The Inquiry into Hyponatraemia-related Deaths

Chairman: Mr John O'Hara QC

Ms Catherine Rodgers
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Your Ref: LIT 477/08/B5/CR

Our Ref: AD-0679-13

Date: 21st October 2013

Dear Ms Rodgers,

Re Complaints regarding Clinical Incidents and Serious Adverse Incidents

Thank you for your letter dated 10th October 2013, in which you informed the Inquiry that "as previously stated in earlier correspondence, it is not possible to provide information on complaints and SAIs which relate solely to clinical incidents as the data is not collected by this category." The systems and procedures for the reporting of Serious Adverse Incidents, and particularly those relating to clinical incidents, are matters of some interest to the Chairman, and therefore I should be very grateful if you could provide clarification on the following.

In my previous letter to you I indicated that the Report by the Comptroller and Auditor General, 'The Safety of Services Provided by Health and Social Care Trusts' (dated 23rd October 2012), the HSC Board 'Annual Complaint Reports' and the Public Accounts Committee's 'Report on the Safety of Services Provided by Health and Social Care Trusts (Thirteenth Report) appear to demonstrate that SAIs are capable of being broken down by clinical category.

I should therefore be grateful if you could provide an explanation as to how such information was made available in the circumstances described above, if it is the Department's position that it is unable to provide information in this manner? If so I would be obliged if you would confirm that the Department has no way of determining from the data it holds, deaths in hospitals which occur as a result of avoidable clinical incidents.

I would also be grateful if an indication might be given as to the steps which it would be necessary to take in order to extract such information from Departmental, Trust or other systems.

I look forward to hearing from you by return.

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Thank you for your assistance.

Yours sincerely,

Anne Dillon

Solicitor to the Inquiry