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 appears to fall to Dr Fiona Kennedy or Ms Denise Boulter according to Appendix 1 of the September 2011 paper which is attached as Appendix III. Is that correct?**

   That is correct. Appendix 1 of the protocol 'Nomination and Role of an HSCB/PHA Designated Review Officer (DRO) September 2011, states that the lead officers who are responsible for nominating a DRO officer are:

   - Regional Lead Doctor (PHA)
   - Regional Lead Nurse (PHA)
   - Regional Lead Social Worker (HSCB)

   This appendix is updated on a quarterly basis to take account of staff changes, the most recent update being October 2013 (see appendix 1).

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

   DROs will all have a health/social care background and hold the relevant qualifications and registrations associated with such; but are not currently practising in a clinical setting and may not have for some time. The key focus of their expertise is the provision of professional input into the commissioning of health and social care services.

   All DROs are senior professionals/officers within the HSCB / PHA operating within their own professional scope of practice. The DRO is not directly involved in the investigation of a SAI. The DRO, based on the information provided by the reporting organisation will:

   - Liaise with reporting organisations on any immediate action to be taken following notification of a SAI, such as seeking assurance that the Trust has identified and addressed any immediate issues of material risk; and continue to liaise with the reporting organisation where relevant.

   - Agree the Terms of Reference for Level 2 and 3 investigations and continue to liaise with the reporting organisation where relevant.

   - Review the completed SAI investigation reports, liaising with other professionals within the HSCB/PHA and RQIA where relevant;

- Liaise with reporting organisations, where clarity may be required or where there may be concerns regarding the robustness of the investigation or issues highlighted with proposed action plans;

- Identify regional learning (where relevant) from the findings and recommendations included in the Trust/s investigation report

The DRO, in the case of a child's death which raises fluids management and nursing issues would be a Consultant in Public Health working closely with a Nurse Consultant and Pharmacy lead.

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**

The most recent DRO protocol has already been submitted (appendix III as referred to in question 1.)

This protocol will be updated following the DRO workshop scheduled for December 2013 in order to take account of the revised 2013 SAI Procedure.

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.

These cases refer to any service user placed/funded by HSC Trusts in statutory/ independent sector accommodation, including:

- Private/Independent hospital/clinic;
- Children homes;
- Nursing or residential care homes

As the organisation which holds the statutory obligation to regulate the above, RQIA are also notified of any SAIs relating to these service areas.

Such an example may include a patient being referred by a Trust to receive treatment in a private/independent hospital as part of a waiting list initiative e.g. to reduce waiting times for orthopaedic surgery. These initiatives may be commissioned by Trusts to provide additional capacity.

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 the "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?

Case Management Reviews (CMR)

A CMR should be undertaken where a child has died or been subject to significant harm and where,

- abuse or neglect of the child is known or suspected

- the child or a sibling of the child is or has been on the child protection register

- the child or a sibling of the child is or has been looked after by an authority, and

- the Safeguarding Board for Northern Ireland (SBNI) has concerns about the effectiveness in safeguarding and promoting the welfare of children of any of the persons or bodies represented on the SBNI.

The SBNI will also consider other circumstances where children have died, where the young person has ended their own life or died within a custodial setting.

The purpose of any such review is to,

- Establish the facts of the case
- Identify what has worked well
- Ascertain if there are lessons to be learned about the way in which professionals or agencies work together
- Identify clearly what these lessons are, how they will be acted upon and what is expected to change as a consequence.
- A report and summary documentation should be prepared to ensure dissemination of learning for the purpose of improving practice and future safeguarding arrangements.

Serious Case Review (SCR)

SCRs in relation to adults at risk are not undertaken as yet in Northern Ireland.

The Northern Ireland Adult Safeguarding Partnership (NIASP) has been asked by the DHSSPS to bring forward a proposal for the introduction of SCRs for adults. This will include criteria for consideration of a SCR and provide guidance on the process and format to be adopted.

As this work is currently underway, the SCR process has been referred to within the revised 2013 procedure in order to take account of this imminent new practice and its subsequent relation to the SAI procedure.

The HSCB through the legacy Regional Child Protection Committee had previous responsibility for the commissioning of Case Management Reviews. This responsibility transferred to the Safeguarding Board for Northern Ireland (SBNI) from t1 September 2012. The commissioning of Serious Case Reviews relating to

vulnerable adults falls within the remit of the Northern Ireland Adult Safeguarding Partnership which is accountable to the HSCB.

Parental/ Family involvement

It is expected that the notifying agency will have advised the family of their view that the case should be referred for a CMR/SCR.

Each agency is requested to provide an Individual Agency Review outlining its involvement and to nominate an individual at a senior level to sit on the CMR Team. The CMR will be chaired by an independent person and this chairperson and the SBNI Case Management Review Chairperson will meet with the family members at the outset to explain the terms of reference and to offer the family the opportunity to contribute to the review. On occasion this may be through a written submission or with representatives of the CMR Team meeting with relevant family members. The level of participation of family members will on occasion be constrained if there are on-going criminal proceedings.

At the conclusion of the review the family will be advised of the outcome and where meetings have occurred the family will be able to be accompanied by a support person, this may be their solicitor.

The SBNI will also in the future have responsibility for undertaking a Child Death Overview process. All deaths of children under 18 years of age will require to be notified to the SBNI for consideration.