The Inquiry into Hyponatraemia-related Deaths
Chairman: Mr John O'Hara QC

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

Our Ref: AD-0670-13

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 Belfast Trust. They helped to explain the Trust's role in the areas in which the Inquiry is interested.

It would be helpful if the Trust 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 some of these matters.

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

The continuing assistance of the Trust 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.

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Counsel to the Trust indicated to the Inquiry (18 September transcript page 148) that the Trust proposed that its representatives would be the Chief Executive the Medical Director and the Director of Nursing of the Trust and the Clinical Director of the RBHSC. That appears to the Inquiry to be appropriate. Please confirm that these will be the Trust's representatives. 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 BELFAST HEALTH AND SOCIAL CARE TRUST PAPERS

1. At tab 3A, the membership of the "Children's Hospital Governance Group" is given by job title e.g. Clinical Director, Clinical Lead for Surgery etc. It would be helpful if the names of the individuals who currently hold those posts and are, therefore, members of that governance group, could be identified.

2. It is stated at page 6 of the Trust's paper, in relation to the Assurance Framework, that "the current version which was approved by Trust Board in June 2013 has taken account of the recommendations of the Francis Report and the need to strengthen the arrangements for learning from significant events". It would be helpful if examples could be given of the places in the Assurance Framework where those recommendations are reflected.

3. At page 12 of the Trust paper, reference is made to a recent initiative, the development of a "quality forum". It is not clear beyond the very general description in the paper what that forum actually does. Is there any further documentation or information which would assist?

4. At page 13 of the Trust's paper, there is reference to the "Belfast Risk and Audit Tool (BRAAT). It is stated that the tool consists of 31 standards and reference is then made to Appendix 6 to the paper. However, Appendix 6 is entitled "Health Care Quality and Safety Improvement Plan 2013/14". Please confirm whether the reference to Appendix 6 is correct.

5. At pages 13 and 14 of the Trust paper, reference is made to work which is ongoing within the Trust following the publication of the Francis Report. It appears that as inevitably happens in these circumstances, publication of such a report has helped the Trust to identify areas in which improvements might be made. It would be helpful if the Trust could provide some further information before week commencing 11 November about progress which has been made in these areas, including incident reporting, complaints management and medical/nursing training and education.

6. Pages 14 – 16 of the Trust paper (and Appendices 8 – 10) deal with complaints. It would be helpful to have further information on the following points:

   - At the bottom of page 14, reference is made to the use of lay reviewers who can assist or even chair investigations. In what circumstances are they used?

- How are the complainant and the public assured that any investigation is independent, especially when there is no lay involvement?

- The policy and procedure for the management of complaints and compliments at Appendix 8 includes as its own Appendix 7 advice on how a complaint should be investigated. There is very limited reference to the family. The procedure is that the investigator is to prepare a draft response which is shared with the relevant staff "to ensure factual accuracy and agreement". It is then ratified and signed off by others. The only reference to the family is that a meeting is to be offered to them "to discuss the outcome of the investigation". The clear suggestion is that the family has nothing to contribute to the investigation beyond making the initial complaint. Can that really be the correct approach?

7. At pages 16 – 17 of the Trust paper, the management of adverse incidents is explained. Specific reference is then made to Appendix 11, the adverse incident reporting and management policy. At paragraph 4.6 of that policy, it is stated that members of staff who make a prompt and honest report will not be disciplined except under five circumstances. The fourth of those is:

> "Where, in the view of the Trust and/or any professional registration body, the action causing the adverse incident is far removed from acceptable practice"

   Please indicate by way of example conduct which is regarded as being "far removed from acceptable practice".

8. At Appendix 12 which is referred to at page 17 of the Trust paper, the terms of reference are given for the "Children's Hospital Incident Panel (CHIP)". It would be helpful if the members of that Panel could be identified by name, i.e. the risk quality co-ordinator, the clinical director etc. In addition, it would be helpful if there were minutes (suitably anonymised) of any of its recent weekly meetings which could help develop the Inquiry's understanding of its work.

9. At pages 18/19, the reporting of serious adverse incidents is dealt with. It would be helpful if examples could be provided of SAIs which have been reported to Trust board meetings, of the quarterly and annual reports made on SAIs to the Assurance Committee of the Trust Board and of reports to the HSCB from the Children's Hospital.

10. At page 21 of the Trust paper, reference is made to a number of senior staff having undertaken specialist training in root cause analysis. Has anyone on

the paediatric side undergone this specialist training? If so, who is that person/are those people? When were they trained?

11. At page 31, the Trust responds to the issue which has been raised during the hearings and has been raised again about the assertion of privilege for experts' reports obtained in advance of inquests. The Chairman will want to discuss this during the hearings in week commencing 11 November. The issue here is not so much whether the Trust is entitled to claim privilege but how it can possibly engender public confidence by obtaining an expert's report which is critical of some actions performed by doctors or nurses and then withholding that report from the Coroner. The Trust has a duty to provide quality care to patients. It also has a duty to assist the coroner in identifying what, if anything, went wrong in the treatment of a patient. It may be suggested that these duties are separate from any duty to put forward any line which some of its staff want to take. If the Trust has an expert's report which agrees with the coroner's expert but which is rejected by its own staff why not share the expert's report and advise the staff to get separate legal representation|?

12. At pages 38 and 39, there is an explanation about the dissemination of external standards and guidelines. There is no reference in this section to any recommendations made in NCEPOD Reports. Do such recommendations from NCEPOD go to the Standards and Guidelines Committee of the Trust? In addition, are there any recent minutes of this important committee which could help develop further the Inquiry's understanding of its work?

13. At page 41 under the general heading "Current Management of Hyponatraemia", at paragraph 3, there is a reference to Appendix 37b in which the Medical Director wrote to all consultants and career grade staff on 22 August 2013. It would be helpful to obtain the details of the response which the Medical Director received broken down as follows:

(i) How many individuals was the letter sent to?

(ii) How many confirmed that they did not administer intravenous fluids to children in the course of their work?

(iii) How many confirmed that they had completed training?

(iv) Of those who confirmed that they had completed training, how many confirmed that they had completed one or more elements of that training between the letter being issued on 22 August and responses being due on 30 September 2013?

PAPER 2 – Belfast H&SC Trust

HYPOTHETICAL SCENARIO

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

- 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.

- There is an incomplete record of her fluid intake and output.

- 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 RVHSC 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 Belfast HSC Trust to operate.

Apart from dealing generally with that issue, please deal with the following specific points:

1. Who would the Belfast Trust expect to lead the investigation – the Western Trust (for Altnagelvin) or the Belfast Trust (for the RBHSC)?

2. What individual/s would lead the investigation into the girl's death in the SAI?

3. How would the Belfast and Western Trusts work together on the investigation?

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

5. How would the Belfast Trust engage with the designated review officer (DRO)?

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

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

8. Who would report the child's death to the Coronial Service?

9. Would the investigation take place and produce a report before the inquest?

10. If so, would the outcome of the SAI investigation be reviewed after the inquest and, if so, how?

11. Would the SAI investigation be shared with the Coroner?

12. How would the family be assured that the SAI investigation would be independent and that there was no "cover-up" or unwillingness to face up to errors? How would the Belfast Trust ensure the independence of the investigating team?

13. If the investigation disclosed failings such as inadequate consultant care, inadequate record-keeping or failure to pay heed to the parents, how would such lessons be learned under Section 8.0 of the procedure 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?

14. Would 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?