Paper 2 – Questions re: Hypothetical Scenario

Context

The HSCB and PHA are responsible for the administration of the Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAI), updated October 2013. (See appendix 2).

The primary aim of the process is for the HSCB/PHA to identify possible learning from SAIs which has been identified following the investigation by Trusts in order to reduce the risk of recurrence.

The following answers to the hypothetical scenario questions therefore reflect the HSCB/PHA role in this process:

- Ensure immediate actions have been taken by Trust/s following notification of the SAI
- Review the final investigation report which has been produced by the Trust/s, to ensure a robust investigation has been undertaken, seeking further clarification if necessary
- Identification of regional learning (where relevant) from the findings and recommendations included in the Trust/s investigation report.

The HSCB/PHA Designated Review Officer is not directly involved in the Trust/s investigation.

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

   Based on the clinical scenario and under the current 2013 Procedure for the Management and Follow up of SAIs, we would expect the WHSCT to instigate, ie report, the SAI.

   The BHSCT can also report this child death as an Interface Incident, see section 3.4 appendix of the 2013 procedure (attached). This will allow HSCB to follow up if WHSCT have not already submitted the SAI.

   Should the same SAI be submitted by both WHSCT and BHSCT, the SAI administrative process will identify that both these SAIs relate to one case and will liaise with both Trusts to identify the Trust who will lead the investigation.

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

   This SAI crosses three HSC Trusts i.e.

- BHSCT
- WHSCT
- NIAS

As per guidance (see appendix 12 of revised 2013 procedure), the general rule is for the provider organisation with the greatest contact with the patient/service user to lead the investigation and action. The decision should be made jointly by all organisations concerned, with the Chair and Membership of the Investigation Team being agreed by the DRO at the outset. Should there be a difficulty in determining who the lead organisation should be, the DRO would escalate this within normal arrangements.

In this scenario the WHSCT would most likely lead the investigation with relevant input from the organisations listed above. The WHSCT would also be expected to adhere to the guidance relating to 'investigation team membership' (appendix 10) which includes the securing of an independent chair.

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

Where a SAI involves multiple (*two or more*) HSC providers of care, a decision must be taken regarding who will lead the investigation. This may not necessarily be the initial reporting organisation.

The general rule is for the provider organisation with the greatest contact with the patient/service user to lead the investigation and any further action required. The decision on which organisation should lead the investigation must be agreed by all organisations involved and if necessary referring to the HSCB DRO for advice. If agreement on the lead organisation is not reached, this will be escalated within normal arrangements.

It will be the responsibility of the lead organisation to engage all organisations in the investigation as appropriate. This involves collaboration in terms of identifying the appropriate links with the other organisations concerned. In practice, separate meetings in different organisations may take place, but a single investigation report and action plan should be produced by the lead organisation, and submitted to the HSCB in the agreed format.

Detailed guidance on Joint Investigations and Investigation team membership is provided in appendices 10, 11 & 12 of the revised 2013 procedure, this includes arrangements to ensure that an appropriate level of independence throughout the investigation is maintained.

As per guidance, it is our expectation that the lead organisation would highlight any process issues to the DRO, in a timely manner.

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

   In the circumstances, this SAI would be a level 3 investigation for the following reasons:

   - it involves hyponatraemia and has occurred despite there having been considerable attention to preventing such cases;
   - the patient has died;
   - it will be in the public interest and therefore will be high profile in nature;
   - it is a complex incident that involves multiple organisations.

5. **How is the designated review officer selected?**

   - The decision as to who would be the most suitable DRO in this case will be determined by the Lead Doctor and the Nurse;
   - They will liaise with each other and appoint a DRO who has a suitable level of competence and expertise, and has experience of dealing with more complex SAIs. The Lead Doctor and the Nurse will ensure that the DRO will bring objectivity and the ability to challenge to the process, along with the ability to test the robustness of the process;
   - The DRO will be fully aware of the support available at a senior level within the HSCB and PHA in a complex case such as this.
   - If required, the HSCB/PHA will secure additional expertise to support the DRO.

6. **Who selects the designated review officer?**

   In this case the lead doctor and nurse will appoint the DRO.

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

   As described above, the DRO in this case would have the ability to review a clinical investigation, would have a suitable level of competence and experience of dealing with more complex SAIs, and would bring objectivity to the process. The DRO would have the ability to challenge conclusions contained within the investigation report and would be able to test the robustness of the process undertaken. The DRO would be a senior officer who would have the ability to demonstrate resilience and perseverance.

The DRO will be fully aware of the support available at a senior level within the organisations, ie Director level and Chief Executive, in such a complex case.

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

As the death of the child occurred in the Belfast Trust, they will be responsible for initially supporting the family in the bereavement. As part of that process it would be expected that they would also inform the family that the death of their child will be formally notified to the HSCB as part of the SAI process. It would also be expected that the Belfast Trust would explain the SAI process fully to the parents at what is a very difficult time.

