Neutral Citation No [2014] NIQB 74 | *Ref:* **TRE9292**

*Judgment: approved by the Court for handing down (subject to editorial corrections)** | *Delivered:* **22/05/14**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION (JUDICIAL REVIEW)

A's Application [2014] NIQB 74

IN THE MATTER OF AN APPLICATION BY A FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

and

IN THE MATTER OF A DECISION MADE AND PROCEDURES ADOPTED BY THE BELFAST HEALTH AND SOCIAL CARE TRUST SURROUNDING THE SERIOUS ADVERSE INCIDENT OF 11 AUGUST 2011

and

IN THE MATTER OF DECISIONS MADE AND PROCEDURES ADOPTED BY THE HEALTH AND SOCIAL CARE BOARD SURROUNDING THE "SIGNING OFF" OF THE SAI REPORT IN AND AROUND 13 NOVEMBER 2012

TREACY J

Introduction

[1] This is a challenge to the manner in which a Serious Adverse Incident ("SAI") review was carried out by Belfast Health and Social Care Trust in relation to an incident which occurred on 11 August 2011 at Grove Medical Centre in which the Applicant was stabbed multiple times by her ex-partner.

[2] There is a further challenge to the manner in which the SAI Review was signed off by the Designated Review Officer ("DRO") of the Health and Social Care Board.

Relief Sought

[3] The Applicant seeks the following relief:

(a) An order of *certiorari* quashing the decision of the Respondent Trust not to hold an independent review in respect of the SAI dated 11 August 2011 and the decision not to hold an SAI investigation in an unbiased, procedurally fair and independent manner.

(b) An order of *certiorari* quashing the decision of the Health and Social Care board to sign off the SAI report in or around 13 November 2012.

(c) An order that an independent review be conducted in respect of the subject SAI either by a third party or by the Respondent Trust but with procedural safeguards.

(d) A declaration that said decisions were unlawful, ultra vires and of no force or effect.

(e) A declaration that there has been inordinate and inexcusable delay

Grounds upon which Relief is Sought

[4] The grounds relied upon are as follows:

Against the First Respondent:

(a) The Respondent breached the following legitimate expectations of the Applicant:

(i) That there would be an independent review of the SAI carried out where appropriate.

(ii) That the SAI review would be free from bias, prejudice and conflict of interest.

(iii) That the Applicant would have input into the SAI process via herself or her legal representatives.

(iv) That all relevant correspondence, documentation and information would be placed before the review panel.

(b) There was a lack of fair procedures in that:

(i) An independent review was not carried out.

(ii) The review was not free from bias, prejudice and conflict of interest.

(iii) The Applicant did not have input into the SAI process via herself or her legal representatives.

(iv) All relevant correspondence, documentation and information were not placed before the review panel.

(c) The First Respondent breached the Article 2, Article 3 and Article 8 rights to bodily integrity and to participation in meetings involving their children without fear of violence, of the Applicant and all women/service users who are in a similar position to that of the Applicant, and of whom she is representative in that:

(i) The SAI report and investigation did not fulfil its purpose in improving the Respondent's service for users as the SAI process was procedurally and fundamentally flawed for the reasons outlined at 2b above.

(ii) In failing to review its policies and procedures effectively and lawfully the Respondent Trust continues to breach the Article 2, Article 3 and Article 8 rights of the Applicant and the service users of whom she is representative.

Against the Second Respondent

(a) The Health and Social Care Board did not carry out a proper review of the SAI procedure as carried out by the first respondent. The Designated Review officer only had sight of the SAI report and did not have sight of any of the documentation which would have been before the SAI review panel. The DRO could not have carried out a thorough review of the SAI process in the circumstances.

(b) The DRO did not ensure that the SAI guidelines were complied with for example:

(i) She did not look at whether serious consideration was given to the involvement and full participation of the Applicant in the process.

(ii) She did not look at whether the review panel Chairperson was from another field of practice.

(c) The guidelines relating to homicides by individuals with mental health problems recommend that any SAI review be an external review. The DRO did not look at whether an external review was appropriate in the circumstances.

(d) The House of Commons Health Committee recommends that victims/service users be permitted to 'fully participate' in the SAI process. The DRO has not looked at whether the Applicant was permitted to full participate.

(e) The DRO failed to look at whether the SAI review was free from bias, prejudice and conflict of interest.

(f) The DRO failed to look at whether all relevant correspondence, documentation and information were placed before the review panel. The DRO appears to have accepted that a risk assessment was done 'mentally' by the Trust staff and was never committed to paper and the DRO appears to have accepted and condoned the exclusion of Mr Tumelty, a witness to the agreement reached between the Trust and the Applicant, from the SAI process.

