Witness Statement Ref. No. 084/2

DEPARTMENTAL AND GENERAL GOVERNANCE

Name: Paul Simpson

Title: Mr

Present position and institution:

Retired since 1 May 2009

Previous position and institution:

Deputy Secretary, Strategic Planning and Modernisation Group

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement of 4th July 2005]

None

Previous Statements, Depositions and Reports:
[Identify by date and title all those made since your Witness Statement of 4th July 2005]

None

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	Date:	
WS-084/1	04/07/2005	Witness Statement to the Inquiry

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

DETAILS OF YOUR CAREER HISTORY, QUALIFICATIONS AND EXPERIENCE

(1) In your earlier witness statement to the Inquiry dated 4th July 2005 **[Ref: WS-084/1, page 1],** you stated that in 1995 you were Deputy Chief Executive, Health and Social Services Executive DHSS. Arising from that:

(a) State the dates on which:

(i) You became Deputy Chief Executive, Health and Social Services Executive;

Ans: I became Deputy Chief Executive in February 1991.

(ii) You ceased to hold that position.

Ans: I ceased holding that position on 31 March 1997.

(b) Provide your job description and outline the duties and responsibilities of that post.

Ans: I do not have this information. It may be in the Department's HR records.

(c) Who was the Chief Executive during the period when you were Deputy Chief Executive? If more than one person was Chief Executive, please identify each holder of the post and the periods for which each post holder held the position.

Ans: The Chief Executives during this period were Mr John Hunter (until 31 December 1996) and then Clive Gowdy until 01 April 1997.

(2) Describe your career history prior to becoming Deputy Chief Executive, Health and Social Services Executive.

Ans: I joined the Northern Ireland Civil Service in 1971 as a trainee EO2. I became an Assistant Secretary responsible for HPSS Human Resources in April 1984 and served in DHSS for 4 years before transferring to the Department of Economic Development (now DETI). I returned to DHSS in February 1991 on my appointment to Deputy Chief Executive following an open competition.

(3) In your earlier witness statement **[Ref: WS-084/1, page 1],** you stated that from April 1997 to December 1999 you were Chief Executive of the Health and Social Services Executive. Arising from that please answer the following:

(a) Provide a copy of your job description and outline the duties and responsibilities of this position.

Ans: I do not hold this information.

(b) When did the Health and Social Services Executive cease to exist?

Ans: The HSSE ceased to exist on the creation of the Northern Ireland Executive in 2000.

(c) Why did the Health and Social Services Executive cease to exist?

Ans: ***With the increase in the number of Departments to meet the requirements of the Northern Ireland Executive, DHSS lost responsibility for social security. The reduced scope of the Department meant that the Permanent Secretary could take on the responsibilities formerly those of the Chief Executive, including those of Accounting Officer for Health and Social Services expenditure.***

(d) What replaced the Health and Social Services Executive?

Ans: ***The HSSE was not replaced and its functions were reallocated within the Department.***

(4) In your earlier witness statement **[Ref: WS-084/1, page 1],** you stated that in 2000 you were Deputy Secretary, HPSS Management Group. Arising from that please answer the following:

(a) When were you appointed Deputy Secretary HPSS Management Group?

Ans: ***01 January 2000.***

(b) Provide your job description for this post and outline the duties and responsibilities of the post.

Ans: ***I do not hold this information.***

(c) When did you cease to be Deputy Secretary HPSS Management Group?

Ans: ***July 2003.***

(5) In your earlier witness statement **[Ref: WS-084/1, page 1],** you stated that your position at the date of that statement was Deputy Secretary Strategic Planning and Modernisation Group and that you had held that post for 2 years. Arising from that:

(a) On what date did you take up this post?

Ans: ***July 2003.***

(b) Provide the job description for the post and outline the duties and responsibilities.

Ans: ***I do not hold this information.***

(c) State the date on which you ceased to hold this post.

Ans: ***November 2006.***

(d) Describe your career history since you ceased to hold this post to date.