As per the response to Question 2, the BHSCT can report this as an interface incident, in the first instance. This is in line with the new criterion added to the 2013 procedure '*any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked after Child or a child whose name is on the Child Protection Register'.*

As also outlined in the response to Question 2, the WHSCT would be responsible for reporting and leading on the investigation of the SAI. It would be the investigation team's responsibility to ensure effective engagement with the family at all stages of the process, establishing the extent to which they wish to become involved, and meeting to discuss and share the draft report of the investigation, discussing the findings, and presenting them with an opportunity to comment on the findings. The SAI procedure places importance on the fact that teams involved in investigations ensure sensitivity to the needs of the service user/relatives/carers involved in the incident and agree appropriate communication arrangements, where appropriate.

Investigation teams will refer to service user/carer engagement when completing section 4 of the Investigation Report template (see appendix 7) which highlights this requirement.

Section 5.4 and Appendix 7 (section 4.0) of the revised 2013 procedure outlines the involvement of family members 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?

In this scenario, it would be expected that the Belfast Trust would have immediate contact with the parents after the death and would discuss a range of support services available to the parents, including bereavement counselling and advocacy. This may include the Patient Client Council. The SAI process would also be fully explained to the parents at this difficult time.

As the investigation moves forward, it would be expected that the Western Trust would ensure a comprehensive level of engagement with the parents throughout and following the SAI investigation, taking account of their wishes, as outlined in the response to Question 8, and linking with BHSCT as appropriate.

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

The doctor providing the child's care at the time of death is required by law, to report the child's death to the Coronial Service, as per definition of 'unexpected death.' In this scenario it would be the doctor in charge of the child's care within BHSCT.

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

In this scenario, it would be expected that the SAI investigation would take place and produce a report, before the inquest as the timescale for coronial investigations is typically much longer than for SAI investigations.

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

Yes, if a coroner's verdict identified new issues for health and social care services, these would be reviewed by professional staff in HSCB/PHA and learning/actions required may be revised to take account of the Coroner's verdict and would be disseminated to HSC organisations in the normal way.

13. Is the SAI investigation shared with the Corner?

The HSCB/PHA does not routinely share the SAI investigation report with the Coroner, but would do so if requested.

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 the errors? How would the HSCB ensure the Independence of the investigating team?

In this scenario, which is a level 3 investigation, the WHSCT is responsible for ensuring a robust, open and transparent investigation. The timescales for reporting, Chair and Membership of the investigation team will be agreed by the HSCB/PHA DRO at the outset (see Appendix 11 Guidance notes for Level 3 investigations). If the DRO cannot agree the Membership of the investigation team with the reporting organisation, they can escalate their concerns to their Assistant Director and as necessary, Director and Chief Executive for resolution at senior level (as per 5.3 of the Procedure).

As in the response to Question 8, it would be expected that the Trust would fully and comprehensively engage with the family throughout the process, ascertaining to what extent the family wish to be involved in the process and ensuring effective communication during the process.

Appendix 10 of the 2013 procedure provides guidance to support this process i.e. where multiple (two or more) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

15. a) 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?

In this scenario:

- It would be the responsibility of the Trust to take appropriate action if the findings of the investigation include failings such as inadequate consultant care, inadequate record keeping or failure to listen to the parents. This could include any of the actions outlined in the response to Question 15(b);
- In respect of a failure to pay heed to the parents, there should be an acknowledgement from the Trust that this had happened, including as appropriate an apology.
- If the investigation report identifies local learning, this will be implemented by the Trust.

- If the investigation report or the DRO identifies any regional learning, the DRO will highlight this to the Regional SAI Review Group, who will determine the most appropriate method for dissemination of learning. Depending on the nature of the issue/s identified, this may be via a learning letter which goes out to all Trusts, a learning event/workshop, enhanced training, a targeted initiative.
- Assurances on implementation of action from learning letters are reported to the HSCB/PHA Safety and Quality Alerts Team to ensure action required has been fully implemented by Trusts

15(b) What actions might be taken, or at least considered, in relation to either the public bodies or any individuals who were involved?

- Discussion of the case by the local clinical teams, including staff involved directly;
- Refresher training for staff involved and if necessary, other staff;
- An article in the new HSCB/PHA Learning Matters newsletter;
- A learning letter from HSCB/PHA;
- Full or partial cessation of a service;
- Instigate the Trust protocol for disciplinary action*;;
- Inform the relevant training body if there are performance concerns regarding a member of staff in training;
- Immediate removal or adjustment of clinical duties of a member of staff.
- Report individuals to their respective regulatory bodies;

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?

Yes – the family should be given a copy of the draft and final investigation report. This would be expected to be reflected in the terms of reference, agreed by the DRO. It would be expected that the Trust would ensure effective engagement with the family at all stages of the process. This would include meeting with the family to share and discuss the draft report and the findings of the investigation. This would afford the family the opportunity to comment upon the findings.

Section 5.4 and Appendix 7 (section 4.0) of the revised 2013 procedure outlines the involvement of family members in the SAI investigation.