(g) The DRO failed to look at whether statements were taken from all relevant witnesses and staff. For example Mr Tumelty and his apprentice, Ms Jenkins were present at a meeting with Maria Maguire, social worker, at which it was agree that 2 separate LAC reviews would take place on 11 August 2011. Mr Tumelty's apprentice took minutes at that meeting. Neither Mr Tumelty nor his apprentice was invited to attend the meeting held by the Review team in November 2011.

(h) As a public authority the HSCB is carrying out a purportedly independent review of the SAI report. This review is to improve the service provided but it also touches upon issues dealing with the breach of the Article 2, 3 and 8 rights of the Applicant and therefore it is imperative that the review be thorough, proper, and that all relevant matters be taken into consideration.

(i) The SAI report and investigation by the Trust did not fulfil its purpose in improving the Trust's service for users as the SAI process was procedurally and fundamentally flawed for the reasons outlined above.

The HSBC is complicit in this in the signing off on the report and it is inconceivable that the review by the HSBC can be anything other than tainted by the flaws in the SAI process.

(j) In failing to review its policies and procedures effectively and lawfully the Respondent Trust continues to breach the Article 2, 3 and 8 rights of the Applicant and the service users of whom she is representative and the HSBC is complicit in this in the signing off on the report and it is inconceivable that the review by the HSBC can be anything other than tainted by the flaws in the SAI process.

Factual Background

[5] An Agreed Statement of Facts was handed into Court and states as follows:

(1) The Applicant, was in a relationship with B (the assailant). There are two children from that relationship, namely XX (3/10/08 and subject of a care order) and YY (10/10/09). The Applicant has eight older children who are not in her care and she has been involved with social services for a considerable period of time.

(2) YY's name was placed on the child protection register (potential sexual abuse) following his birth in October 2009 and there have been periodical case conferences and LAC reviews held in respect of the children.

(3) There have been ongoing issues between the Applicant and B, in relation to allegations of sexual abuse which were made by two of the Applicant's daughters against their mother's former partner and her brother.

Trust Proceedings

(4) On 12 January 2011 there was a pre-proceedings meeting between the Trust and the Applicant. At that time both XX and YY were living with the Applicant but there were ongoing concerns regarding her ability to provide good enough parenting. The mother was present but her solicitor was not and therefore the meeting was rescheduled.

(5) 26 January 2011 - the pre-proceedings meeting took place and a pre-proceedings plan was agreed.

(6) 16 March 2011 - Review pre-proceedings. Both parents present. Applicant broke down during the meeting and invited the Trust to take the two

children into care. The children were at the offices. The mother left the meeting. B, their father, assumed the immediate care of the children.

(7) 28 March 2011 - the Applicant signed a placement plan allowing the children to be cared for by their father, (B) (this was e-mailed to mother's solicitors on 30 March 2011).

(8) Looked After Child Review - 13 April 2011 it was agreed that there would be a phased return of YY and XX to their mother's care. Both parents were caring for the children in a shared care arrangement.

(9) On 27 April 2011 the Trust initiated care proceedings in respect of YY (care order already granted in respect of XX). The Trust indicated that YY was likely to suffer neglect and emotional abuse due to the concerns relating to the Applicant. It was noted that the child was registered under the category of potential sexual abuse on the Child Protection Register.

It was noted at this time that YY was removed under voluntary accommodation to his father's care in March 2011. The Applicant visited regularly and the relationship between her and B was assessed as positive.

(10) On 5 May 2011 a care order application was listed for first directions. The Applicant consented to an interim care order on the basis that she would care for the children between Monday and Friday and B would have the children between Friday and Sunday. The Guardian supported the making of an interim care order.

(11) Incident over weekend - 15 May 2011 whereby the police were contacted by the Applicant (on Sunday night) who alleged that while spending the weekend with B and having previously consented to sex with him she had been raped that afternoon, following an argument. The file was sent to the PPS. B was not prosecuted on this complaint made by the Applicant.

(12) On 17 May 2011 the Trust lodge a C2 application seeking removal of the children to foster care.

(13) On 19 May 2011 the case transferred from Family Proceedings Court to the Family Care Centre. In furtherance of the Trust C2 seeking removal of children into Trust foster care, the mother consented to the children going into foster care and they were duly placed in care.

(14) Looked After Child Review on 30 May 2011. The Applicant attended this LAC review and B had the minutes of the LAC review read to him afterwards.

(15) 6 June 2011 - First directions in Family Care Centre.

