065/1

Witness Statement Ref. No. 065/1

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Name: Noel McCann

Title: Mr

Present position and department/employer: Director of Planning and Performance Management, DHSSPS

Length of time in post: 1 year 5 months

Previous position and department/employer in 1995: Head of GP Fundholding Branch, DHSS

Previous position and department/employer in 2000: Head of Regional Policy Unit (Secondary Care Directorate), DHSSPS

Previous position and department/employer in 2001: Head of Regional Policy Unit (Secondary Care Directorate), DHSSPS

Membership of Professionals Bodies: None

Particular areas of interest
[Please attach additional sheets if more space is required]

(i) How and when did you first become aware of the deaths of Adam, Lucy and Raychel?

In relation to Lucy Crawford – on reading media publicity relating to the inquest in February 2004.

In relation to Raychel Ferguson – in late February 2004, on receipt of a copy of the Coroner's correspondence to the Chief Medical Officer about Lucy Crawford (006-001-022), which contained a reference to Raychel Ferguson.

I was not aware of the death of Adam Strain until I saw the Department's press release of 1 November 2004, announcing that there would be an independent inquiry.

(ii) Explain the steps you took as Director of Planning and Performance Management to discover why the deaths occurred and to ensure that lessons would be learned to include details of those with whom you consulted, when they were consulted and for what reason.

None specifically, as all of the deaths took place before I was appointed as Director of Planning and Performance Management in February 2004. Since then, my responsibilities have included measures to improve quality in the HPSS, including its approach to continuous quality improvement. These measures stem from the consultation paper *Best Practice Best Care*, which was issued by the Department in April 2001. They include:

- improvements in governance (a duty of quality was imposed on all HPSS bodies in April 2003);
- better regulation and monitoring of health and social services bodies (principally through the new Regulation and Improvement Authority, which was established last year);
- the development of a wide range of service and governance standards;
- links with appropriate bodies in Britain to ensure up to date knowledge and learning; and
- improvements in the way that safety issues are reported and managed.

In line with this agenda and in response to the Lucy Crawford case, the Department developed guidance on the reporting and management of serious adverse incidents. I issued this guidance to the HPSS on 7 July 2004 (see copy of Circular HSS (PPM) 06/04 attached at Tab A).

(iii) What was the system in place in Northern Ireland at the time of Adam Strain's death in 1995 for reporting untoward deaths to the DHSSPS and disseminating information on the outcomes of Coroners' Inquests within the health service?

Prior to the July 2004 guidance, I understand that no formal systems were in place in 1995 for reporting all untoward deaths to the DHSSPS. In line with guidance issued in 1973 in HSS4 (CS) 1/73 *("Notification of Untoward Events in Psychiatric and Special Care Hospitals"* – see copy attached at Tab B), Boards notified the Department of details of untoward events (unauthorised absences; accidents; and sudden, unexpected or unnatural deaths) involving patients in psychiatric or special care hospitals. In line with further guidance issued in 1997 *"Notification of Untoward Events in Psychiatric and Specialist Hospitals for People with Learning Disability"* (THRD 1/97, see copy attached at Tab C), the newly-established Trusts were asked to notify the Department of untoward events. That guidance also noted that these events should also be reported to HSS Boards and to the Mental Health Commission.

In terms of disseminating information on the outcomes of Coroners' Inquests, I am not aware of any standard Departmental procedure being in place. Any cases where specific guidance to the HPSS is indicated would be considered on its own merits.

Particular areas of interest (Cont'd)

(iv) What was the role of the DHSSPS in reporting, analysing and disseminating the information referred to at (iii) above and in ensuring that lessons learned would be fed into teaching/ training and the care of patients?

I have not been involved in Departmental work on mental health or learning disability issues, so I would not have been not aware of any specific action taken by the Department in relation to the above notifications. In terms of reporting adverse incidents generally, I am not aware of any role undertaken by the Department.

(v) What procedures existed in 1995 to ensure the fulfilling of roles relating to the reporting, analysing, disseminating of information from a Coroner's Inquest or untoward death and to ensure that lessons would be learned?

I would not previously have been involved in the area of coroner's reports and I would not therefore have been aware of any procedures relating to coroner's cases. It is likely that any cases where specific guidance to the HPSS was indicated would have been considered on their own merits.

Particular areas of interest (Cont'd)

(vi) With reference to issues (iii) to (v) above, what was the situation in 2000 and 2001 respectively?

See my earlier comments at (iii) – (v) above.

