Were we different from them about closing units or closing hospitals?

A. Well, we would have been similar in relation to maybe the more rural parts of England and Scotland. We certainly wouldn't have had the same kind of problems as they were having in the south of England with the heavy urbanisation, but we had real difficulties in terms of trying to balance accessibility and quality.

THE CHAIRMAN: The reason I'm asking is this. I understand how other issues necessarily appear on your desk and they're very thorny to work through. But to the extent that this has been advanced this week as an explanation for some level of delay between here and England about moving clinical governance forward, those issues were not absent in England. So England was moving on, arguably at a faster pace than we were, despite having comparable issues to the ones which you and previous witnesses have spoken about.

A. Well, I have mentioned two differences, chairman, which were, first of all, the political context was different, there was no read-across to England in that sense, and the financial context was different.

THE CHAIRMAN: Yes.

A. We were working with extremely restricted resources, which England was not doing at that time.

THE CHAIRMAN: Right. You'll never get anybody in the Health Service in England to admit that they have enough money -- that is another matter, isn't it?

A. Indeed.

MR REID: To some extent though the political context was different in Scotland and Wales from what it was in England.

A. Mm.

Q. Given devolution moving on in those regions at different paces. But they still managed to bring in clinical governance, seemingly at a faster pace than Northern Ireland did. Do you have any reason why those particular regions were able to do things better or faster than Northern Ireland?

A. I can't really say. I mean, I'm certainly aware, looking at some of the documentation, that there were strong leads being given by clinical colleagues, particularly in Scotland. I'm really not sure about

Wales, but I was conscious that in Scotland there was a very strong Chief Medical Officer and associated medical lead. And I would imagine my colleagues in Scotland, the equivalent to people like me, were probably being pushed along quite strongly by their medical colleagues.

Q. It's interesting you say that about the strength of some of the leadership because one of the criticisms that Professor Scally has made in his report is the fact that the department didn't seem to have a clear leadership role in bringing forward the development of clinical governance. Do you think perhaps that some leadership could have been more satisfactory within the department in order to bring forward this development of clinical governance?

A. Probably, yes.

THE CHAIRMAN: When you say that Scotland had a very strong Chief Medical Officer and associated medical lead, can you illustrate that for me? Give an example of in what way that officer -- was it a male or female?

A. I think it was a male. I honestly can't remember the names now, it's such a long time ago.

THE CHAIRMAN: In what way was their lead stronger?

A. In my mind I recall that whoever was there at the time was particularly interested in the whole business of the

quality of services provided by individual consultants and whether or not their results should be published in some sort of league tables. I remember that was a big issue. It sort of registered in my mind that here was someone in Scotland really being quite brave about this because at that point in time the idea of publishing league tables of consultant performance was regarded as really quite radical. So I came away with a strong impression that we had somebody who was really pushing the agenda in Scotland.

THE CHAIRMAN: Thank you.

MR REID: Can I ask you about the 1998 healthcare consultants' report, which has been referred to in some detail over the last few days.

A. Sorry, which report?

Q. I'll bring it up for you not. 338-006-106, please, and the following page, 107.

A. Oh yes.

Q. This is the report by Healthcare Risk Resources International. February 1999, a survey of risk management in the HPSS organisations. This isn't actually the report, this is an appendix to an NIAO report. Are you aware of this particular report?

A. No, and, as I say in my witness statement, this one just doesn't register with me at all, I'm afraid. I don't

recall this report.

Q. Given that the issues covered by the report should have been something that, in your role as chief executive and deputy secretary, you should have been aware of?

A. Yes.

Q. Do you have any reason why you weren't aware of it at the time?

A. I really can't recall.

Q. If you weren't aware of it, who would have been the person commissioning a report such as this?

A. Well, I think Mr Gowdy indicated in his testimony that he commissioned it. I should be clear about this, what I'm saying is that now I can't recall it. When I was there at the time, it may be something that indeed I did see, but what I'm saying is from this perspective I just don't remember it at all.

THE CHAIRMAN: It'd be baffling if you didn't see it at the time, wouldn't it?

A. Yes, I imagine I must have seen it, I imagine it must have been taken at the departmental board meeting at some point, but I don't recall it.

MR REID: At this juncture can you say anything about the department's reaction to this report?

A. No, I really can't, no.

Q. And were you still in post whenever the Deloitte &

Touche reports were commissioned and subsequently reported?

A. Can you give me the dates of that?

Q. 2003/2004.

A. Yes, I would have been in post.

Q. Do you recall those?

A. I don't, not in detail.

Q. And do you think you would have been involved, even if you can't recall, in the commissioning of those reports?

A. I probably would have been, yes, but I just don't recall.

THE CHAIRMAN: But I think since you have heard the evidence over the last few days, you know that the theme of this evidence is that these were weaknesses which were being highlighted in order for action to be taken on them and our concern is this: it's clearly an important and positive thing for Mr Gowdy to have commissioned HRRI to do this report.