(16) 19 July 2011 – report completed by Dr Richard Bunn, Consultant in Forensic Psychiatry, in relation to B at the request of his legal representatives. Dr Bunn had access to B's medical notes and records and examined B on 7 July 2011. Dr Bunn references that B 'was accused of rape and threatening to harm' the Applicant. Dr Bunn concludes that B is mentally well. There is no current evidence of mental illness. He can manage his property and affairs.' He states that 'In my opinion the relationship between [B] and his children's mother has been strained and difficult at best, which may be a source of discord.' He recommends that B should continue with the input from Lifeline but 'there is no indication to refer [B] to a Community Psychiatric Nurse or Consultant Psychiatrist.'

Events leading up to LAC Review - 11 August 2011

(20) 26 July 2011 - meeting held with the Applicant, Mr Tumelty (her solicitor), Ms Lee (trainee solicitor) and Ms Maguire (principal social worker). It was agreed that the paternal grandmother could attend the LAC on 11 August and that separate arrangements would be made for the attendance of B. There would be two separate LAC reviews taking place 15 minutes apart.

(21) 5 August 2011 - B's solicitor telephoned the social worker to say that B would be attending at the LAC review. It was emphasized by her that there were no charges against B, that parents should be present at LAC review and that there was nothing to say that he should not be present. Ms Killen also informed the social worker that she had telephoned Mr Tumelty to inform him that her client would be attending at the LAC.

(22) On 5 August 2011, Ms Killen, the father's solicitor telephoned Mr Tumelty to inform him that her client (B) would be in attendance at the LAC Review scheduled for 11 August 2011. The change in arrangement was not communicated to Mr Tumelty directly by the Trust.

(23) 8 August 2011 the Trust sought legal advice from their solicitor and Counsel involved in the care proceedings.

(24) 8 August 2011 - the Applicant was informed by the social worker, that B will attend at the LAC Review on 11 August 2014.

(25) 10 August 2011 - Ms Killen, solicitor for B telephoned DLS to inform the solicitor for the Trust that her client B would be attending the LAC Review the next day. Ms Killen made it clear that her client wanted to attend and although he had been excluded before he was not prepared to be excluded again. Ms Killen stated that she had made it clear to Mr Stephen Tumelty, solicitor for the Applicant (she had telephoned him last Friday) that her client would be attending.

(26) 10 August 2011 - further legal advice as to how LAC review should be managed obtained from Counsel.

(27) 11 August 2011 - LAC review at 10.30 am. The following measures were put in place to facilitate the review:

- On arrival the Applicant and B had separate rooms.
- An additional member of staff was present at the meeting.
- Both parties sat on the same side to avoid eye contact and were separated by social worker and solicitors sitting in between.
- Both parties had their solicitors present (the Applicant had her solicitor and a trainee solicitor and B has his solicitor and mother present).

(28) Prior to the meeting it was agreed that:

- Both parties to be present when the various professionals at the meeting shared information about the children.
- Both parties to give their views separately.
- Both parties to be invited back to hear the decisions

(29) When the Applicant and Mr. Tumelty arrived, Mr. Tumelty stated that he was unaware of the presence of B and would need to consult with his client. This he did before deciding to go ahead with the meeting.

(30) The meeting went as planned and all parties agreed that they would be prepared to attend further LAC Reviews based on the same format and that they were happy with the arrangement.

(31) At the conclusion of the meeting B, his solicitor and his mother were escorted out of the social services section of Grove Wellbeing Centre by the social worker (Mr. Lawrence O'Kane).

(32) The Applicant, and her two solicitors waited approximately ten to fifteen minutes and they were then escorted out of the social services section of the Centre.

(33) The Applicant and her solicitors leave the Grove Centre and after parting from each other, she is observed via CCTV on the York Road. The Applicant then returns back to the Centre.

(34) After leaving social services, B goes into the cafeteria with his solicitor and mother. This is positioned on the ground floor close to the reception area of the Centre.

(35) After the Applicant returns to the Centre and enters the reception area - a public area. B is observed running to the reception area where he repeatedly stabs the Applicant before running out of the Centre.

(36) The Grove Wellbeing Centre is a Council owned facility. Social Services have their offices on the fourth floor of the Centre. The Centre has health facilities (eight GP's, physiotherapy, OT, nurses), general wellbeing facilities (e.g. antenatal and parenting services, daycare centre) a library, and leisure facilities (e.g. swimming pool, fitness suite, sports halls). The Centre is open to members of the public and provides a range of health and wellbeing facilities for local residents.

(37) The PSNI conducted a full scale criminal investigation as a result of which B was arrested and remanded in custody. B has been found guilty of the charges brought against him and has been given a period of imprisonment for his offences.

(38) Throughout the care order proceedings, B was aware of the Applicant's address. No applications was ever made to keep her address confidential or for special arrangements for court attendances in relation to the parents.

