

## **Directorate of Legal Services**

PRACTITIONERS IN LAW TO THE
HEALTH & SOCIAL CARE SECTOR

2 Franklin Street, Belfast, BT2 8DQ DX 2842 NR Belfast 3

Your Ref: AD-0441-12 Our Ref: HYP B04/2 Date:

16<sup>th</sup> November 2012

Ms A Dillon
Solicitor to the Inquiry
Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast
BT1 4GB



Dear Madam

# RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS- CLAIRE ROBERTS

I refer to the above matter and to your letter dated 16<sup>th</sup> October 2012, referenced as above. My client has instructed me, as follows:-

1. Most of the information from this period was held either in paper format or in a defunct system which has since been replaced several times. Unfortunately, the Trust cannot locate any relevant documentation from this period as, although the Trust retains documentation for a certain period of time, you will appreciate that it is physically impossible and of very limited use to retain this information indefinitely, as systems have since developed somewhat. However we have been able to provide a description of the type and range of information from that period, as follows:

A range of indicators were examined usually on a quarterly basis against peer hospital performance showing any variance that existed. These included:

Volumes of activity
Average Length of stay
Daycase rates
Readmission Rates
Mortality Rates
Complication rates

During that period data quality and analytical tools were poor compared with today's standards resulting in less specific and useful information.

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- 2. Dr McBride has advised that he has no clear recollection, but given the sensitivity of this matter, Dr McBride would probably have advised the Chief Executive verbally regarding same.
- 3. Copy of the SAI report form which was submitted to DHSSPSS and EHSSB attached.
- 4. Copy of the SAI report form which was submitted to DHSSPSS and EHSSB attached.

This completes my client's response to your afore-mentioned letter.

Yours faithfully

Angela Crawford

Auchawlard

Solicitor

### SERIOUS ADVERSE INCIDENT REPORT

1. Organisation: Royal Hospitals Trust

Incident Identifier No. SAI 1-3-06

### 2. Date and brief summary of incident:

An inquest into the death of a nine year old child will be held in Belfast Coroner's Court on 25 April 2006. The girl died in the RBHSC in 1996 and a consented limited hospital post mortem examination of the brain was carried out. She had a history of epilepsy and a diagnosis of encephalitis was considered on admission. She had a respiratory arrest within 2 days and died later that day in ICU and a Death Certificate was issued recording the cause as cerebral oedema secondary to status epilepticus.

Following UTV 'Insight' October 2004 into paediatric deaths from hyponatraemia, the parent contacted the hospital and after reviewing notes it was considered in retrospect that the known hyponatraemia which was treated may have had a part to play in the medical condition leading to death, and after a meeting with the family the death was reported to HM Coroner.

### 3. Why incident considered serious:

- (i) warrants regional action to improve safety or care within the broader HPSS;
- (ii) is of public concern; or√
- (iii) requires an independent review.

### Briefly, explain why this SAI meets the criteria:

HM Coroner has obtained independent expert reports. The parents have posed detailed questions and this Inquest is likely to provoke considerable public and media interest

#### 4. Immediate action taken:

Not applicable

Classification of incident as initially assessed by organisation: Catastrophic / Major / Major / Minor / Insignificant

5. Is any regional action recommended? Y/N (if 'Yes', full details should be submitted):

Not known at this stage

Are there any aspects of this incident which could contribute to learning on a regional basis?

Not known at this stage

6. Is an Independent Review being considered? Y/N (if 'Yes', full details should be submitted):

Not at this time

7. Other Organisations informed:		Date informed	Other (please specify) Y/N
HSS Board	Υ	28 Mar. 06	
HM Coroner	Υ	December 2004	
Mental Health Commission	N		
NIHSE	N		
PSNI	Υ	As above	Date informed:
RQIA	N		Date informed:

**8.** I confirm that the designated senior manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Department. (*delete as appropriate*)

Report submitted by: Mrs J Champion, Risk Manager Ext

(name and contact details of reporting officer)

Date: 28 March 2006

Completed proforma should be sent, by email, to:

@dhsspsni.gov.uk

If e-mail cannot be used, fax to

CR - INQ 302-164-003