(vii) With reference to issues (iii) to (v) above, what is the situation now?

In terms of disseminating information on the outcomes of Coroners' Inquests, I am not aware of any standard Departmental procedures in place. Any case where specific guidance to the HPSS is indicated is considered on its own merits and specific action is taken.

In July 2004, the Department issued interim guidance on the "Reporting and Follow Up of Serious Adverse Incidents" in Circular HSS (PPM) 06/04 (copy attached). The circular requires HPSS organisations to report serious adverse incidents to the Department where the organisation considers the incident to:

- be serious enough to warrant regional action to improve safety or care within the boader HPSS;
- be of public concern; or
- require an independent review.

On receipt, these reports are made available to professional and policy leads in the Department and officials also meet regularly to discuss incidents reported and to consider if any Departmental action is required. A briefing was provided to HPSS staff recently on incidents which have been reported since last July and it is envisaged that this will be a regular feature in the future. In addition, an annual adverse incidents report is planned for the future once the system has become fully established.

In order to ensure that HPSS staff can learn from patient safety incidents which occur in the NHS, the Department has been negotiating with the National Patient Safety Agency ("NPSA") in England a service-level agreement. This is expected to be signed later this year and will enable the HPSS to share the benefits of learning from research and analysis conducted by the NPSA.

(viii) Describe in detail the systems in place in 1995, 2000 and 2001 within the DHSSPS to monitor the performance and accountability of Health Boards and Trusts to include the type of information that the Department would expect to receive.

In general terms, the Government's priorities for Northern Ireland are published in a "*Priorities and Budget*" paper. This includes a public service agreement for each Department setting out the main objectives, budgets, planned citizen outcomes, key service channels and targets. For DHSSPS, this identifies high level targets under 7 strategic outcomes as follows:-

- increase in life expectancy, improvement in health and well-being and reduction in health inequalities;
- equitable access to life saving interventions;
- improvements in quality, efficiency, effectiveness, value for money and accountability of health and social care services;
- more effective hospital services;
- equitable access to high quality, modern, acute primary and community care services;
- better life chances for children and support for families
- fast, responsive and effective fire-fighting and rescue services.

The Department's Business Plan sets out the action it will take to contribute to the delivery of Public Service Agreement ("PSA") targets. In addition, the Department publishes "*Priorities for Action*", which sets out the Department's expectations of the HPSS in delivering the PSA targets and gives more detailed requirements for issues such as service improvement, efficiency, effectiveness and reform. Short and medium term targets are set on the basis of the Department's analysis of the capacity of the HPSS to

deliver effective, quality services and to make improvements in the quality of service, the methods of delivery and the level of service provided.

On foot of *Priorities for Action*, Boards and Trusts submit, for Ministerial approval, Health and Wellbeing Investment Plans (HWIPs) and Trust Delivery Plans (TDPs) respectively. These set out how they will meet identified priorities and targets.

The Departmental tracks progress with *Priorities for Action* during the year through a series of progress review meetings with the Chief Executives and senior managers of Boards and Trusts. In addition, those discussions also address resource utilisation, plans for reform, modernisation and efficiency, progress on risk management governance arrangements and measures taken to engage with the public. Progress on *Priorities for Action* is reported to the Departmental Board and progress against specific PSA targets is reported to the Department of Finance and Personnel and also to the Office of the First Minister and Deputy First Minister. The Minister also has annual accountability meetings with each of the Boards to review achievements against plans and to discuss the year ahead. In addition to this formal monitoring structure, ad hoc groups are established to monitor performance of service providers in specific areas such as waiting lists. In terms of financial management, detailed monitoring is undertaken by Finance Directorate.

Position in 1995, 2000 and 2001

Prior to 2000, the (then) HPSS Management Executive published a yearly Management Plan setting out a corporate agenda for the HPSS. Similar to the later *Priorities for Action*, the Plan provided direction to the HPSS. Boards were then required to submit Action Plans for Ministerial approval and Trusts also prepared their business plans on the basis of the priorities identified in the Management Plan. Similar to now, there were accountability reviews between the Management Executive and the Boards, dealing with Board targets in the preceding year, a review of the financial position and plans for the incoming year.

The arrangements outlined above in relation to 1995 remained in place until 2000/2001. *Priorities for Action* was first issued in 2001 and, since then, I understand that the arrangements outlined above have been in place.

Particular areas of interest (Cont'd)

(ix) Give details of any changes to the systems in place for the monitoring of Health Boards and Trusts since 2001 together with the reasons for such changes.