Serious Adverse Incident Review

(39) The serious adverse incident review process commenced on 11 August 2011 when the Trust reported the incident to the Board and Public Health Agency. The incident was also reported to the Department of Health, Social Services and Public Safety under the early alert procedure.

(40) This is an internal review process and the guidance states that –

> "A key objective in the SAI process is to ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent re-occurrence."

(41) There is guidance in relation to the Procedure for the reporting and follow up of Serious Adverse Incidents which provides guidance and templates for reporting.

(42) The SAI investigation report was not completed within 12 weeks from the date of the incident and the Trust liaised with the Board to seek a time extension, which was granted.

(43) The chair of the Review was Ms Lesley Walker, Co-Director in Children's Services within Belfast Health and Social Care Trust.

(44) Ms Walker wrote to Mr Tumelty, solicitor on 22 September 2011 and had a telephone conversation with him on 23 September 2011.

(45) Mr Tumelty, solicitor provided written input to the Review by letter dated 23 September 2011.

(46) There were two meetings of the Review Panel on 26 September 2011 and 15 November 2011 and a site inspection. Mr Tumelty and the Applicant were not invited to the Panel Review meetings.

(47) By letter dated 5 March 2012 the Trust wrote to the Board advising that the Review may be delayed to enable the Trust to seek legal advice.

(48) By letter dated 27 March 2012 Ms Walker wrote to the Applicant's solicitor.

(49) Mr Tumelty, solicitor sends a letter to DLS dated 5 April 2011 referencing a "Proposed judicial review of the failure of the Belfast Trust to carry out a timely and independent review of the Serious Adverse Incident".

(50) The Serious Adverse Incident report was completed by the Trust on 25 April 2012.

(51) Solicitors for the Trust send a letter dated 25 April to Mr Tumelty to advise him that the SAI report was being shared with the PPS and their views sought regarding the sharing of the report with other parties. It was also highlighted that the report would be forwarded to the Regional Health and Social Care Board and their views would also be sought as to whether the report could be shared with other parties at this time.

(52) The PPS confirm with DLS on 27 April 2012 that they had no objection to the report being released.

(53) By letter dated 3 May 2012 Mr Tumelty responds to the Trust letter of 25 April.

(54) Under cover of letter of 23 May 2012 the SAI Report was shared with the Applicant's solicitor, Mr Tumelty.

(55) The Review is not complete until the Board notify the Trust that they consider it to be adequate.

(56) The DRO of the Board (Ms Rooney) raised further queries with the Trust and gave them until 26 September to deal with same and provide appropriate responses.

(57) By letter dated 1 October 2012 to Mr Tumelty, the DRO on behalf of the Board, indicated that she was satisfied with the responses and that the Trust had taken all appropriate steps, in line with policy and procedure, best practice and legal advice involving both parents in the review. She states "all those involved in the incident had an opportunity to contribute to the review although you will acknowledge that as a result of the commencement of legal proceedings it was deemed inappropriate that you would be further involved."

(58) There was correspondence sent on behalf of the Applicant through her MLA, Mr Wilson, which was also responded to by the appropriate personnel.

(59) The Applicant has issued civil proceedings (by way of Writ and Statement of Claim) against the Respondents in the High Court and has issued a criminal injury claim.

Statutory Framework

[6] The Applicant's case is based in the main on the Health and Social Care Board documents entitled 'Procedure for the reporting and follow up of Serious Adverse Incidents' and 'Regional Template and Guidance for Incident Investigation/Review Reports'. The Relevant parts of each are set out below.

Procedure for the reporting and follow up of Serious Adverse Incidents

2.0 Introduction

'The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Trusts, Family Practitioner Services (FPS) and Independent Service Providers (ISP) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of the business of an HSC organisation/Special Agency or commissioned service.

...

This new process aims to:

- Focus on service improvement for service users.
- Recognise the responsibilities of individual organisations and support them in ensuring compliance.
- Clarify the processes relating to the reporting, investigation, dissemination and implementation of learning arising from SAIs which occur during the course of the business of an HSC organisation/Special Agency or commissioned service.
- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication.
- Ensure trends, best practice and learning is identifies, disseminated and implemented in a timely manner, in order to prevent recurrence.
- Provide a mechanism to effectively share learning in a meaningful way across the HSC.
- Maintain a high quality of information and documentation within a time bound process.

5.0 Process

...

Management and follow up of Serious Adverse Incidents

...

