

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

Your Ref: NSCB04/1
NSCW50/1
NSCS071/1

Our Ref: AD-0297-12

Date: 15th February 2012

Dear Ms Bolton,

Re: Investigation into the death of Adam Strain

I refer to the copy of the Royal Health Hospitals Annual Health and Safety Report (for the period 1.4.95 - 31.3.96) which you forwarded to the Inquiry on the 22 December 2011.

You will note the reference at page 10 of the report (copy attached) to a fatality of a patient which occurred in November 2005. This death was the subject of "a full internal investigation" and a report was forwarded to the Coroner.

We would be grateful if you could locate the report of this internal investigation, and provide the Inquiry with a copy. It is unclear whether the death which was the subject of this investigation and report was that of Adam Strain. We emphasise that we require the report even if it did not relate to the death of Adam Strain, but in that event you may wish to redact the name of the patient concerned.

I look forward to receiving your response by 22nd February 2012.

Yours sincerely,



Anne Dillon
Solicitor to the Inquiry

Secretary: Bernie Conlon

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5 Injuries reportable under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1995 (RIDDOR)

A total of 66 injuries (16% of all accidental injuries) were reportable to the Health & Safety Inspectorate, 58 because they resulted in absence of over 3 days, 7 which were defined as major injuries and one was a fatality. Details are given in Tables 4 and 5.

The reportable injury rate is 1152 per 100,000 staff per year. This compares with Health and Safety Executive estimates of 3,000 per 100,000 staff per year for the healthcare sector in Great Britain [REDACTED]

[REDACTED]. The Trust's figures suggest under reporting and / or failure of ascertainment. This will be the subject of investigation and further action during the forthcoming year.

In November 1995 a fatality was recorded of a patient within the Medical Directorate. A full internal investigation has been carried out together with investigation by the RUC and Health & Safety Inspectorate. These reports have been forwarded to the Coroner.

Table 4 - RIDDOR Reportable Injuries - Injuries causing over 3 days absence

Cause	Number
Cut with material/object	6
Hot/cold contact	2
Patient Lifting/Handling	8
Manual Lifting/Handling	9
Slip/Trip/Fall	16
Contact with substance	1
Contact with Equipment	2
Person to Person Assault	5
Struck by object	2
Struck against something	4
Other	2
Struck by vehicle	1
TOTAL	58