Ans: ***I transferred to the Department of the Environment in November 2006 and retired in May 2009.***

(6) State any relevant qualifications which you hold and the date(s) on which you obtained them.

Ans: ***None.***

ACCOUNTABILITY ARRANGEMENTS IN THE HPSS

(7) Describe the accountability arrangements in the HPSS in the period between 1995 and 2003. In particular, describe the Department's role and functions in those arrangements.

Ans: In general terms, the Department expected Boards and Trusts to deliver the objectives set out in successive annual Management Plans and to do so within the annual budgets set for them. The principal line of accountability was from the Boards to the Department.

(8) Describe the specific arrangements by which the Royal Group of Hospitals HSS Trust was held accountable for the discharge of its functions in the period 1995-2003. In particular:

(a) Were you personally involved in holding the Trust to account? If so, please answer the following:

Ans: See (8)(ii) below.

(i) Describe your involvement in holding the Trust to account.

Ans: See (8)(ii) below.

(ii) Were issues concerning clinical care or the quality of care ever raised by or with the Trust in the course of holding the Trust to account? Please give details and examples.

Ans: (a) (i) and (ii) - In the period from 1995 to April 1997, I helped to prepare the Agendas for annual accountability reviews between the Department and the four Boards and attended these meetings either with, or on behalf of, the Chief Executive. From April 1997 to 31 December 1999 I led these meetings as Chief Executive. From 01 January 2000 to 2003, my recollection is that I continued to do so as Deputy Secretary, HPSS Management Group. The line of accountability was from the Boards to the Department. My recollection is that there were no arrangements for the HSSE and later, the Department, to hold formal accountability reviews with Trusts. The four Boards dealt with the Trusts on a day to day basis and agreed annual performance targets and budgets with them. At no point in the period from 1995 and 2003 was I involved in holding the RGH Trust formally to account for the discharge of its clinical functions.

(9) Mr William McKee, former Chief Executive of the Royal Group of Hospitals HSS Trust, has told the Inquiry (**Ref: transcript day 76, 17th January 2013, page 6 lines1-4)** that "*in 1993/1994 …and subsequently for many years I was specifically not held responsible for clinical safety, clinical quality, clinical matters.*" He confirmed (**Ref: transcript day 76, 17th January 2013, page 16 line 4)** that the Board of the Trust had no such responsibility either. His evidence was that the Trust only became responsible for clinical quality in January 2003 when a circular was issued by the DHSSPS advising Trusts that they now had a duty of quality(**Ref: transcript day 76, 17th January 2013, page 7 lines 13-19 and page 8 lines 1-9).**

Ans: The Management Executive issued on 01 October 1993 circular METL 2/93 "Accountability Framework for Trusts". This set out the general "light touch" approach determined by Ministers for the monitoring of Trusts by the Department. There is nothing in this circular which specifically requires Trusts to account for clinical standards or safety, except for a reference at paragraph 18 which includes the following:

"Intervention by the ME in the affairs of a trust should be exceptional, in line with the principles of maximum delegation. It may be judged necessary in certain circumstances eg:-

- Items of concern relating to patient or client care."

This carries a presumption by the Department that Trusts were responsible for patient and client care. Although it may be assumed that Trusts have a responsibility for all actions carried out by their employees, the Department did not highlight their specific responsibility for the standards of clinical care and safety until the issue of "Governance in the HPSS" in January 2003 (HSS (PPM) 10/2002).

However, Mr Hugh Mills, former Chief Executive of the Sperrin Lakeland Trust, was asked by the Chairman if the Trust reported Lucy Crawford's death to the Western Board in 2000 "*because the Trust felt that it had a responsibility for clinical care*" and replied "*Oh, certainly the Trust had a responsibility for clinical care.*" (**Ref: transcript day 110, 17th June 2013, page 45 lines 18-20**). Arising from this, please answer the following:

(a) Do you agree with Mr McKee that, prior to the issue of HSS(PPM) 10/2002 on 13th January 2003 **[Ref: 306-119-001]** and the coming into operation of the statutory duty of quality in Article 34 of the Health and Personal Social Services (Quality Improvement and Regulation) Order 2003 in April 2003, the Royal Group of Hospitals HSS Trust had no responsibility for clinical care? Or do you agree with Mr Mills that in 2000 the Sperrin Lakeland Trust did have responsibility for clinical care? Please give reasons for your answer.