5.5 Governance lead will electronically acknowledge recipe of the SAI report, issuing HSCB unique identification number, confirming the DRO and requesting the completion of an investigation report within 12 weeks from the date the incident is reported ... (All investigation reports should be completed in line with the HSC Regional Template and Guidance for Incident Investigation/Review Report – Appendix 3)

...

5.10 Investigation reports must be submitted within 12 weeks from the date the incident is reported. If it is likely that the organisation/practice cannot complete the investigation within this timescale an update should be provided by completing Section 14 of the initial SAI report detailing the reason for the delay and the expected date for completion.

...

5.13 When the investigation report is received, the DRO will consider the adequacy of the investigation report and liaise with relevant professionals/officers ... to ensure that the reporting organisation/practice has taken reasonable action to reduce the risk of recurrence and determine if the SAI can be closed.

5.14 If the DRO is not satisfied that the report reflects a robust and timely investigation s/he will continue to liaise with the reporting organisation/practice and/or other professionals/officers ... until a satisfactory response is received.

5.15 When the DRO is satisfied (based on the information provided) that the investigation has been robust and recommendations are appropriate, s/he will complete the DRO Form validating their reason for closure. The DRO ... will agree that recommendations identified are appropriately addressed including development of any action/implementation plan ...

[7] **(Appendix 3) Health and Social Care Regional Template and Guidance for Incident Investigation / Review Reports**

Introduction

...

This template and guidance notes should be used, in as far as possible, for drafting all HSC incident investigation/review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports. It should assist in ensuring the completeness and readability of such reports. The headings and report content should follow as far as possible the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

All investigations/reviews within the HSC should follow the principles contained within the National Patient Safety Agency (NPSA) Policy documents on 'Being Open – Communicating Patient Safety Incidents with Patients and their Carers'

...

(**The following is the list of headings in the template along with details of the suggested content thereunder where relevant)**

Introduction

Team Membership

List names and designation of the members of the Investigation team. Investigation teams should be multidisciplinary and should have an independent chair. The degree of independence of the membership of the team needs careful consideration and depends on the severity/sensitivity of the incident. However, best practice would indicate that investigation/review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice. In the case of more high impact incidents ... patient/server user or carer representation should be considered. ...

Terms of Reference of Investigation / Review Team

The following is a sample list of statements that should be included in the terms of reference:

- To undertake an initial investigation / review of the incident
- ...

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the investigation.
Clear documentation should be made of the time-line for completion of the work.

Summary of Incident / Case

...

Methodology for Investigation

This section should provide an outline of the methods used to gather information within the investigation process. The NPSA's 'Seven steps to Patient Safety' is a useful guide for deciding on methodology.

- Review of patient/service user records (if relevant)
- Review of Staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
    - Organisation-wide
    - Directorate Team
    - Ward/Team Managers and front line staff
    - Other staff involved
    - Other professionals (including Primary Care)
- Specific reports requested and provided by staff
- Engagement with patients/service users/carers/family members
- Review of Trust and local departmental policies and procedures
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive.

Analysis

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care provided.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's 'Seven Steps to Patient Safety' and 'Root Cause Analysis Toolkit'.

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decision, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

...

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users/carers/family members within this process.

Conclusions

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any ongoing engagement/contact with family members or carers.

Involvement with Patients/Service Users/Carers and Family Members

Where possible and appropriate careful consideration should be made to facilitate the involvement of patients/service users/carers/family members within this process.

Recommendations

List the improvement strategies or recommendations for addressing the issues above. Recommendations should be grouped into the following headings and

cross-referenced to the relevant conclusions. Recommendations should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions.

...

Learning

In this final section it is important that any learning is clearly identified. Reports should indicate to whom learning should be communicated and copied to the Committee with responsibility for governance.

Arguments

Applicant's Arguments

[8] The Applicant argues that she has sufficient locus standi to bring this application as the attack upon her was the serious adverse incident triggering the SAI review. Further, she is affected by the outcome of the review as:

(a) There shall be further LAC review in the future at which she and B may be in attendance.

(b) She would like to know that should she be the subject of a further SAI that she will be included in the SAI process and that such a process shall be full, independent and proper.

[9] The Applicant argues that the decisions are capable of judicial review as there is a significant public interest element that is the safety of attendees at LAC meetings and the failure of the SAI process to improve the service for service users and to prevent a reoccurrence following the SAI involving the Applicant.

Procedural Unfairness

[10] The Applicant argues that the subject decisions were procedurally flawed in that the Applicant and her solicitor had insufficient input into and participation within the SAI process. In particular the Applicant complains that the 24 hour window in which to provide a written submission was insufficient, that the Applicant was not invited to attend the SAI review, that the Applicant's solicitor was excluded from the process due to the ongoing claim (it is submitted in this regard that the Applicant has been penalised for asserting her Article 6 rights) and that no witness statement was sought from the Applicant, her solicitor or her solicitor's apprentice.