Priorities for Action was first issued in 2001. The only change that I am aware of in the process of monitoring since then is that formal review meetings between Departmental officials and Trust Chief Executives began in the autumn of 2002.

(x) Describe in detail the system in place in 1995, 2000 and 2001 to ensure that Health Boards and Trusts have in place an adequate and accessible complaints system for members of the public.

The *Charter for Patients and Clients* was published in March 1992. It explained how the Government's commitment to quality was being carried forward in the HPSS. It set out the kind of service that people had a right to expect, the information they were entitled to receive to enable then to make informed judgements about their care and treatment, and what they could do if things went wrong.

The Charter advised patients and clients of the arrangements in place within Boards and Trusts to deal with complaints. (These arrangements are akin to those outlined in the formal procedure that followed in 1996.) The Charter provided advice and information on how to make a complaint, support services available and what to do if a person remained dissatisfied. It also alerted the patient/ or client to their right to refer the matter to the NI Commissioner for Complaints.

In 1996, the current HPSS complaints procedures were introduced to ensure that an individual could raise concerns and receive a response or explanation addressing those concerns. The procedures deal with complaints made by any person about any matter connected with the provision of HPSS services. There are 5 separate HPSS Complaints Procedures:

- one for hospitals services and community services
- one each for family health services i.e. GPs, dentists, opticians, and pharmacists.

Under this system, complaints can be made to any member of staff, although some complainants prefer to make their initial complaint to someone who has not been involved in the care provided. In these circumstances, the complainant is told to address their complaint to the Complaints Officer or an appropriate senior officer. All HSS Trusts and all Family Health Service Practitioners have named Complaints officers.

Complaints may be made verbally or in writing. Having received a complaint, the first responsibility of staff is to ensure that the patient's immediate care needs are being met. If, after consideration of a verbal complaint, the person wishes to pursue the matter further, a copy of the complaint will be passed to the Complaints Officer. In all cases, the complainant is told how the complaint will proceed and advised on the availability of advocacy services. Where an immediate or "on-the-spot" response is not possible, a complaint will progress along the local resolution stage.

As part of their complaints procedure, all HPSS bodies must have a local resolution process. This is the first stage of the HPSS Complaints Procedure. Its primary objective is to provide an opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances and as close to the source of the complaint as possible. Complainants who are dissatisfied with the result of local resolution may request an Independent Review.

Independent Review is the second stage. The right to have a complaint reviewed is not automatic and a request for review is considered by a convenor in consultation with an independent review panel lay chair, both of whom are appointed by the local HSS Board. Their role is to provide the complainant with an independent and informed view on whether any more can be done to resolve their complaint. Where the

convenor feels that local resolution has not adequately addressed a complainant's concerns, the case is passed back to the service provider for further local consideration. If the convenor considers that local resolution has been adequately pursued – in that the complaint has been properly investigated and an appropriate explanation given – and that nothing further can be done even though the complainant remains dissatisfied, the complainant is advised of the reason for this decision and informed of their right to put their case directly to the NI Commissioner for Complaints.

The target timescale for a full investigation at the local resolution stage of a complaint is 20 working days. For family health services this target is 10 working days. In 2002, as part of its wider quality agenda, the Department embarked on a review of the HPSS Complaints procedure. A public consultation paper on the review is expected to be issued in the autumn.

(xi) **Describe in detail the procedures that the DHSSPS, Hospital Trusts and Health Boards are required to have in place to handle allegations relating to the running of hospitals or work related activities of members of the medical or nursing profession following a complaint by any person or persons within the hospitals, Boards and Trusts.**

This is not a matter that comes within the responsibility of Planning and Performance Management Directorate and I am not aware of the procedures that are in place.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: [signature] **Dated:** 1/7/05

Noel McCann
Director of Planning & Performance Management

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk
Room D4.13, Castle Buildings
Stormont Estate
Belfast, BT4 3SQ

Tel: [redacted]
Fax:
Email:
noel.mccann[redacted]

Your Ref:
Our Ref:
Date: 7 July 2004

For action:

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies
General Medical, Community Pharmacy
General Dental & Ophthalmic Practices

For information:

Chief Officers, HSS Councils
Directors of Public Health in HSS Boards
Directors of Social Services in HSS Boards and Trusts
Directors of Dentistry in HSS Boards and Trusts
Directors of Pharmacy in HSS Boards and Trusts
Directors of Nursing in HSS Boards and Trusts
Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups

Circular HSS (PPM) 06/04

Dear Colleague

REPORTING AND FOLLOW-UP ON SERIOUS ADVERSE INCIDENTS: INTERIM GUIDANCE

Introduction

1. The purpose of this guidance is to provide interim advice for HPSS organisations and Special Agencies on the reporting and management of serious adverse incidents and near misses, pending the issue of more comprehensive guidance on safety. This will be issued once the work currently being undertaken by the Department on the strategic review of the reporting, recording and investigation of adverse incidents and near misses has been concluded.