Ans: While I agree with Mr Mills that Trusts have always had a general responsibility for clinical care, Mr McKee is also correct to say that the Department did not require specific arrangements to be put in place until 2003.

(b) What did you consider to have been the major changes brought about by Circular HSS(PPM) 10/2002 in relation to the reporting of adverse incidents?

Ans: The introduction of systematic reporting of clinical standards and performance and the allocation of responsibility to named individuals and committees within each Trust.

(c) Who did you consider had responsibility for clinical care in Health Service hospitals in Northern Ireland prior to the issue of HSS(PM) 10/2002 and the coming into operation of Article 34?

Ans: Individual clinicians have the principal responsibility for the care of their patients. The introduction of new systems for auditing and monitoring the quality of care was designed to support clinicians but does not remove this personal responsibility.

(d) How did that responsibility arise? For example, did you consider it to be statutory, or by virtue of a circular or direction, or by custom and practice? Please give details of any relevant statute, circular or direction.

Ans: See (9)(c) above.

(e) To whom did you consider that those who had responsibility for clinical care in Health Service hospitals in Northern Ireland prior to 2003 were responsible?

Ans: See (9)(c) above.

(f) Describe what arrangements were in place to ensure that those responsible for clinical care in Health Service hospitals in Northern Ireland discharged their responsibilities prior to 2003.

Ans: I do not have the detailed information to answer this but it will probably have varied from hospital to hospital and would have involved various arrangements among clinicians of clinical audit and peer review.

(g) If Trusts were responsible for clinical care prior to 2003, what was the purpose of the duty of quality in Article 34 and what difference did it make?

Ans: Its purpose was to ensure a consistent systematic approach across all hospitals and to signal that Ministers were allocating a higher priority to clinical safety.

(10) Mr Thomas Frawley, the former General Manager of the Western Health and Social Services Board, has told the Inquiry that the Department was responsible for "*holding whole system to account*"**[Ref: WS 308/1 page 11]**.

Arising from this, please answer the following:

(a) Do you agree with Mr Frawley that the Department was responsible for "*holding whole system to account*"? Please answer for the period 1995-2003. Please give reasons for your answer.

Ans: I cannot recall the relevant circulars setting out the Department's arrangements for holding Boards to account during the period 1995 to 2003. In relation to Trusts, they are set out in METL 2/93, "Accountability Framework for Trusts".

(b) If it is the position that that the Department was responsible for holding the system to account, please explain how the Department did so.

Ans: See (10)(a) above.

(c) Whether or not you agree that the Department was responsible for holding the system to account, please describe what arrangements were in place in the period between 1995 and 2003 to enable you personally and/or the Department to know what was going on in the HPSS and of issues affecting the HPSS.

Ans: In additional to formal accountability reviews with Boards, the Department had a management information system in place which enabled it to track performance against financial requirements and the achievement of Regional Strategy and annual Management Plan targets.

(11) Dr Paddy Woods has told the Inquiry [**Ref: 323-001a-001**] that formal accountability meetings took place between the Department and Sperrin Lakeland HSS Trust twice per year usually mid-year and end of year. He has advised that individuals who might have had responsibility for the oversight of Sperrin Lakeland in 2000 and who might have received reports of issues affecting the Trust would have included yourself, Clive Gowdy, John McGrath and Alan Gault. Arising from this:

(a) Please confirm whether you were involved in accountability meetings with the Sperrin Lakeland Trust during the period 2000-2002.