[11] Relying on the Parliamentary recommendation that when SAIs are being investigated, 'those directly affected should always be included as full participants in the process', the Applicant further submits that:

(a) She was kept in the dark as to when the report had been completed.

(b) The Report conflicts with her version of events.

(c) She found the Trust to be obstructive and letters from her solicitor went unanswered for months.

(d) She was not kept informed of the review's progress.

[12] The Applicant argues that there was inordinate delay in both the completing of and the release of the reports contrary to a key objective in the HSCB's own guidance

[13] The Applicant argues that the chair of the review was not independent and was not from a separate field of practice contrary to the HSCB's own guidance.

[14] The Applicant submits that all relevant matters were not taken into account as per the methodology for investigation in the HSCB's guidance.

Wednesbury Unreasonable

[15] The Applicant argues that no reasonable decision maker could have decided:

(a) That a risk assessment was in fact carried out, or in the alternative, that a risk assessment carried out in someone's head could be sufficient.

(b) That there were no predicators.

(c) That the SAI review was sufficiently robust.

(d) That it was not necessary to recommend a review of the policies and procedures for assessing risk to service users, in particular that a full risk assessment be carried out taking into account all relevant information. If there is a risk of violence or aggression to a service user then the risk ought to be assessed and the appropriate measures taken to reduce such a risk.

Article 3 and Article 8 Rights

[16] The Applicant argues that the decisions breached her Article 3 and Article 8 rights in that her life was put at risk and that because of this she should be assured a full, proper and independent investigation of the circumstances surrounding the SAI.

Serious Adverse Incident Team

[17] The Applicant argues that according to the SAI guidance the chair should have been appointed from outside the area of practice but that this was not the case. Further, the Applicant argues that the chair was not independent.

[18] The Applicant argues that there is no evidence that the Trust gave any consideration to the guidance that the degree of independence of the membership needs careful consideration.

[19] The Applicant argues that there was actual bias on the part of the chair that was influenced by the fact that there would be a personal injury case.

[20] The Applicant argues that the DRO did not carry out a fresh review and that, as such, deficiencies in the original report could not be cured by the exercise which she carried out.

Failure to take relevant factors into account:

[21] The Applicant argues that the review failed to take the following relevant factors into account:

(a) The mental health difficulties and vulnerabilities of the Applicant.

(b) The assertions made by the Applicant that she was in danger from B.

(c) The fact that the rape investigation was ongoing.

(d) That B was being prosecuted for assaulting the Applicant and committing criminal damage to her telephone.

(e) The fact that B had displayed violence to others.

(f) The fact that the risk assessment was flawed by reason of these matters and also because it did not assess any risk to which the service users may

be exposed to any public area through which it may be necessary to pass in order to attend and exit the LAC review.

(g) Whether an undocumented risk assessment carried out in the circumstances where a service user had expressed a fear of violence from another service user complied with policy. The model anticipates that available documentation would include risk assessment.

The conclusion of the SAI review was based on mistakes of facts

[22] The Applicant argues that the SAI report was based on the following mistakes of facts:

(a) That the original plan had been to only have the Applicant attend and then to meet the father afterwards. It is now agreed that the original arrangement had been to have 2 meetings 15 minutes apart.

(b) That the Applicant and her solicitor had been asked to attend.

(c) That the report of Dr Bunn which only spoke to competency, was reliable in terms of assessing B's violence.

(d) That the relationship of the Applicant and B was characterised by acrimony and concerns of violence should be disregarded.

(e) That the Applicant or Mr Tumelty were happy with or agreed to change the agreed arrangements.

(f) That the social work team need not consider any risk to which service users may be exposed to in any public area through which it may be necessary to pass in order to attend LAC reviews.

(g) That in conducting the risk assessment it was appropriate that consideration was given to looking at social service records relating to B's very troubled childhood.

[23] The Applicant argues that because of the points made at paragraphs 17 and 18 above the conclusions of the SAI review were Wednesbury unreasonable.

Failure to involve all relevant parties

[24] The Applicant argues that the SAI review failed to properly involve all relevant parties in contradiction of the guidance. This led to a one-sided and mistaken version of the subject events to be presented to inquiry team.

Failure to take account of the legitimate expectations of service users

[25] The Applicant argues that the SAI review failed to take account of the legitimate expectations of service users, in that:

(a) There was inordinate and unjustifiable delay in making the report available.

(b) The recommendations are geared towards staff safety rather than the safety of service users.

(c) The review was not conducted in an open, fair and independent manner.

