Paper 2 - Belfast H&SC Trust - Hypothetical Scenario

Reporting the incident (Question 5)

On investigation immediately after the child's death in RBHSC the scenario outlines that doctors in RBHSC identify significant issues regarding the patient's care in Altnagelvin Hospital before transfer.

In accordance with the SAI Procedures 1 October 2013 the following would be expected to happen:-

A Belfast Health and Social Care Trust (BHSCT) Incident form in this instance would be completed as soon as possible after the child's death to include a brief description of the incident and any issues regarding the care leading up to the child's death. The incident form as well as being reported on Datix would be escalated within the Specialist Hospitals and Womens Health Directorate to the Director or Co-director for that service to consider reporting as an SAI.

The Director/Co-director as per SAI criteria will approve that this incident should be reported under the following criteria:-

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;

The Director, taking advice from Corporate Governance within the Medical Directorate will consider if the majority of issues lie with another Trust and therefore whether the SAI should be notified to the HSCB as an Interface Incident.

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. (SAI Procedures October 2013 section 3.4)

The Directorate after agreement with service managers and senior managers in Medical Directorate will then complete a HSC Interface Incident Notification Form (Appendix 3 SAI Procedures Oct 2013). We include a completed copy of this form for the scenario for reference in Appendix 1.

Prior to the introduction of the revised HSCB procedure, it would have been custom and practice that either the Medical Director and /or the Co Director of Risk and Governance would discuss a possible SAI with their counter parts in any other Trust involved in the delivery of care implicated in a SAI. We anticipate introduction of the

interface form would not impact on this practice and as such the Trust would still contact the Western Health and Social Care Trust (WHSCT) regarding the report.

The HSCB on receipt of this form will contact WHSCT to advise them of the notification in order to ascertain if they will be reporting the incident as a SAI.

As the scenario indicates that Altnagelvin Hospital recognises that the girl's death is unexpected and unexplained it would be expected by BHSCT that the WHSCT would then report the incident as a SAI if they had not already done so.

Investigating the incident (Questions 1, 2, 3, 4)

As per SAI Procedure Oct 2013 appendix 12 the general rule is for the provider organisation with the greatest contact with the service user to lead the investigation and action. As though this patient died in BHSCT both organisations may need to seek advice from the Designated Review Officer (DRO) appointed at HSCB regarding who should take the lead. In this case as it has been identified at this stage that the issues surrounding the patient's care were found wholly to have been in Altnagelvin, then the WHSCT would be the lead organisation.

As such the WHSCT would be responsible for agreeing with HSCB if a level 2 or level 3 investigation is required. It would be expected that a level 2 investigation would be required as the incident prima facie would not meet the following requirements for level 3:-

- The incident is particularly complex involving multiple organisations;

- The incident has a degree of technical complexity that requires independent expert advice;

- The incident is very high profile and attracting a high level of both public and media attention.

As a level 2 investigation the WHSCT would be expected to instigate the investigation immediately following reporting the SAI. They would take lead in determining the Team membership and Terms of Reference and would forward this to the DRO within 4 weeks of reporting the SAI. The DRO would then advise if they felt a more independent/multi-professional Chair and/or membership is required. They would also ensure that both organisations are represented. The membership would be required to adhere to guidance on appendix 10 of the SAI Procedures Oct 2013 and ensure the following:-

- As two or more organisations are involved the Chair must be completely independent of those organisations. They should have relevant experience of that service area and/or of chairing investigations. The DRO will advise in sourcing a Chair from the HSCB Lay People panel if required.

- Membership will include senior professionals from the all service areas relevant within each organisation. The Co-director for Risk and Governanc in BHSCT would expect to be contacted by the relevant Head of Quality and Safety in WHSCT to propose membership from someone with a senior medical position in the service area where the child was admitted and cared for (if different) who has investigation experience, plus consider a senior clinician from another directorate with expert knowledge. Both Trust Medical Directors should also be in contact regarding this. As the lead investigation will be in WHSCT it would not be expected that any further members from BHSCT would be required. It would be expected that WHSCT would have no more than 3 other members of a similar make-up ensuring a multidisciplinary panel plus a trained and/or experienced facilitator to co-ordinate the review.
- At least one member of the team would have experience in Root Cause Analysis techniques and this team member should be from the lead Trust.
- Members of the team shall be separate to those who provide information to the team.

It would be responsibility of WHSCT to organise the investigation communication process in terms of ensuring meetings and information involves all team members as appropriate. All team members must be in agreement with the planned approach and terms of reference. This may include inviting external experts to the review e.g. consideration to inviting the patient's GP to ensure a complete picture of the relevant medical history is gathered. The Chair will organise this if agreed and HSCB would be available to assist.

Family involvement (Questions 6, 7, 12, 14)

The investigation team should also invite the family or the representatives of the family to the panel to gather information they feel relevant to the period of care from the family perspective. The confidentiality of anyone involved in the case would need to be protected in this situation.

As the patient died in the Trust a link person would be identified to communicate with the family in the aftermath. As per the Trust Being Open policy they would be expected to answer any questions asked and inform them if there is an SAI and the name of a corresponding link person in WHSCT to communicate with during the SAI investigation. They would also give the family information regarding the SAI process including its purpose and aims as well as an assurance regarding the independent nature of the investigation and team.

