MINUTES OF THE DIRECTORS OF PUBLIC HEALTH / CMO
MONDAY 6 JUNE 2005
10.00 AM - 1.00 PM
ROOM C5.15, CASTLE BUILDINGS

PRESENT	DEPARTMENT
DPH	Dr H Campbell (Chairman)
Dr W McConnell	Dr N Chada
Dr D Stewart	Dr L Doherty
Dr A Telford	Dr H Neagle
Prof J Watson	Dr M Scott
	[redacted]
Dr B McCloskey (HPA)	

1. WELCOME / APOLOGIES

[redacted]

2. MINUTES OF THE MEETING HELD 11 APRIL 2005

[redacted]

3. MATTERS ARISING

- **Chronic Pain Management**

[redacted]

- **Abortion**

[redacted]

4. SCREENING

[redacted]

5. REVIEW OF PATHOLOGY

[redacted]

6. PAEDIATRIC CARDIAC SURGERY

[redacted]

7. GUIDANCE FOR THE MANAGEMENT OF PATIENTS ACCESSING OUT OF AREA TREATMENT

[redacted]

8. REPORTING SERIOUS INCIDENTS

These incidents will be reviewed again in June to check the effectiveness of the system and whether any points can be identified for future training purposes. The main issue is how to define 'serious incidents.' Members agreed that

information should be created on a UK wide basis, that the pace of reporting was improving and that the process is for the purpose of learning, not to apportion blame.

9. CHILDREN'S ACQUIRED BRAIN INJURY

[redacted]

10. HUMAN ORGAN INQUIRY

[redacted]

11. INFECTION CONTROL STRATEGY

[redacted]

12. UPDATE ON IMPLEMENTATION OF THE REVIEW OF PUBLIC HEALTH

[redacted]

13. CEMACH MATERNAL DEATHS REPORT

[redacted]

14. SAC PAEDIATRICS COMMUNITY HEALTH REPRESENTATION

[redacted]

15. ANY OTHER BUSINESS

[redacted]

SERIOUS ADVERSE INCIDENTS REPORTED TO DHSSPS UNDER HPSS (PPM) 06/04

In June 2004, guidance on the reporting and follow-up of serious adverse incidents was issued to HPSS organisations and special agencies (HSS (PPM) 06/04). This guidance highlighted the need for the Department to be informed about incidents which were regarded as serious enough to:

a. require action to be taken to ensure improved care or safety for patients, clients or staff;
b. be of public interest; and/or
c. merit consideration of an independent review of the incident.

This paper provides a summary of the first 59 incidents reported to the Department following publication of this guidance. Where appropriate, the Department has sought further advice/update from the relevant HPSS organisation. It is hoped that a more detailed report will be provided to HPSS organisations and special agencies in the near future. A briefing meeting on serious adverse incident report is to be held on 15 June 2005. This will provide an opportunity for HPSS staff and Departmental officials who are involved in these reporting arrangements to:

a. raise awareness on particular issues;
b. cascade learning; and
c. consider any changes to enhance the current system.

DR MAURA BRISCOE
19 May 2005

Serious Adverse Incidents reported to DHSSPS under HSS(PPM)06/04

Up to & inc. SAI 38/05

59 incidents reported

Acute Trusts	13
Community Trusts	22
Mixed Trusts	21
Boards	3

Deaths

Total	11

- Death of baby with meningococcal septicaemia – public health issue
- Incorrect Blood Transfusion -Inquest Hearing – media interest
- Unexpected death following 2 visits to A&E
- Death 12 days after wheelchair coach accident
- Patient dies after hernia surgery
- Baby dies after complicated surgery. No ICU bed
- Patient dies – not unexpected. No regional ICU bed
- Patient dies after incident in bathroom
- Expected death of looked after (fostered) child. Media interest
- Sudden death of patient shortly after admission to Psychiatric Unit
- Death following overdose of insulin

Suicides (not inc. in deaths total)

[redacted]

Serious Incidents

- Neonate may have received too much oxygen whilst on ventilator
- Surgical stapler malfunction/ central line damage
- Major complication during/following appendix operation
- GP self injection of morphine while on duty
- 9 mth delay in CT scan of patient
- Ventilation at different hospitals (2)
- Assault on vol. accommodated young person during home visit weekend
- Medication by chemist caused drowsiness
- Care assistant suspended after not revealing previous conviction

Miscellaneous

Serious Criminal Behaviour 4 (Involving arrests)

Attacks on or threats to Staff/property 8

Large scale incidents 4