Respondent's Arguments

[26] The Respondent argues that the LAC review was well-managed and concluded without incident.

[27] The Respondent argues that in relation to future LAC reviews the Trust will be required to consider the participation of each parent in light of the relevant statutory and legal obligations placed upon it and in light of the facts and evidence available at the time.

[28] The Respondent argues that the SAI review was conducted in a proper manner and the Review involved all relevant parties.

[29] The Respondent argues that the focus and purpose of the SAI review was to ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner in order to prevent reoccurrence. A multi-disciplinary review of the incident was conducted. There is no statutory duty on the Trust to provide recommendations within the context of the SAI review process for 'countless other women who live in the Belfast area'. This is not the purpose or remit of the review process. The function of the Review is to aid learning and change.

[30] The responsibility for the protection of people against criminal actions lies with the police.

[31] The Trust and the Board completed their SAI Review and report. In that report they make recommendations commensurate with their findings and purpose of the Review. In fact the LAC Review process was well managed and passed without incident. The fact that B subsequently acted in the way he did was not predicted nor can such events be prevented in the future. The Trust and Board cannot make recommendations which would ensure that B (or others) do not act in such a criminal manner should they choose to do so (even if that is the purpose of a SAI Review which it is not).

Procedural Unfairness

[32] In relation to the contention that the Applicant and her solicitor had insufficient input into the Review the Respondent submits that the review process took into account all relevant information pertinent to the nature and purpose of the SAI review. Mr Tumelty was provided with the opportunity to engage in the process and indeed did so on behalf of the Applicant. Mr Tumelty was never excluded from the process. His written contributions/letters were received and considered during the process by the Trust personnel and the DRO for the Board; he was spoken to on the telephone and provided with the report and recommendations. The issue of the Applicant's Article 6 rights does not arise as the SAI review is not a 'legal proceeding' in which there is a determination of the Applicant's 'civil rights and obligations'.

[33] In relation to the contention that there was inordinate delay in the completing and release of the report the Respondent submits that the guidance indicates a period for completion but also provides for extension of time. In this case the Board was kept fully informed throughout and an extension of time was duly requested and this request was granted. The delay was not inordinate but was necessary to ensure that the review was conducted in a proper, fair and reasonable manner.

[34] In relation to the contention that the chair was not independent and was not from a separate field of practice the Respondent notes that the guidance is guidance only and is not binding on the Trust. The chair is highly qualified and experienced and was capable of bringing her independence and experience to the review. In addition the DRO appointed by the Board is totally independent and had the function of considering the report and making recommendations.

[35] In relation to the contention that all relevant matters were not taken into account the Respondent submits that all relevant matters *were* taken into account. This information included the social workers files which included contact records and the outcome of meetings. In addition, the social worker carried out a risk assessment of both parents attending the meeting and whilst this may not be formally set out in a document it nonetheless took place and was informed by legal advice given. The note

of the social worker indicates the various measures which would be implemented in facilitating the review. The review also had access to police documentation in relation to incidents of domestic violence and ongoing criminal cases.

Wednesbury Unreasonable

[36] In relation to the risk assessment the Respondent argues that it was not carried out in someone's head. The social worker spoke to the parents and obtained their views and the views of the solicitors. As in many cases, urgent decisions need to be taken in relation to the processes involved which responds to the competing and changing interests of all those involved. The Trust social workers did not act alone; they took legal advice from their own Counsel and solicitor regarding the issues that arose. Having discussed and considered the various competing interests a planned approach was formulated whereby measures were put in place to deal with concerns raised and to reflect legal obligations.

[37] The Trust had available to it various information including a psychiatric report on B which did not raise any concerns in relation to him. There were no predictors that B would behave in the way that he did.

[38] In relation to the robustness of the review the DRO carried out her own independent consideration of the SAI review and report. In doing so, she raised further queries with the Trust and having considered the responses she concluded that the review was sufficiently robust.

[39] The Review did consider all the relevant information.

Articles 3 and 8 ECHR

[40] The Trust does not have an obligation to protect the Applicant from 'inhumane or degrading treatment' or assault from B. The state is obliged to protect the Applicant from assault by third parties.

[41] The Applicant is incorrect in her assertion that the Trust 'decisions' put the applicants life at risk. There is no evidential basis for this. It was B's criminal behaviour that put the Applicant's life at risk. The acts of the Trust did not lead to a breach of the Applicant's Article 3 and Article 8 rights; this is a quantum leap without any basis, evidence or foundation.

[44] There is a lack of force in the argument that there is public interest in a further independent SAI review being held. The review was conducted by an experienced

member of the Trust staff who was independent of the events which occurred prior to the incident.