2. This interim guidance highlights, in particular, the need for the Department to be informed immediately about incidents which are regarded as serious enough for regional action to be taken to ensure improved care or safety for patients, clients or staff. It also draws attention to the need for the Department to be informed where a Trust, Board or Special Agency considers that an event is of such seriousness that it is likely to be of public concern. In addition, the guidance requires Trusts, Boards or Special Agencies to inform the Department where they consider that an incident

requires independent review.

3. The guidance complements existing local and national reporting systems, both mandatory and voluntary, which have been established over the years. These provide for specific incidents relating, for example, to medical devices and equipment, medicines, mental illness, child protection, communicable disease and the safety of staff to be reported to various points in the Department. **These systems should continue to be used in addition to the action required by this interim guidance.** In the context of contractual arrangements for the independent family practitioner services, practices should report serious incidents, in the first instance, to the relevant HSS Board, which will communicate with the Department as appropriate.

Background

4. The consultation paper *Best Practice Best Care*, published by the Department in April 2001, recognised the need for more effective arrangements for monitoring adverse incidents. As a result, a Safety in Health and Social Care Steering Group was established by the Department, with a remit to develop a strategic approach to the reporting, recording and investigation of adverse incidents and near misses and the promotion of good practice to minimise risk.

5. As part of its work, the Steering Group is also undertaking an evaluation of the effectiveness of systems used to identify and manage adverse incidents and near misses, including the Northern Ireland Adverse Incident Centre (NIAIC). NIAIC operates a voluntary system for reporting and investigating adverse incidents in the HPSS and issues alerts and other material on the safety of devices and equipment.

6. It is hoped that the Steering Group will conclude its work later this year, following which comprehensive guidance on safety and the promotion of learning will be brought forward. This may include links, where appropriate, with the National Patient Safety Agency in the NHS.

Defining Serious Adverse Incidents

7. Preliminary feedback from the Steering Group's work highlights a lack of uniformity in incident reporting and management in the HPSS. This also applies to the definition of what constitutes a serious adverse incident.

8. In line with the action required by this Circular, the Department considers that a serious adverse incident should be defined as "*any event or circumstance arising during the course of the business of a HSS organisation/Special Agency or commissioned service that led, or could have led, to serious unintended or unexpected harm, loss or damage*". This may be because:

- it involves a large number of patients;
- there is a question of poor clinical or management judgement;
- a service or piece of equipment has failed;
- a patient has died under unusual circumstances; or
- there is the possibility or perception that any of these might have occurred.

9. Examples of serious adverse incidents include:

- any incident involving serious harm or potentially serious harm to a patient, service user or the public. This could include disease outbreaks, apparent clinical errors or lapses in care;
- any incident which has serious implications for patient or staff safety – involving potential or actual risk to patients or staff;
- any incident involving serious compromises or allegations of serious compromises in the proper delivery of health and social care services.

10. The above list is not exhaustive and Annex A provides a more comprehensive list.

Key Issues for HPSS Organisations

11. HPSS organisations and Special Agencies should be developing a culture of openness. Policies should be in place to raise awareness and to actively encourage the reporting, assessment, management and learning from adverse incidents and near misses. If they have not already done so, all HPSS organisations and Special Agencies should nominate a senior manager at board level who will have overall responsibility for the reporting and management of adverse incidents within the organisation.

12. All HPSS organisations and Special Agencies should have developed, or be developing, centralised systems which facilitate the collection, analysis and reporting of adverse incidents and near misses relating to patients, clients, staff and others. These systems should be capable of supporting an analysis of the type, frequency and severity of the incident or near miss and, where appropriate, should record the action taken.

13. In those situations where a body considers that an independent review is appropriate, it is important that those who will be conducting it are seen to be completely independent. In addition, such reviews should normally be conducted by a multi-professional team, rather than by one individual. It is also important that the Department is made aware of the review at the outset.

Action

14. HPSS organisations and Special Agencies should continue to use established local or national reporting and investigation mechanisms to manage adverse incidents. This will include, where appropriate, notifying other agencies such as the Police Service, the Health and Safety Executive, professional regulatory bodies or the Coroner. Where there is any doubt as to which agencies should be notified, advice should be sought from the Department.