What then seems to be missing on the paper trail that we have is any identifiable follow-up to it. So if as important an organisation as the Health Service has a report which highlighted areas, of some strengths to be fair, and some areas of weakness, then if they're not followed up, it undermines the point of getting the consultants in in the first place, doesn't it?

A. I have to agree with that point, yes.

MR REID: If I can ask you just about audit. Your predecessor, Mr Hunter, has said that the primary responsibility for clinical care in hospitals until his departure in 1997 lay with professional committees, including clinical audit committees.

A. Mm.

Q. And in his testimony he repeated the fact that he thought those were very important. What was your relationship with the audit committees during your tenure as chief executive of the Management Executive?

A. None. There was no reporting line through to the Management Executive from audit committees. Do you mean audit committees at hospital level?

Q. I'm talking about generally the area or regional audit committees.

A. I imagine there must have been times when the regional audit committee would have been doing work which would have drawn the attention of the management -- or where we were asked to do things. I honestly can't recall any specific examples of that.

Q. Would you agree with Mr Hunter about the importance of those regional audit committees?

A. Yes, indeed. Sorry, there was one, I think, one.

Q. Sorry, the regional audit committee.

A. Yes.
Q. I think you've already accepted, as with other witnesses, that there was no system for notification of serious adverse incidents as far as you are concerned.
A. No, there wasn't.
Q. If I could ask you just about some of the specific cases that the inquiry is concerned with. You've said in your first witness statement, WS084/1, page 3, you were asked how many and when did you first become aware of the deaths of Adam, Lucy and Raychel. Adam was around the time of the Insight programme in October 2004.
A. Yes.
Q. Just before the establishment of the inquiry. In Lucy, it was the departmental board meeting of 27 February 2004. Mr Gowdy, the Permanent Secretary, has said that that may have been the first time he was made aware of Lucy Crawford's death. You heard that evidence the other day?
A. Yes, I did.
Q. In terms of Raychel, you think you were involved in a copy of a submission to the minister, dated 20 February 2003.
A. Mm-hm.
Q. If we can bring up that reference, 006-039-389. You're cc'd into it in February 2003.

A. Yes.
Q. The Permanent Secretary has said that he didn't know or he can't recall being made aware of Raychel's death until after he was made aware of Lucy's death in February 2004. Do you know any reason why you wouldn't have reported this up the chain to the Permanent Secretary?
A. I really -- no. I mean, I see from the submission that Clive's name is not on it. Probably -- I'm guessing now because I can't recall the detail -- at the time I probably would have assumed that since it had gone to the CMO, the CMO and Clive would have been talking to each other about this. It wouldn't have occurred to me that I needed specifically to go and tell him about it.
Q. You assumed because it was being discussed at these levels, the CMO, Dr McCarthy and Dr Carson and so on, that Mr Gowdy would already know?
A. Indeed.
Q. And you would have met the CMO and the Permanent Secretary on a monthly basis at some of the board meetings; is that right?
A. Yes, I would.
Q. Can you remember any discussions about the hyponatraemia deaths until that February 2004 meeting?
A. No, none. I have to admit, I didn't even know what

hyponatraemia actually was until I was told about it.
THE CHAIRMAN: I'm not sure you were alone, Mr Simpson.
MR REID: Mr Chairman, I have nothing further for Mr Simpson at this point.
THE CHAIRMAN: Okay. Any questions from the floor?
Mr Simpson, thank you very much. It has been possible to take your evidence rather more briefly because you've effectively acknowledged and accepted much of the evidence given earlier this week, so unless there's anything more that you want to say, thank you for coming and you're free to leave.
A. Thank you very much.
(The witness withdrew)
THE CHAIRMAN: Ladies and gentlemen, as I've explained, and again with apologies to Dr Carson, because of Mr Stewart's unavailability today, we're going to have to bring a halt to today's hearing at this stage. Let me go over again, just for some clarification, what is going to happen this week.
I will start this by reminding you that when the inquiry started, the original programme was that after we heard the historic evidence, there would be a short series of conferences or seminars focusing on where the Health Service is now and what more might possibly be done in the future.

Because of our constantly shifting timetable and because events like that do take some time to organise, the planning of them became problematic and I have decided not to wait for that to happen but instead to take a different route so that I can complete my report to the minister and deliver it in January. As you will have seen, what has happened is that I've issued requests for information to various people and organisations who are centrally involved in today's National Health Service, and they have responded helpfully and in great detail.
What will now happen is that starting on Monday, representatives of those organisations will come here and I will have what is in effect a public discussion with them, covering areas like candour, complaints, how serious adverse incidents are now reported and followed up on, the involvement of families in those investigations, claims for privilege and statements for coroners. There are other issues, but that's just a sample list. I will lead that discussion, the questioning will be by me, not by inquiry counsel, and the tenor will be to see where we are now and where else we might go in the future. So in effect, it's an opportunity to air and exchange ideas.
It will not be negative in the sense of being

critical of what is happening now. It is for that reason that nobody has been granted interested party status for next week and it's also for that reason that no Salmon letters have gone out to anybody who'll be attending next week.

