Dr Jean Keeling
[redacted]

Your Ref:

Our Ref: AD-0055-09

Date: 10th July 2009

Dear Dr Keeling,

I am the solicitor to the above named Inquiry. I understand from Dr Harvey Marcovitch that he has recently spoken to you regarding the provision of a paper to the Inquiry dealing with the topic of unexpected deaths in hospitals and lines of communication.

To provide you with a little of the background of the Inquiry, I have attached a copy of the current Terms of Reference. The Inquiry was established in November 2004 by the then Minister for Health in Northern Ireland, Angela Smith MP. Her decision was made against the background of public concern about the treatment in local hospitals of children who died of hyponatraemia, which was highlighted in a documentary entitled "When Hospitals Kill".

The Inquiry team's current proposal to deal with the topic is that a paper in 2 sections, dealing with unexpected deaths and lines of communication would be provided. The first element would constitute background information, dealing with the following questions;

1. Between 1995 to date what was/is the system of procedures and practices in the UK for recording, reporting and dissemination of information on unexpected deaths in hospital to the hospital within which the unexpected death occurs, the treating clinicians (including doctors and nurses), the Trust, Area Board and DHSSPS including the Chief Medical Officer?

2. Between 1995 to date what was/is the system of procedures and practices in the UK for ensuring that the information on unexpected deaths in hospitals is/was analysed and that any lessons to be learned from those deaths feed/fed into the teaching and training of doctors and nurses and the care of patients?

3. Between 1995 to date what is/was the system of procedures and practices in the UK for the reporting and dissemination of information on the outcomes or lessons to be learned from Coroner's Inquests to the hospital where the patient was

treated, other hospitals, the doctors and nurses, Trusts, Boards and the DHSSPS, including the Chief Medical Officer?

4. Between 1995 to date what was/is the system of procedures and practices in the UK for ensuring that the information on the outcomes or lessons to be learned from Coroner's Inquests is/was analysed and feeds/fed into the teaching and training of doctors and nurses and the care of patients?

These questions are framed using the structure of the healthcare system in Northern Ireland. In the UK, I understand that the Chief Medical Officer may not necessarily be made aware of unexpected deaths and so I would ask that you would substitute the relevant structure as exists in other parts of the UK. It has been suggested that a coroner be asked to respond to point 3. I would welcome your comments on this and the possibility of you dealing with points 1, 2, and 4.

The second limb of the paper (or separate paper should you feel that to be more appropriate) would deal with issues going forward, such as:

1. The scope for improvement to the current system of the recording and reporting of unexpected deaths in hospitals, to what institutions/statutory authorities should such deaths be reported to outside the individual hospital concerned and what procedure should be established to enable it to be done in a systematic manner.

2. The scope for improvement in the system of procedures and practices for ensuring that the information on unexpected deaths in hospitals is analysed and that any lessons to be learned from those deaths feed into the teaching and training of doctors and nurses and the care of patients.

3. The scope for improvement in the system of procedures and practices for the reporting and dissemination of information on the outcomes or lessons to be learned from Coroner's Inquests to the hospital where the patient was treated, other hospitals, the doctors and nurses, Trusts, Boards and the DHSSPS including the Chief Medical Officer.

4. The scope for improvement in the system of procedures and practices for ensuring that the information on the outcomes or lessons to be learned from Coroner's Inquests is analysed and feeds into the teaching and training of doctors and nurses and the care of patients.

Should you be in a position to assist the Inquiry, I would be grateful for your views on this. In the event that you are willing to undertake this task, please let me have an indication of your fees and a timeframe within which you would be able to supply the papers.

My contact details are below should you wish to discuss this matter in more detail with me.

[redacted]

I look forward to hearing from you.

Yours sincerely,

ANNE DILLON
Solicitor to the Inquiry

Direct Dial: [redacted]
Email: [redacted]

[redacted]

TERMS OF REFERENCE

(REVISED NOVEMBER 2008)

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

THE HEALTH AND PERSONAL SOCIAL SERVICES ORDER (NORTHERN IRELAND) ORDER 1972

In pursuance of the powers conferred on it by Article 54 and Schedule 8 to the Health and Personal Social Services (Northern Ireland) Order 1972, the Department of Health, Social Services and Public Safety hereby appoints Mr John O'Hara QC to hold an Inquiry into the events surrounding and following the deaths of Adam Strain and Raychel Ferguson, with particular reference to:

(i) The care and treatment of Adam Strain and Raychel Ferguson, especially in relation to the management of fluid balance and the choice and administration of intravenous fluids in each case.

