WHSSA Minutes approved at WHSSA Mtg on 25/3/04

[redacted]

154/04 ANY OTHER BUSINESS

(ii) Erne Hospital

At its meeting on 25 March 2004 the Administrative Services Committee received an update from Mr Lindsay in relation to the tragic death of a child four years ago in the Erne Hospital.

The Chairwoman referred to the issue raised by Mrs Grant at the Administrative Services Committee in relation to the number and types of notes taken within a clinical situation and asked Mrs Kelly to clarify for the meeting the protocol for note taking. The Chairwoman asked that the minute recorded that there was only one set of clinical notes retained for an individual patient.

Dr McConnell pointed out that when a medico-legal allegation is made, at that point an internal investigation will be undertaken and external and expert reports may be sought for the purpose of examining that healthcare negligence case.

These documents are entirely separate from clinical notes and they are reports purely for particular healthcare negligence case.

He went on to explain that there is now a system which encourages medical staff to submit incident reports in all situations so that the system in general can learn lessons from these incidents.

In response to Mr Rogan, Dr McConnell confirmed that historically there had been some reluctance by staff to complete incident reports for all situations, but progress away from the blame culture was being made.

Commenting, Dr Downey informed members that the Board's protocols for untoward events and near miss reports would be discussed at the Governance and Risk Management Committee meeting to be held on 25 March 2004 and these protocols would be brought to a future Administrative Services Committee meeting.

Mrs Grant referred to her initial comment concerning the time delay between an adverse incident and the lessons learnt reaching other hospital Trusts. She felt strongly that recurrent funding should be provided so that equipment necessary to prevent another such similar adverse incident occurring can be prevented.

Mr Lusby asked for clarification in relation to the procedure for clinical note taking.

Mrs Kelly confirmed that the original, clinical notes were retained for individual patients and that entries within the clinical notes were made by doctors, nurses, and other health and social care professionals. These original notes would be used in a legal situation if required. Mrs Kelly assured Mr Lusby that this protocol ensured the integrity of the clinical notes.

Dr McConnell added that in addition to the existing guidance in relation to the retention of notes, that further major improvements would occur when a more paperless system became operational and the introduction of a unique patient health care number would ensure that authorised personnel can easily access and update any patients' notes throughout Northern Ireland.

The Chairwoman thanked members for their contribution.

14/04 [redacted]

[redacted]

15/04 [redacted]

[redacted]

[redacted]

11. [redacted]

12. [redacted]

13. [redacted]

14. [redacted]

16. [redacted]

17. **Administrative Services Committee – Erne Hospital**

Steven to provide Non Executive Members with a copy of the Chief Medical Officer's report in relation to the tragic death of a child at the Erne Hospital, when it becomes available.

S Lindsay

18. [redacted]

[redacted]

A154/04 ERNE HOSPITAL

Mrs Kelly provided members with an update in relation to the tragic death of a child four years ago at the Erne Hospital. She said that following the recent Ulster Television "Insight" programme, the Minister of Health, Social Services and Public Safety had now set up an Independent Inquiry with regard to the allegations made in the programme surrounding the deaths of three children across Northern Ireland. Mrs Kelly informed members that because of this Inquiry, the Permanent Secretary had asked the Root Cause Analysis Group, established by Sperrin Lakeland Trust, to discontinue its work.

Mrs Kelly said that valuable training for staff incorporated within the Root Cause Analysis had taken place and this training would now be incorporated within Sperrin Lakeland Trust's Clinical and Social Care Governance procedures.

Mrs Kelly distributed to members a copy of the Press Release setting out the Terms of Reference for the Independent Inquiry. She informed members that Mr John O'Hara, QC, had been appointed to conduct the Inquiry into the events surrounding the deaths of the three children. Mrs Kelly then took members through the key points of the Terms of Reference which covered the care and treatment of the three children, the actions of the statutory authorities, other organisations and responsible individuals concerned in the procedures, investigations and events which followed the deaths of the children and the communications with, and explanations given to, the respective families and others by the relevant authorities. In addition, Mrs Kelly said that Mr O'Hara will have the discretion to examine and report on any other relevant matters which arise in connection with the Inquiry.

Mr Williams asked that, as one of the statutory authorities involved in the Independent Inquiry process, how much involvement had the Board previously had in the detail surrounding the cases.

In response to Mr Williams, Mrs Kelly confirmed that she was a member of the Root Cause Analysis Steering Group and participated in the training for staff as part of that Group.

Dr McConnell explained that in line with Clinical and Social Care Governance arrangements, there were informal procedures in place which gave early details of any untoward incidents. He said that a more formal system was being established in co-operation with the DHSSPS for dealing with such incidents in the future. However, Dr McConnell indicated that the Board felt that more detail was required within this new formal system. In the meantime, Dr McConnell said that the Board and the Trust had in place its own formal procedure for reporting untoward incidents.

In response to Mr Williams, Dr McConnell said that this procedure was established following these incidents and, whilst it would not have prevented the initial incident occurring, it should ensure awareness of future incidents so that any pattern of events could be watched for.

Mr Lindsay reminded members that the Board's responsibility was to commission quality services for the entire Western Board area population and while the Trusts reported directly to the DHSSSPS on Clinical and Social Care Governance issues, it was important that the Board should learn lessons from any adverse incident.

Dr McConnell felt that lessons with regard to these incidents should be learnt across the whole of the United Kingdom as well as within the Western Board and Northern Ireland.

Commenting, Mrs Grant hoped that lessons will be learnt from these tragic incidents. She asked if the public would be allowed to make submissions to the Independent Inquiry.

In response, Dr McConnell said that by contacting Dr O'Hara directly or through the Board, clarification could be sought with regard to individuals making submissions to the Inquiry.

Mr Lindsay tabled a letter he had received from Omagh District Council following the 'Insight' T.V. programme regarding Sperrin Lakeland Trust. He also tabled a first draft of a possible response from the Board. Mr Lindsay read the key points from these letters and copies of both letters were then distributed to members.

Members agreed to consider the Board's draft response and to advise the Chief Executive on any amendments they considered necessary.

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