085/1

Witness Statement Ref. No. 085/1

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Name: Mr Paul Martin

Title: Mr

Present position and department/employer:

Chief Inspector – Social Services Inspectorate

Department of Health, Social Services and Public Safety

Length of time in post: November 2000-present

Previous position and department/employer in 1995:

Social Services Inspector, Department of Health and Social Services

Previous position and department/employer in 2000:

Assistant Chief Inspector, Department of Health, Social Services and Public Safety

Previous position and department/employer in 2001:

As per present position

Membership of Professionals Bodies:

Northern Ireland Social Care Council

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?

I cannot recollect when I first became aware of the deaths of Adam, Lucy and Raychel, although the death of Lucy was specifically highlighted at a Departmental Board meeting on 27 February 2004 (004-019-236).

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

None, as this was not relevant to my role at that time.

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.

I have had no discussions with any colleagues in relation to this matter.

(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.

The case of Lucy was, in my recollection, initially raised at the Departmental Board meeting on 27 February 2004 (004-019-236). I received an update on the case of Lucy Crawford at the Board meeting on 28 May 2004 (004-020-255) (004-020-259-261).

(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.

The Permanent Secretary raised the issue of the deaths of the children from hyponatraemia at the Board meeting on Friday 22 October 2004. This was raised following the UTV Insight programme, which had raised a number of concerns about this case. There was agreement that an independent investigation was required to address the totality of the issues raised by the programme. The Permanent Secretary, as chair of the Departmental Board, agreed to seek agreement from the Minister on the appropriate action to be taken. Although I have had no direct involvement in the cases of Adam, Lucy and Raychel, I am currently involved in the further improvement of our Department's safeguards and protection of children through the development of a Regional Child Death Review Protocol. This work is being undertaken following the publication of the independent inquiry into the death of David Briggs and injury to his brother Samuel (The Lewis Report – Published Sept 2003). The Inquiry Team was advised of this work in December 2004.

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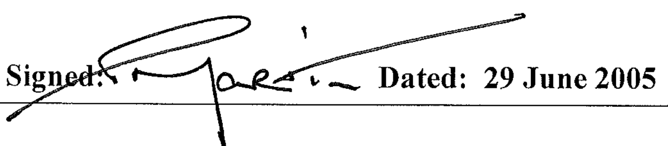
Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

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



Signed: **Dated: 29 June 2005**