Quality & Performance Improvement Unit.
Room D2.4

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Dr M McCarthy

SENT TO
DR McCARTHY –
THURS 27/4/2006

Castle Buildings
BELFAST
BT4 3SQ
Tel: [redacted]

Email:
elaine.lawson[redacted]

Ref: SAI 53/06
Date: 27th April 2006

REPORTING AND FOLLOW UP ON SERIOUS ADVERSE INCIDENTS: INTERIM GUIDANCE

The attached incident has been reported to the Department under the Arrangements outlined in the Interim Guidance circulated as HSS (PPM) 06/04.

The report is copied to you for information only and to associate with your papers on SUB / 253 / 2006.

Many thanks.

E Lawson

Cc: Mr P Maguire.

Dr McCarthy
For information and to associate with your papers on SUB/253/2006.
(copy SAI report original letter 11/4/06 letter attached)

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 of admission 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: Major

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	Y	28 Mar. 06	
HM Coroner	Y	December 2004	
Mental Health Commission	N		
NIHSE	N		
PSNI	Y	As above	**Date informed:**
RQIA	N		

8. I confirm that the designated senior manager has been advised of this SAI and is content that it should be reported to the Department.
Report submitted by: Mrs J Champion, Risk Manager Ext [redacted]
(name and contact details of reporting officer)

Date: 28 March 2006

Completed proforma should be sent, by email, to:

adverse.incidents[redacted]
If e-mail cannot be used, fax to [redacted]

DS 13 | L4
11 APR 2006

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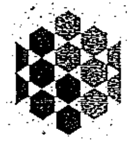
Room D2.4



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FAO Elaine Lawson

Jim - this should be sent to Dr McCarthy in her capacity as Director of Secondary Care. SCD are aware of this case, having briefed Minister on 19/4/06. Dawson.

Dr I Carson
Dr M Briscoe
Dean Sullivan

25/4/06.

Castle Buildings
BELFAST
BT4 3SQ
Tel: [redacted]

Email:
elaine.lawson[redacted]

Elaine - as previously advised, this and other similar issues are not ones on which I am qualified to comment. You should secure views of our professional medical colleagues. Dean 25/4/06

Ref: SAI 53/06
Date: 11th April 2006

REPORTING AND FOLLOW UP ON SERIOUS ADVERSE INCIDENTS: INTERIM GUIDANCE

Further to my letter of 28/03/06, regarding the reporting of SAI 53 /06, I would be grateful if you could let me know if you were content with the action taken or proposed by the organisation reporting the incident.

If not, could you then make me aware of the outcome of your contact with the reporting organisations. I would be grateful if you could let me know by 18/04/06.

Many thanks.

pp Roisin Perkins

E Lawson

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Dr I Carson
Dr M Briscoe
Mr D Sullivan

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Tel: [redacted]

Email:
elaine.lawson[redacted]

Ref: SAI 53/06
Date: 28th March 2006

REPORTING AND FOLLOW UP ON SERIOUS ADVERSE INCIDENTS: INTERIM GUIDANCE

The attached incident has been reported to the Department under the Arrangements outlined in the Interim Guidance circulated as HSS (PPM) 06/04.

I would be grateful if you could consider the information reported, and let me know if you are content with the action taken or proposed by the organisation reporting the incident. If not, please contact the organisation directly with your comments or concerns. I would be grateful if you could then make me aware of the outcome of your contact with the reporting organisation.

Many thanks.

E Lawson

Cc : Mr P Maguire