Alternative Remedies

[45] The Respondent asserts that the Applicant has a number of alternative remedies available to her.

Serious Adverse Incident Team

[46] The Respondent argues that there is no evidence before the court to support the assertion that the chair of the Review was not independent.

[47] The Trust actively considered who should chair the review and all relevant factors were considered before appointing the chairperson. The guidance was not ignored but rather when weighing up all relevant factors the approach taken was more appropriate to the nature of the SAI review being undertaken and the specifics in the case.

[48] The degree of independence of the membership team was carefully considered in light of the nature of the SAI review itself.

[49] The Respondent argues that there is no evidence before the court to assert that Ms Minnis lacked independence.

[50] The Respondent argues that it is for the Applicant to place evidence of a lack of independence before the court. No such evidence is provided.

Failure to take relevant factors into account

[51] The Respondent argues that all relevant considerations were taken into account

Mistaken Facts

[52] This is refuted.

Wednesbury Unreasonable

[53] No evidence is produced to support the claims that the SAI Review process undertaken by the Trust failed to take into account material actors and/or took into account mistaken facts. The Respondents assert that regard was had to all these factors.

The SAI Review failed to properly involve all relevant parties within the SAI process

[54] The Trust did carefully consider this. The Applicant was to be invited to attend at the SAI review meeting but the subsequent response of Mr Tumelty required further consideration and legal advice to be taken and acted upon. In the circumstances, the Trust ensured the involvement of the parents through written communication. Once legal proceedings were intimated the Trust became concerned that the contribution from Mr Tumelty and the Applicant would change to one focussing on culpability rather than on contributing to a learning exercise.

Legitimate Expectations

[55] The SAI considered all relevant matters. The delay was occasioned for a number of reasons and was justifiable in ensuring that the SAI Review process was conducted thoroughly, fully, properly and without potentially prejudicing those involved. The Trust conformed with its statutory requirements in this regard.

Discussion

[56] Firstly, it is important to understand what is being claimed by the Applicant. No claim is being made in relation to the actual event. Such claims are being pursued through criminal proceedings and civil action. Indeed it would appear that many of the issues canvassed in these proceedings are a feature of the pending civil litigation.

[57] Second, it is important to recognise that it is beyond the remit of the court to tell the Trust or the Board how to perform their internal reviews/investigations unless some public law illegality is found.

[58] I would note that the complaints process should have been exhausted as this is and was the most appropriate forum to discuss the performance of the Trust/Board reviews. Judicial Review is not the appropriate remedy in the instant case and the claim is rejected on this ground however I propose to deal with the other issues for the sake of clarity and completeness.

[59] What is being claimed are various rights regarding the means by which the SAI review is carried out and signed off upon. The rights claimed are claimed under the headings of legitimate expectation, lack of fair procedures and breach of Articles 2, 3 and 8 ECHR.

[60] Once a public body undertakes a procedure it must carry it out fairly. In this case the relevant procedure is the SAI review. The guidance document is guidance only

and is not binding on the Trust. The document expresses a preference for involving patients and service users in the review, but it is clear that there is no *duty* to do so and there is no expectation to do so if it is not 'appropriate' or 'possible'. It is entirely within the discretion of the Trust and/or Board to decide whether it is 'appropriate' or 'possible' in any case. In the instant case, due to legal advice received in relation to the other litigation, further involvement in the process was curtailed. This is for the discretion of the Trust. Similarly, the level of independence is a matter for the discretion of the Trust/Board and should only be disturbed by the Courts if the choice of panel members and chair was manifestly unlawful, which cannot be said in this case. Again the type and amount of information to be considered is for the discretion of the Trust/Board and should only be disturbed if manifestly unlawful and no such manifest unlawfulness is disclosed in these proceedings.

[61] Even if the process were capable of being biased, the evidence adduced by the Applicant falls far short of the standard required to suggest actual bias. Further, based on the assertion by the Applicant I cannot conclude that a 'fair-minded and informed observer [would] conclude that there was a real possibility, or a real danger ... that the tribunal was biased' [Re Medicaments and Related Classes of Goods (No 2) [2001] 1 WLR].

[62] For the reasons advanced by the Respondent which I have earlier summarised I also find that there was no procedural unfairness.

[63] I reject the submission that there has been any breach of Articles 2, 3 or 8. I cannot find any sufficient grounds in the submissions or evidence that would make out this argument.

[64] In relation to the arguments advanced regarding the actions of the DRO I conclude that if any rights accrued to the Applicant under the process, the extent of those rights are that the relevant personnel performed their functions as outlined in process and used their discretion lawfully. I find that the DRO did just that.

Conclusion

[65] For the above reasons the application is rejected.