

Witness Statement Ref. No. 071/1**INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS****Name:** Dean Sullivan**Title:** Mr**Present position and department/employer:** Director of Secondary Care, DHSSPS**Length of time in post:** 2 years and 1 month**Previous position and department/employer in 1995:** Auditor, National Audit Office, London**Previous position and department/employer in 2000:** Management Consultant, PA Consulting Group, Belfast**Previous position and department/employer in 2001:** Management Consultant, PA Consulting Group, Belfast**Membership of Professionals Bodies:** Member of the Chartered Institute of Public Finance and Accountancy

Particular areas of interest

[Please attach additional sheets if more space is required]

(i) How and when did you first become aware of the deaths of Adam, Lucy and Raychel?

As I recall, I became aware of the deaths of Lucy and Raychel in the Spring of 2004 following CMO's interview on UTV (ref 006-037-375). I became aware of the death of Adam following media coverage in Autumn 2004.

(ii) Describe in detail the steps you took to discover why the children died and to ensure that lessons would be learned.

My understanding was and is that the identification of the cause of death of the three children is the role of the Coroner; there was an inquest following each of the three deaths.

Re ensuring that lessons are learned from these and other cases I provided some input to the preparation of the Department's 2004 circular HSS (PPM) 06/04 in relation to the reporting and follow up of serious adverse incidents.

(iii) Give details of your colleagues and others within the DHSSPS with whom you consulted in respect of these deaths to include reasons why each was consulted by you and the outcome of such consultations.

I did not consult with Departmental colleagues in respect of any of the three deaths, each of which occurred some time before I joined the Department in May 2003.

Particular areas of interest (Cont'd)

- (iv) What was the system in place in Northern Ireland at the time of Adam Strain's death in 1995 for reporting untoward deaths to the DHSSPS and disseminating information on the outcomes of Coroners' Inquests within the health service?**

Other than arrangements for the notification of untoward events in psychiatric and special care hospitals, I am not aware of any formal system being in place in 1995 for the reporting of untoward deaths to DHSSPS.

I do not know of the system in place in 1995 for the dissemination of information on the outcomes of Coroners' Inquests within the local health service.

- (v) What was the role of the DHSSPS in reporting, analysing and disseminating the information referred to at (iv) above and in ensuring that lessons learned would be fed into teaching/training and the care of patients.**

I do not know the nature of the role of the Department in 1995 in relation to reporting, analysing and disseminating the information referred to at (iv) above and in ensuring that lessons learned would be fed into teaching/training and the care of patients.

- (vi) What procedures existed in 1995 to ensure the fulfilling of roles relating to the reporting, analysing, disseminating of information from a Coroner's Inquest or untoward death and to ensure that lessons would be learned?**

To the best of my knowledge, the Coroner is not obliged under Coroners' rules to report incidents on untoward deaths to the Department.

I do not know of the system in place in 1995 for the dissemination of information on the outcomes of Coroners' Inquests within the local health service.

Particular areas of interest (Cont'd)

(vii) With reference to issues (iv) to (vi) above, what was the situation in 2000 and 2001 respectively?

To the best of my knowledge, the arrangements described in (iv) to (vi) above did not change in the period 1995 to 2001 inclusive.

(viii) With reference to issues (iv) to (vi) above, what is the situation now?

The Department established formal arrangements for the reporting and follow-up of serious adverse incidents in July 2004 (circular HSS (PPM) 06/04).

Other points you wish to make including additions to any previous Statements, Depositions and or Reports

[Please attach additional sheets if more space is required]

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

Signed:



Dated:

3/7/05