15. The Department will expect urgent local action to be taken to investigate and manage adverse incidents.

16. In addition, where a **serious** adverse incident occurs, it should be reported immediately to the senior manager with responsibility for the reporting and management of adverse incidents within the organisation. If the senior manager considers that the incident is likely to:

- be serious enough to warrant regional action to improve safety or care within the broader HPSS;

- be of public concern; or
- require an independent review,

he/she should provide the Department with a brief report, using the proforma attached at Annex B, within 72 hours of the incident being discovered. The report should be e-mailed to adverse.incidents[redacted]. In cases where e-mail cannot be used, the report should be faxed on [redacted]

Action by the Department

17. The Department:

- will collate information on incidents reported to it through this mechanism and provide relevant analysis to the HPSS;
- may also, where appropriate, seek feedback from the relevant organisation on the outcome of the incident to determine whether regional guidance is needed;
- may, in independent reviews, provide guidance in relation to determining specialist input into such reviews.

Enquiries

18. Any enquiries about this Circular from the nominated senior manager should be made, in the first place, to Jonathan Bill, Planning & Performance Management Directorate, on [redacted] or by e-mail at Jonathan.Bill@[redacted]

19. This guidance will be reviewed once the Safety in Health and Social Care Steering Group has concluded its work, at which point further, comprehensive, guidance will be issued. In the meantime, the Department will welcome feedback on the issues covered in this guidance. This should be addressed to Jonathan Bill on the e-mail address above, or to Room D2.3, Castle Buildings, Stormont, Belfast, BT4 3SQ.

Yours sincerely

NOEL McCANN
Director of Planning & Performance Management

ANNEX A

SERIOUS ADVERSE INCIDENTS - EXAMPLES

The following are examples of serious adverse incidents. It is not an exhaustive list and is intended as a guide only. Where there are any doubts about an incident it should be reported.

Major Incidents

- Any circumstance which necessitates the activation of an HSS Trust, HSS Board or wider community Emergency Plan

Clinical incidents

- Any clinical incident whose consequences would be regarded as severe
- Serious drug events which might require regional or national guidance, to prevent occurrence or reoccurrence within HPSS/NHS organisations, e.g. maladministration of a spinal medicine, major prescription error causing, or with the potential to cause, serious damage or death of a patient

Court Proceedings

- Any incident which might give rise to serious criminal charges
- Impending court hearing, including Coroners' Inquests, or out of court settlement in cases of large scale litigation
- Legal challenges to the HSS Trust or HSS Board

Incidents involving staff

- Serious complaints about a member of staff or primary care contractor
- Serious error or errors by a member of staff or primary care contractor
- Significant disciplinary matters (e.g. suspensions of staff)
- A serious breach of confidentiality
- Serious verbal and/or physical aggression towards staff

Mortality/morbidity incidents

- Clusters of unexpected or unexplained deaths
- The suicide of any person currently in receipt of health and personal social services on or off HPSS premises, or who has been discharged within the last twelve months.
- Death or injury where foul play is suspected
- Situations when a patient or patients require(s) additional intervention(s) as a result of serious failures in diagnostic processes
- The accidental death of, or serious injury to, a patient, a member of staff, or visitor to HPSS or primary care premises, or involving HPSS or primary care staff or equipment
- Significant harm to children where reported under child protection arrangements
- Vulnerable adult abuse

Premises/equipment incidents

- Serious damage which occurs on HPSS premises or premises on which primary care services are delivered, or to HPSS property or property on which primary care services are delivered, or any incident which results in serious injury to any individual or serious disruption to services (e.g. evacuation of patients due to fire)
- Failure of equipment so serious as to endanger life, whether or not injury results
- Suspicion of malicious activity e.g. tampering with equipment
- Circumstances that lead to the provider no longer being able to provide an element of service

Mental Health or Learning Disability incidents (including substance misuse services)

- The disappearance, absence without leave or absconding of a patient (whether or not detained under the Mental Health Order 1986) where there is serious cause for concern
- Escapes by patients (whether or not detained under the Mental Health Order 1986) from secure accommodation/area
- Homicide, or suspected homicide, by any patient who has received mental health services
- Unexpected death
- All deaths within secure settings
- All deaths of persons who are subject to the Mental Health Order or equivalent legal restriction who has or is receiving mental health service care and treatment
- Any serious criminal acts involving patients, or staff
- An incident that causes serious harm that places life in jeopardy
- Serious injury, resulting in the need for emergency medical treatment via an A&E department, sustained by patient, staff or visitor on HPSS property
- Where a member of staff is suspected of harming patients or serious fraud
- Hostage taking, mass / organised disturbance
- Any omissions/failings of security systems/procedures that jeopardise security
- All incidents reported to or involving the police

