084/1

Witness Statement Ref. No. 084/1

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Name: Paul Simpson

Title: Mr.

Present position and department/employer: Deputy Secretary, Strategic Planning and Modernisation Group, DHSSPS

Length of time in post: As Deputy Secretary in the Department, 8 years. In current post as Deputy Secretary, Strategic Planning and Modernisation Group, 2 years

Previous position and department/employer in 1995: Deputy Chief Executive, Health and Social Services Executive, DHSS. From April 1997 to Dec 1999, Chief Executive, Health and Social Services Executive

Previous position and department/employer in 2000: Deputy Secretary, HPSS Management Group, DHSSPS.

Previous position and department/employer in 2001: As in 2000

Membership of Professionals Bodies:	**None**

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?

In relation to Adam, I cannot recall precisely, but through media coverage around the time of the Insight programme in October 2004.
In relation to Lucy, through a discussion at a Departmental Board meeting on 27 Feb 2004 (ref 004-019-236)
In relation to Raychel, through a copy of a submission to the Minister, dated 20 Feb 2003 (ref 006-039-389)

(ii) Describe in detail the steps you took to discover why these children died and to ensure that lessons were learned for the future.

This was not within my direct policy responsibility, but I participated in the Departmental Board discussion on 22 October 2004 (copy relevant extract of minutes attached) which recognised the gravity of the allegations in the Insight programme and led to the recommendation to the Minister to establish the independent Hyponatremia Inquiry

Particular areas of interest (Cont'd)

(iii) Give details of colleagues within the DHSSPS and others with whom you discussed the steps to be taken in response to the children's deaths, to include the reason why they were contacted by you, when and the outcome of your discussions.

My answer to (ii) above refers. I participated in Departmental Board discussions of the Departmental response to the Insight programme in October 2004

(iv) In your role as a member of the Departmental Board, explain what information you received or solicited about the procedures, investigations and events that followed the deaths of Adam, Lucy and Raychel.

I received an update on action being taken by the Department following the inquest on the death of Lucy Crawford at the Departmental Board meeting on 27 Feb 2004 (ref 004-019-237). Further information was provided at a meeting of the Departmental Board on 28 May 2004 in relation to media coverage and the need to maintain public confidence in the Erne hospital (ref 004-020-255 & 259-261)

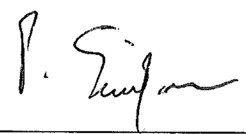
(v) Again in your role as a member of the Departmental Board, explain what steps you took to discover why the children died and to ensure that any lessons would be learned.

My answer to (ii) above refers.

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]

None

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

Signed 

Dated: 4 July 05

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

DEPARTMENTAL BOARD

Minutes of the meeting held on Friday, 22 October 2004, in the Conference Room, D2, Castle Buildings at 11.00am.

Present:	Mr Gowdy (Chairman)	Mr Cole
	Mr Hill	Mr Martin
	Mr Simpson	Dr Morrow
	Mr Hamilton	Dr Campbell
	Mr Maguire	

In attendance: Mr Owens, Ms Crothers

1.0 Apologies

1.1 Apologies were received from Miss Hill and Mrs Wilson.

2.0 Minutes of previous meeting (DB/109/2004 and DB/109/2004(S))

2.1 The minutes of the previous meeting, held on 8 October 2004 were agreed without amendment.

3.0 Chairman's Report

3.1 The Chairman referred to UTV "Insight" programme concerning the deaths of two children from hyponatraemia which had been screened on the previous night. He stated that some serious issues had been raised which the Department needed to consider carefully. The

Chairman expressed concern that the programme appeared to identify new material and information which had not previously been known to the Department. The Chairman indicated that he would be discussing the matter with the Minister as a matter of urgency.

3.2 Board Members concurred with the Chairman's comments and there was general agreement that given the gravity of the allegations there was a need for an independent investigation which would have to look at the totality of issues raised by the programme. In doing so it was noted that the General Medical Council was already investigating a complaint regarding the doctor involved in the Lucy Crawford case.

3.3 The Chairman concluded that the Department needed to reflect very carefully on the issues raised and to seek agreement of the Minister on the appropriate action to be taken as a matter of urgency.