Health and Social Care Board

Health & Social Care Board
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Chief Executives of HSC Arm's Length Bodies

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13 January 2016

Dear Colleagues

Revision to the Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAI)

In October 2013, the criteria for reporting a SAI were revised to include the death of every child in receipt of HSC services. The rationale behind this change was to provide clarity in terms of reporting all child deaths and to enhance the culture of learning and review.

The report "The Right Time, The Right Place" by Sir Liam Donaldson on governance arrangements across the HSC (January 2015) indicated that the current requirement for all child deaths to be reported and investigated as SAIs seemed to be having "*a detrimental effect on the system*". He also stated that "*the process itself was distressing for families, burdensome for staff, and was not producing any useful learning*". Hence, he recommended that, "*the deaths of children from natural causes should not be classified as Serious Adverse Incidents.*" This was an issue the HSCB/PHA had already identified and work had commenced on an alternative arrangement for child death notification.

As a result of the above recommendation, SAIs relating to child deaths, will in future be managed under the following refined process.

Process for Reporting Child Deaths

DHSSPS, working in partnership with HSCB/PHA and Trusts, has agreed to pilot a new process for reviewing and notifying child deaths as part of the new Regional Mortality and Morbidity Review (RM&MR) System which is based upon the functionality of the systems and processes already in operation in the BHSCT and the SHSCT.

When the system is fully implemented, it will allow for the electronic recording and reviewing of all adult and child deaths in hospitals in Northern Ireland, with each death being considered as part of a M&M review meeting. It is anticipated the electronic system will be fully operational in all Trusts by April 2017.

From 1 February 2016, (see DHSSPS circular HSS(MD) 1/2016 Process for the Reporting of Child Deaths, issued 13 January 2016) all child deaths will be recorded on a Child Death Notification form (CDNf) and reviewed at a M&M meeting. Within the BHSCT, their electronic system will produce the form and in all other Trusts they will commence using a paper based process until such times as the fully implemented RM&MR system is operational. This process will be introduced and regarded as a pilot with review being performed after one year.

From this date, any incident involving the death of a child which meets the redefined SAI criteria (appendix 1) will continue to also be reported and reviewed as a SAI. However, the death of other children, including those with a terminal illness where death was expected, will not in future be automatically reported as SAIs. Instead they will be reviewed under the new CDNf, and review at M&M meeting system, with reporting to the HSCB/PHA being by way of the CDNf. The new system will also allow for cases to be subsequently reported as SAIs following a M&M meeting, should that be necessary.

Child death notifications will be received by HSCB/PHA via a centralised email account, cdnotifications@hscni.net and will be recorded on the DATIX risk management database. As with the SAI process, the HSCB/PHA Paediatric Professional Group will continue to review all notifications received, identify common themes and/or regional learning and share as appropriate. If necessary, this group will also consider whether any case should have been reported as a SAI and request it from the relevant Trust.

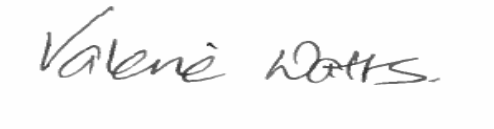
I would therefore ask you to refer to the revised SAI criteria as at 1 February 2016, (appendix 1) when determining whether an incident should be reported as a SAI. This appendix replaces section 4.0 of the current Procedure for the Reporting and Follow up of SAIs.

I would also ask you to update the SAI leaflet you currently share with service users, families and carers, following a SAI, (*What I need to know about a SAI*), in order to reflect this change.

I would ask that you circulate this letter to all relevant staff within your organisation and if you require any further information in relation to any of the above issues, please contact the following HSCB/PHA staff.

SAIs	**Child Death Notifications**
Mrs Anne Kane, HSCB	Dr Joanne McClean, PHA
anne.kane@hscni.net	joanne.mcclean@hscni.net

Yours sincerely



Valerie Watts
Chief Executive

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cc Trust Medical Directors
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Trust Governance Leads
Mr B Godfrey, DHSSPS
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