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Ms Anne Dillon
Inquiry into Hyponatraemia-Related Deaths
Arthur House
41 Arthur Street
BELFAST BT1 4GB

Your Ref: AD-0679-13
Our Ref: LIT 477/2008/B5/CR

Date: 5 November 2013

Dear Ms Dillon

SERIOUS ADVERSE INCIDENT (SAI) CLINICAL DATA

I refer to the above and previous correspondence on the provision of SAI data regarding clinical incidents and the recent reference in the Inquiry's Opening statement in relation to SAI data on the deaths of children refer.

The HSCB has advised that during the 2012 year there were 9 "clinical" SAIs reported which involved the death of an individual aged under 18 years of age. These SAIs were either in the acute service programme of care or in the Maternity and Child Health Programme. Two of the 9 SAIs reported in 2012 were also notified to the Department through the Early Alert Notification System.

I am instructed that the purpose of the SAI reporting system is to identify and promote learning from the events and is not used solely to capture information in relation to deaths. The SAI guidance includes 8 criteria which can be used to determine if an incident that constitutes an SAI, one of which is if the incident was as a result of an unexpected/unexplained death of an individual. You will also be aware of the revised guidance issued by the HSCB in October 2013 which requires HSC organisations to report the deaths of any child up to the age of 18 in respect of HSC services as an SAI. The definition of HSC services includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register.

There have been ongoing National Confidential Enquiries into maternal and perinatal deaths (stillbirths and neonatal deaths) for many years, although the names have changed from CESDI (Confidential Enquiry into Stillbirths and Deaths of Infants) 1993-2003; CEMACH (Confidential Enquiry into Maternal and Child Health) 2003-2009; CEMACE (Centre for Maternal and Child Enquiries) 2009-2011; MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) since 2012.

Throughout this period Northern Ireland has collected and contributed data to these enquiries through what is now called the NIMACH (NI Material And Child Health) Team in the Public Health Agency. They analyse local data as well as anonymising the data before it is sent to the

UK Confidential Inquiry. Trusts all contribute to NIMACH data and, although not a statutory requirement, virtually all maternal and perinatal deaths are reported to NIMACH.

I have been asked to raise with you the potential sensitivity around the figures being shared in this correspondence. You will note there is a real risk that, taken out of context, the information could unnecessarily damage public confidence in the Health Service and cause upset and alarm to the families of children who have died during 2012. Throughout the inquiry process, the Inquiry Team has consistently dealt with the evidence in a sensitive and appropriate manner. We are, however, very concerned as to the potential negative impact of any media reporting in relation to the information contained in this letter and I would ask you to bear this in mind.

Should you require any further information, please do not hesitate to contact me.

Yours sincerely

pp Frances Crazier

CATHERINE RODGERS
for The Solicitor
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