ANNEX B

SERIOUS ADVERSE INCIDENT REPORT
1. Organisation:
2. Brief summary (and date) of incident:
3. Why incident considered serious:
4. Action taken:
5. Is any regional action recommended? (if so, full details should be submitted) Y/N -
6. Is an Independent Review being considered? (if so, full details should be submitted) Y/N -
7. Other Organisations informed PSNI Y/N - Coroner Y/N - NIHSE Y/N - HSS Board Y/N - Other (please specify) Y/N -
8. Report submitted by (name and contact details of nominated senior manager or Chief Executive)

Completed proforma should be sent, by email, to:

adverse.incidents[redacted]

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

MINISTRY OF HEALTH AND SOCIAL SERVICES
HSS4(OS) Branch
Dundonald House Upper Newtownards Road Belfast BT4 3SF
Telex [redacted] Telephone [redacted]

Please reply to The Secretary
Your reference

The Chief Administrative Officer of
each Health and Social Services Board

Our reference A1034/73
Circular Ref No HSS4(OS) 1/;
Date 30 October 1973

Dear Sir

NOTIFICATION OF UNTOWARD EVENTS IN PSYCHIATRIC AND SPECIAL CARE HOSPITALS

1. I am writing to draw your attention to a long-standing administrative arrangement whereby the Northern Ireland Hospitals Authority undertook to notify the Ministry of the details of all untoward events involving patients in psychiatric or special care hospitals. Untoward events include

a) unauthorised absences;

b) accidents; and

c) sudden, unexpected or unnatural deaths.

2. It is essential that this practice be continued. Each Health and Soci Services Board should therefore arrange for a telephone message to be sent HSS4(OS) Branch, Dundonald House, Upper Newtownards Road, Belfast BT4 3SF, (telephone [redacted] extension [redacted]) as soon as possible after the occu of any such untoward event, with the following information:

a) the nature of the occurrence (ie whether an unauthorised absence, a accident or a sudden, unexpected or unnatural death);

b) a brief description of the circumstances of the event;

c) the name of the patient involved and his hospital status;

d) the name of the hospital of which he was an in-patient and if the incident occurred in any place other than that hospital, the locati of the event;

e) the date and time of the occurrence; and

f) whether the patient's relatives, the RUC and the Ministry of Home Affairs, as appropriate, have been informed of the event.

3. To enable the necessary information to be furnished to the Ministry, e Health and Social Services Board should ask the psychiatric and special car hospitals within its area to notify the Board by telephone, in the first pl of the details of an untoward event immediately its occurrence becomes kno Immediate notification is particularly important where a death has occurred

Yours faithfully

L. b. Gillis

P (W).B. (HSS)

(2)

Trusts and Human Resources Directorate

HSS
EXECUTIVE

Chief Executive of each HSS Trust

Chief Executive/General Manager of each
Health and Social Services Board

13 May 1997

HSS (THRD) 1/97

Dear Sir/Madam

NOTIFICATION OF UNTOWARD EVENTS IN PSYCHIATRIC & SPECIALIST HOSPITALS FOR PEOPLE WITH LEARNING DISABILITY

Circular HSS (OS) 1/73 requires Health and Social Services Boards to notify the Department of any untoward events involving patients in psychiatric or special care hospitals.

Since their establishment it has become the practice for Trusts to notify the Department of such events directly. At the same time untoward events whether occurring in hospital or otherwise are reported to HSS Boards and to the Mental Health Commission for Northern Ireland under separate arrangements.

Following a review of its business areas the HSS Executive has decided that, from receipt of this letter, untoward events should be notified to the Trusts and Human Resources Directorate, Room 605, Dundonald House, telephone [redacted] Serious incidents should be notified by phone in the first instance and all incidents should be reported in writing. Trusts should, of course, continue to follow any requirements placed on them by their commissioning Boards and the Mental Health Commission concerning untoward events.

Yours faithfully

John Townson
Deputy Director

cc. Mr Walsh (Mental Health Commission)

Health and Social Services Executive
Dundonald House Upper Newtownards Road Belfast BT4 3SF Northern Ireland Telephone [redacted]