Ms Joanna Bolton
Directorate of Legal Services
2 Franklin Street
BELFAST
BT2 8DQ

Our Ref: AD-0669-13

Date: 14th October 2013

Dear Ms Bolton,

RE: DEPARTMENTAL AND ADDITIONAL GOVERNANCE SEGMENT

I am grateful for the paper and appendices provided on behalf of the Health and Social Care Board. They helped to explain the Board's role in the areas in which the Inquiry is interested.

As you will understand, the families involved in the Inquiry, and the public generally, are anxious to be re-assured that if and when mistakes are made in the future, there will be effective investigations which result in lessons being learned. It would, therefore, be helpful if the Board could respond to the additional questions and requests for documents set out on the first attached paper in order to help the Chairman develop his understanding of how the serious adverse incident (SAI) procedure works in practice.

It would also be helpful if the Board responded to the hypothetical scenario set out in the second attached paper. That scenario includes elements of the cases about which the Inquiry has heard evidence. The Board is invited to set out how it would expect such a scenario to be dealt with and to answer the specific questions which are asked. In this exercise the emphasis should be on the way in which the incident is investigated rather than on the clinical details which are necessarily somewhat vague.

It would be helpful if the Board was able to respond to the two papers by 30 October.

The continuing assistance of the Board is much appreciated. Our exchanges will be shared with the parties and made public in order to set the scene for the evidence which will be given in week commencing 11 November. Your letter of 24 September includes the Board's proposal as to its four representatives. That proposal is accepted. It would be helpful if curriculum vitae of each of the four representatives could be provided by 31 October.

Yours sincerely,

Anne Dillon
Solicitor to the Inquiry
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PAPER 1

FURTHER ISSUES ARISING FROM THE HSC BOARD PAPERS

1. In a case involving child health/acute paediatrics the nomination of the designated review officer (DRO) appears to fall to Dr Fiona Kennedy or Ms Denise Boulter according to Appendix I of the September 2011 paper which is attached as Appendix III. Is that correct?

2. What range of experience, qualifications and skills are held by potential DROs who may be nominated in the case of a child's death which raises fluids management and nursing issues? Can you provide examples of individuals who have been nominated as DROs in such circumstances?

3. Please provide a copy of the internal HSCB/PHA protocol which gives further guidance for DROs regarding the nomination and role of a DRO – Appendix IV, Section 12.0.

4. Appendix IV at Section 3.6 refers to the involvement of the RQIA. Setting aside cases involving the Mental Health (Northern Ireland) Order 1986, please clarify by way of example cases which fall "within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation".

5. Section 7.4 of the October 2013 procedure deals with SAIs being "transferred" to other investigation processes. Setting aside the example of an independent/public inquiry, what is involved in "case management reviews"; and "serious case reviews" and how are those reviews conducted so as to involve the family and to provide for lessons to be learned?

PAPER 2 - HSCB

HYPOTHETICAL SCENARIO

- Previously healthy five-year old girl admitted to Altnagelvin Hospital on a Monday afternoon.

- Her condition is not clearly identified but there is a query as to whether she has encephalitis.

- She appears to have mild to moderate dehydration and is put on an intravenous maintenance fluid. Her serum sodium is measured on Monday evening at approximately 8 pm at 140 mmol/L.

- Tuesday morning – the electrolytes are not checked. Her parents express concern during the day that she is lethargic, that she is not talking to them and that she is drifting in and out of sleep.

- She is not seen by her named or any consultant until she suffers seizures.

- Her parents are assured that there is no significant cause for concern and leave the hospital at 9 pm on Tuesday.

- At 3 am on Wednesday, the girl suffers seizures. She is found to have fixed dilated pupils and her serum sodium is measured at 121 mmol/L.

- After efforts are made to restore her electrolytes and after brain scans were conducted, she is transferred to the RBHSC on Wednesday at 10 am.

- She is pronounced dead on Thursday morning after brain stem tests have been carried out.

- Altnagelvin Hospital recognises that the girl's death is unexpected and unexplained.

- The doctors in the RBHSC identify a lack of consultant care, no clear recording of fluid intake and output, the concerns of the parents being ignored and the significant fall in her electrolytes.

Against this background, please explain how the SAI procedure introduced with effect from October 2013 would be expected by the HSCB to operate. Apart from dealing generally with that issue, please deal with the following specific points:

1. Who instigates the SAI – the Western Trust (for Altnagelvin), the Belfast Trust (for the RBHSC) or both?

2. Who leads the investigation into the girl's death in the SAI?

3. How do the two Trusts work together on the SAI?

4. At what level of SAI would the circumstances such as these lead to – level 2 or 3?

5. How is the designated review officer selected?

6. Who selects the designated review officer?

7. What experience and qualities are expected of the DRO in this case?

8. How and to what extent are the parents involved in the SAI investigation?

9. Who, if anyone, assists the parents? How would the parents be made aware of the possibility of assistance? How would they know about the existence and possible contribution of the Patient and Client Council?

10. Who reports the child's death to the Coronial Service?

11. Does the SAI investigation take place and produce a report before the inquest?

12. If so, is the outcome reviewed after the inquest and, if so, how?

13. Is the SAI investigation shared with the Coroner?

14. How is the family assured that the SAI investigation is independent and that there is no "cover-up" or unwillingness to face up to errors? How would the HSCB ensure the independence of the investigating team?

15. If the investigation discloses failings such as inadequate consultant care, inadequate record-keeping or failure to pay heed to the parents, how are lessons learned under Section 8.0 of the procedure by the Western Trust, by the Belfast Trust and by other Trusts? What actions might be taken, or at least considered, in relation to either the public bodies or any individuals who were involved?

16. Will the family be given a copy of the investigation report? If so, when? What chance would the family have to challenge any of the conclusions in the report, either when it is in draft form or when it is complete?