Ans: My recollection is that the Department did not hold formal accountability review meetings with the Trusts. The HSSE's main involvement with Trusts, to the best of my memory, was in dealing with financial issues (pressures, overspending), resolving contractual disputes between Boards and Trusts, dealing with Trust proposals for

capital expenditure for buildings and equipment and HR issues. My Director of Performance Management would have led meetings with Trusts, including Sperrin Lakeland. I led the formal accountability review meetings with the Boards.

(b) Where did those meetings take place?

Ans: See (11)(a) above.

(c) Who represented the Trust at those meetings in the period 2000-2002?

Ans: See (11)(a) above.

(d) Please give examples of matters discussed during those meetings.

Ans: See (11)(a) above.

(e) Outside of formal accountability meetings, did you personally receive reports of issues affecting Sperrin Lakeland Trust in the period 2000-2002? Please give examples of the sorts of issues which were brought to your attention.

Ans: I do not recall receiving reports of issues, including clinical issues, affecting Sperrin Lakeland Trust in the period 2000-2002.

(f) Were issues concerning clinical care ever raised by the Trust or discussed with the Trust either within or outside the formal accountability meetings? Please give examples.

Ans: See (11)(e) above.

(g) You have told the Inquiry (**WS-084/1, page 3**) that you first became aware of the death of Lucy Crawford in February 2004. Arising from that;

(i) Please confirm whether you were made aware by the Sperrin Lakeland Trust during the period 2000-2002 of any untoward deaths occurring following treatment in the Trust's hospitals?

Ans: I was not made aware by the Trust of any untoward deaths at any point. I would have expected the Trust to have made the Department aware once it had established that there were matters of concern - see my answer to Question 9 above.

(ii) Would you have expected the Sperrin Lakeland Trust to have made you or the Department aware of the untoward and unexplained death of a seventeen month old child following treatment at the Erne Hospital? Please give reasons for your answer.

Ans: See (11)(g)(i) above.

(h) Did the Sperrin Lakeland Trust at any time during the period 2000-2002 make you or the Department aware of any of the following:

(i) The allegations of clinical incompetence made against Dr O'Donohoe by Dr Asghar in June 2000 [**Ref: 036a-099-212 to 036a-099-214 and 036a-004-009 to 036a-004-010]**

Ans: The Trust did not make me aware of any of these.

(ii) The Trust's decision to request the Royal College of Paediatrics and Child Health (RCPCH) to assist in investigating those allegations **[Ref: 036a-009-016 to 036a-009-018]**

Ans: See (11)(h)(i) above.

(iii) The first report of the RCPCH representative Dr Moira Stewart [**Ref: 036a-025-052 to 036a-025-060]**

Ans: See (11)(h)(i) above.

(iv) The meeting between the Trust's Medical Director Dr Kelly and Dr Moira Stewart on 1st June 2001 **[Ref: 036a-027-066 to 036a-027-068]**

Ans: See (11)(h)(i) above.

(v) The external review report of the RCPCH by Dr Stewart and Dr Boon **[Ref: 036a-153-318 to 036a-153-323]**

Ans: See (11)(h)(i) above.

(i) Would you have expected that the Trust would have made you and/or the Department aware of any or all of the events set out in (h) above? Please give reasons for your answer.

Ans: Yes - see my answer to (11)(g) above.

ADDITIONAL QUERIES

(12) How and when did you first become aware of the death of Claire Roberts?

Ans: I cannot recall.

(13) Would you have expected the Department to have been contacted regarding the deaths of Adam Strain, Claire Roberts or Lucy Crawford?

Ans: I would have expected the Department to have been contacted once the Trusts concerned realised that there were issues of concern.

(a) What would you have expected had any of those deaths occurred:

(i) post-February 2003 and the publication of the circular HSS(PPM) 10/2002 or

Ans: I would have expected the Department to have been informed and to have pursued with the Trusts concerned what remedial action they were taking in relation to patient safety.

(ii) after the publication of HSS (PPM) 06/04?

Ans: The action required is summarised in paragraph 2 of HSS (PPM) 06/04.