Much of the evidence that I've heard this week and in previous weeks and months has been troubling. I know it has greatly troubled the families, but I also believe from the witnesses I have heard that it causes great concern to those within the Health Service who are committed to it. What I want to do next week is to change the mood or the tenor of these hearings. What I want next week is to have exchanges in which those who work in the Health Service will come forward with different and better ideas than I do on how successfully the service might move forward from its current basis.

I will bring to that debate the lessons and issues which have emerged from our scrutiny of the events from 1995 onwards, and they for their part will bring to the debate the lessons which they have learned from that history and from where they are now. Later today, I will start to issue lists of areas which I want to focus on with each body or individual, starting on Monday with Mr Walsh of the Association for the Victims of Medical Accidents and Ms Maeve Hully of the

relatively new Patient and Client Council.

I anticipate from his paper that Mr Walsh will have some challenging ideas which will influence the discussions as the week progresses. It would therefore be helpful if the organisations whose representatives are to attend from Tuesday onwards would familiarise themselves with Mr Walsh's paper and with what he says on Monday.

Let me finish by adding one thing. The debate which we'll be engaging in is not one which is confined to Northern Ireland. Just to take one obvious and easy example, in England the publication of the Francis report on events in Mid-Staffordshire in recent months has flagged up many issues, not least of which is the re-emergence onto the agenda of the question of a duty of candour.

The situation in Northern Ireland should not be seen in isolation, nor should this inquiry be seen in isolation, because in recent years the department has had the C.diff Inquiry and it's had the Pseudomonas Inquiry, so events such as those we've been investigating should be seen in that overall context.

My intention next week and in the recommendations section of the report which I provide to the minister is to be as constructive and forward looking as I can.

I will be helped very much in doing that if the senior officers who attend next week take that lead and respond to it.

Mr McMillen, we still need to hear from Professor Scally on Wednesday.

MR McMILLEN: Mr Chairman, I was just about to ask if I could address you on that. The inquiry will be receiving a letter in that regard, hopefully within the next hour, and that may move the matter forward.

THE CHAIRMAN: Okay. Any hints about the letter or do you want me to see it first?

MR McMILLEN: Hopefully it will shorten matters greatly and may obviate the need -- it's really a matter for yourself, ultimately, Mr Chairman.

THE CHAIRMAN: Thank you very much. I should say I'm going to make an opening statement on Monday because I want to highlight some of the issues which have emerged over the last 18 months because, for me, they set the context of what the Health Service needs to be concerned about historically; that in turn sets the context for looking at where we are now to see what progress has been made.

The very extensive papers that have been provided to me from people like Dr Carson and the RQIA and the department itself and the other public bodies show me that there has been a huge amount of progress in

a series of areas. I want to probe the extent of that progress because I think the one thing that everybody must recognise we come back to is, "Well, the systems may now be in place, the trigger mechanism for those systems still involves people saying, 'Something has gone wrong here'." And I think on the experience that I have heard about and the families have heard about from the mid-1990s and early 2000s, that is something which cannot be assumed.

So we'll go forward on that basis. I'll look forward to receiving this letter later today, Mr McMillen, and we'll have some discussions through Dr Carson's representatives about when he might be able to accommodate us next week.

MR McMILLEN: Mr Chairman, could I just ask for guidance on one thing? I understand you'll permit closing written submissions.

THE CHAIRMAN: Yes.

MR McMILLEN: I was wondering if at some stage you could give us some guidance on what would assist you best. I assume, for example, you would not be assisted by great swathes of the evidence being set out.

THE CHAIRMAN: Absolutely.

MR McMILLEN: You may want to have a page limit or something like that.

THE CHAIRMAN: In a sense, this segment is actually comparatively easy because, if you think about it, we heard two days of evidence last week and we've heard five days of evidence this week, so going over the factual analysis really isn't very helpful.

MR McMILLEN: Indeed, yes.

THE CHAIRMAN: Partly because there's a very detailed opening by the inquiry itself and then you responded with a very helpful reply to that. The tendency to date in the segments upon which I have received submissions is that they have been quite brief. It's not my instinct to set a page limit on it, but I will think about that over the weekend and come back to you next week.

MR McMILLEN: I'm obliged, Mr Chairman.

THE CHAIRMAN: I think on Monday because there's a bit of sorting out to be done, we'll start at 10.30. I will then make an introductory statement. I've indicated, I think, in the paper which I circulated last week that each of the bodies which are coming before me is free to make an introductory statement of up to 30 minutes. And what I envisage is that, as I said yesterday, the witnesses won't be sworn; strictly speaking, they're not witness, they're speakers, I suppose, Mr Walsh and Ms Hully. I will invite them to take their seats where

Mr Simpson is at the moment and we'll have that debate. It's a public debate. I want to get away from focusing on making it courtroom-like or adversarial insofar as it's possible to do so.

We'll start at 10.30 on Monday. Thank you.

(11.28 am)

(The hearing adjourned until Monday 11 November at 10.30 am)

I N D E X