In BHSCT the link person is usually someone with medical responsibility for the patient and from that service area.

A single final report would be submitted by the lead organisation (approved by all team members) to HSCB within 12 weeks of the SAI being reported.

The family will be offered a copy of the final report by the Chair of the investigating team. It would be expected that (as happens in BHSCT) the lead organisation will do this in any of the following ways as agreed with the family:-

- They can receive the report directly and will be offered a meeting to discuss any aspects of the report.
- They can meet with Senior Trust staff who will provide them with the report. They will take them through the contents of the report and discuss any matters that the family believe are not clear.
- The Trust would recognise the family are going through a very traumatic time and that attending a meeting with a number of Trust staff may cause undue anxiety. For this reason the Chairperson or link Person would offer to meet with the family to discuss any questions or concerns they have about the care received.

The investigation team will consider any comments the family have and update the report as they deem appropriate, reflecting the families view's on sections where agreement cannot be reached.

Learning from the SAI (Questions 5, 8, 9, 10, 11, 13)

The BHSCT would engage with the DRO through reporting of the Interface Incident. After the incident has been reported by WHSCT the next engagement between BHSCT and the DRO will be if the DRO requests information directly from BHSCT regarding aspects of the final investigation report which are specific to the Trust e.g. requesting an Action plan or how learning is shared.

The BHSCT in this scenario will expect to receive a copy of the report from the investigation team when complete. The relevant director responsible for the initial interface incident will be responsible for ensuring any recommendations and learning specific to the Trust are transferred to a Trust Action Plan. The action plan is based on the format as indicated within appendix 8 of the SAI Procedures Oct 2013. The Action Plan is progressed through to completion and progress is monitored and final sign-off takes place at the Trust's SAI Review Board. Learning from this event would be discussed at the Trust's newly formed Learning from Experience Steering Group (a sub committee of Trust Board). Within BHSCT there are other forum where the

case would be discussed and learning take place for example the Audit/Morbidity and Mortality meetings.

As per section 13.7 of the SAI Procedures Oct 2013 the HSCB will disseminate any regional learning through the issuing of a Learning Letter if appropriate. Any learning letter will be received by the Trust through the Chief Executive's office and disseminated through the Management of external guidelines process (see appendix 2).

If during the investigation there are specific concerns regarding the professional performance of staff, the appropriate director will be contacted to consider a separate professional standards investigation. This will include notifying the appropriate professional body.

It would be one of the doctors who were involved in, or responsible for, the patient's care who would notify the Coroner of the child's death. This would normally be done as soon as possible after the death has occurred. If though the family is considering organ donation, the death may not be reported until later (after a decision has been made), in which case it may be a junior doctor who reports the death.

The Coroner's Post Mortem report would normally be requested by the investigation team via the lead organisation to consider during the investigation. At any time during or after the investigation the Coroner's office may ask for a copy of the investigation report (which is always shared with them) and they will usually await this before setting an Inquest date. In this instance the WHSCT will most likely forward the completed investigation report to the Coroner's office on request.

Any queries from the Coroner are sent to the relevant staff for response. This may require amending the final version of the report (with an addendum) but this is rare and has only happened previously regarding factual corrections re communication with the Coroner. The outcome of the Coroner's inquest is shared via the Trust Litigation department with the relevant clinicians and Directors where appropriate.

Appendix 1

HSC INTERFACE INCIDENTS NOTIFICATION FORM

1. REPORTING ORGANISATION: Belfast HSC Trust	**2. DATE OF INCIDENT: DD / MMM / YYYY**
3. CONTACT PERSON AND TEL NO: SeriousAdverseIncident@belfasttrust.hscni.net	**4. UNIQUE REFERENCE NUMBER: BHSCT/II/13/XX**

5. DESCRIPTION OF INCIDENT:

5 Year old female transferred to RBHSC from Altnagelvin Hospital where after brain stem tests were carried out, the patient passed away in hospital.

DOB: DD / MMM / YYYY **GENDER: M / F** **AGE: 5 years**

(complete where relevant)

6. ARE OTHER PROVIDERS INVOLVED? (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*)	**YES**	
	if 'YES' (***full details should be submitted in section 7 below***)	

7. PROVIDE SUFFICIENT DETAILS TO ALLOW FOLLW UP:

Altnagelvin Hospital, WHSCT was the referring organization. Immediate investigation took place by RBHSC medical staff were it was found that there was evidence that prior to being transferred there was a lack of consultant care, no clear record of fluid intake or output, the concerns of the patient were being ignored and there was a significant fall in the patients electrolytes.

8. IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:

Family informed and a link person identified to communicate to family.

Incident form drawn up and urgent de-brief carried about (see above)

Coroner informed

Interface Incident reported after consideration for reporting as SAI.

9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE INVESTIGATION AND FOLLOW UP OF THIS INCIDENT?

WHSCT

HSC INTERFACE INCIDENTS NOTIFICATION FORM

10. OTHER COMMENTS:

The BHSCT will provide any assistance as required in the investigation of this incident and in subsequent sharing of learning and action on recommendations as appropriate.

REPORT SUBMITTED: xxxx DESIGNATION: Senior Manager for Corporate Governance

Email: xxxx@[redacted] Telephone: [redacted] Date: xx/xx/xx

Appendix 2 - Operational flowchart - management of all external guidance / safety alerts