(b) Would you have expected the Department to have been informed of the statement produced by the RBHSC following the Inquest of Adam Strain? **[Ref: 011-014-107a]**

Ans: In view of the wider patient issues raised by the statement, yes.

(14) What was done by the Department following the report of Healthcare Risk Resources International consultants in 1999 that there "*might have been a significant level of under-reporting of adverse incidents*"? **[Ref: WS-062/1, p.4]** Please provide a copy of that report.

(a) How was this report followed up? What was done as a result of the report?

Ans: I cannot recall. I do not have a copy of the Report.

(15) Detail all steps taken by the Department between 1995 and 2003 to encourage or require hospital trusts to manage and improve the quality of care which they provided.

Ans: I do not have the information to answer this.

(16) Between 1995 and 2003, what policies were there for the dissemination of guidelines / protocols from the Department down to Boards/Trusts?

Ans: This was done formally by the issue of circulars that went to the Chief Executives of Boards, Trusts and Agencies.

(17) How was the implementation of such guidelines and protocols by Boards and Trusts examined / assessed / monitored?

Ans: Depending on the nature and priority of the issue, implementation would be by means of requirements for Reports, or checked in Accountability Reviews with Boards.

(18) How would the Department be made aware of issues / areas that required dissemination of information / protocols? In particular, how would Boards / Trusts make the Department aware of such issues?

Ans: The communication of issues would be made by letter, telephone call or face to face.

(19) How would the Department be involved in the dissemination of materials amongst Boards / Trusts?

Ans: The Department disseminated documentation to Boards and Trusts generally through the issue of circulars.

(20) What do you consider to have been the main impetus behind the creation of a formal adverse incident reporting system from 2002?

Ans: I cannot recall the discussion of the issues at the time, but one main driver was the need to ensure the introduction of clear and open systems of monitoring and reporting on a consistent basis across Northern Ireland.

(21) Why was a formal approach not adopted for adverse incident reporting prior to 2002?

Ans: I cannot say. To the best of my knowledge the Department did not have information about patient safety issues which might have produced earlier action.

(22) Prior to 2002, what would you have expected Trusts/Hospitals to have done (if anything) in regard to informing the Department when cases involving deaths due to possible medical mismanagement were involved in:

(a) Formal complaint procedures

(b) Coroner's Inquests

(c) Medical negligence actions

Ans: (a), (b) and (c) above - As I have said in relation to similar questions earlier in this Statement, I would have expected the Department to have been informed where Trusts had reason to believe there were issues of patient safety.

(23) Mr. Clive Gowdy, former Permanent Secretary, DHSSPS, stated in his Inquiry Witness Statement as follows:

"In December 1998, the Department commissioned Healthcare Risk Resources International consultants to undertake a survey of risk management in all HPSS organisations. The terms of reference for the survey were to determine the level of application of risk management methods and the implementation of best risk management practices within these organisations. Incident reporting was one of the items included in the survey. [...] There was a general perception that there might have been a significant level of under-reporting of adverse incidents."

(a) Were you aware of this report and its findings? Please provide a copy of the report if you are able to do so.

Ans: I do not recall discussion of this Report. I do not have a copy. I assume that this Report in part at least led to the production of HSS (PPM) 10/2002.

(b) What was done as a result of the report's finding that "*there might have been a significant level of under-reporting of adverse incidents*"?

Ans: See (23)(a) above.

(24) Departmental Circular PRSC (PR) 2/99 beginning at **Ref: WS-066/1 page 105** refers at paragraph 6.1 [**Ref: WS-066/1 page 119**] to a document **"***Promoting Quality: a Framework for the HPSS***"** which was to be issued in the autumn of 1999**.** Arising from this please answer the following:

(a) Was "Promoting Quality: a Framework for the HPSS" issued in autumn 1999 or at all?

Ans: I do not recall this document.

(b) If it was not published, what were the reasons for that?

Ans: See (24)(a) above.

(c) Can you provide a copy of this document, or any drafts thereof to the Inquiry.

Ans: See (24)(a) above.

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

Signed:

Dated: 7 September 2013