

(ii) Erne Hospital

The Chairwoman asked Mr Lindsay to provide members with an update in relation to the tragic death of a child four years ago in the Erne Hospital.

Mr Lindsay began by providing members with the details surrounding this tragic incident and explained the circumstances which led to last week's Coroner's Report on the incident. He informed members of the key findings of the Coroner.

Following the Coroner's Report, Mr Lindsay said that the Coroner had asked the Chief Medical Officer to consider the findings. Mr Lindsay assured members that the three local hospitals' practices had changed three years ago following the tragic death of the child in Altnagelvin Hospital under similar circumstances.

Mrs Grant shared a newspaper article with members in relation to these tragic deaths. She commented that there appeared to be communication issues and also felt that an external expert should have conducted the investigation at the Erne Hospital. Mr Lindsay said that the Coroner recognised that communication issues did exist.

Commenting, Mrs Kelly felt that these tragic deaths highlighted the very real need for Whole System working which would include the sharing of standards and best practice.

Mr Grant referred to a meeting of the Health Care Committee where she had raised under Any Other Business the issue with regard to the procedure for note taking in relation to adverse incidents which occurred in hospitals. She had expressed concern that more than one set of notes for adverse incidents may be retained. Mr Lusby felt strongly that a set protocol should exist in relation to note taking.

Mr Lindsay undertook to clarify the Chief Medical Officer's remit following the Coroner's request for the Chief Medical Officer to consider the case and he would report back to the Administrative Services Committee. He also undertook to locate a copy of the Health and Social Care Committee minute referred to by Mrs Grant with regard to adverse incidents.

In conclusion, the Chairwoman emphasised that these were tragic incidents and it was hoped that any lessons to be learnt would prevent any similar tragedies from occurring.

SIGNED *[Handwritten Signature]*
CHAIRWOMAN

DATED 27.01.11