(ii) The actions of the statutory authorities, other organisations and responsible individuals concerned in the procedures, investigations and events which followed the deaths of Adam Strain and Raychel Ferguson.

(iii) The communications with and explanations given to the respective families and others by the relevant authorities.

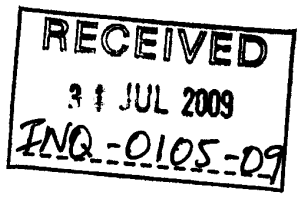
In addition, Mr O'Hara will:

(a) Report by 1 June 2005 or such date as may be agreed with the Department, on the areas specifically identified above and, at his discretion, examine and report on any other matters which arise in connection with the Inquiry.

(b) Make such recommendations to the Department of Health, Social services and Public Safety as he considers necessary and appropriate.

Dr Jean W Keeling

[redacted]



28.07.09

Dear Ms Dillon,

Thank you for your letter of 10/07/09. I did discuss the possibility of providing background information to the Inquiry with Dr Marcovitch and, I think, made clear that I had reservations about my ability to do this.

Having read your specific questions, I am even more concerned about my ability to do so. Your questions seem to assume that uniform and specific protocols for the recording and dissemination of necropsy-derived information have been in place for very many years. This is not the case.

With the establishment of Clinical Pathology Accreditation (UK) Ltd(CPA) in 1992, protocols relating to the timeliness of distribution of Postmortem reports were drawn up in individual departments, including rapid dissemination of information of a 'working diagnosis' to Clinicians in respect of their patients, in the form of a brief note, proforma or preliminary report, to form the basis of discussions with relatives, before the Postmortem report itself was completed. I the case of children, where there is a need for ancillary investigations, such as microbiology or cytogenetics, this takes several weeks. Locally, it was suggested to my colleagues that an appointment should not be offered to parents within six weeks of the death of their child. It was and is usual to send a copy of the postmortem report only to the designated clinician. It was my practice to send a copy to the referring clinician if the child had been admitted initially to another hospital. Once the Accredition process had been in place for a number of years, there was a slow move towards a consensus in the content of some protocols.

Telephone [redacted] e-mail [redacted]

In 1993, in response to complaints about the standard of some Postmortem reports, particularly, I recall, those performed on instruction from Coroner or Procurator Fiscal, the Royal College of Pathologists produced 'Guidelines for the Production of Postmortem Reports', a short booklet distributed to relevant Members and Fellows of the College, indicating a minimum content of such reports. This document was advisory, not compulsory. This was the first attempt to introduce some sort of uniformity into an area with very wide standards of personal practise.

From my letter thus far, I think it is clear that practises in the production of reports have evolved locally. The same is true for the dissemination of information, the only legal requirement being to provide a Cause of Death and subsequently a report, to the Coroner or Procurator Fiscal in cases investigated on their behalf and to the Regional Medial Officer in cases of certain infectious or industrial diseases. From the Pathologists' point of view, further dissemination of information about the death would be the responsibility of the attending clinician and, I expect, would vary from institution to institution. The only other person regularly informed would be the families' General Practitioner.

In respect of question 3, I think you should consult with a Coroner. My understanding is that it is their responsibility to communicate relevant information to Clinicians. My own practise has been to obtain blanket permission from the Medicolegal Authority to inform Clinicians of postmortem findings on their patients, being quicker and more reliable.

It was not until 2002-3 that in Edinburgh, a formal meeting was convened to consider hospital deaths, except within Obstetric departments, where such meetings have been required by the RCOG for many years. Although many Pathologists will have presented cases of in-hospital child deaths at clinical meetings over many years, this was not mandatory, nor were meetings minuted.

Given the limitations I have identified,I am willing to provide background papers for your Inquiry and whilst I will endeavour to answer your questions, some answers, will, of necessity, be imprecise. My hourly rate is £180 and I would expect to complete them before the end of this year.

Having been retired for 4 years, I would make enquiries amongst practising pathologists in respect of current practice in their units. This information would be anonymized.

Your Inquiry team may find parts of a chapter 'Sudden death of children in hospital' provide useful background information

Yours sincerely

J W Keeling

Berry J. Sudden death of children in hospital. in Busuttil A, Keeling JW. Paediatric Forensic Medicine and Pathology. Hodder Arnold 2008 pp363-384.