HSC Business Services Organisation

Directorate of Legal Services
PRACTITIONERS IN LAW TO THE HEALTH & SOCIAL CARE SECTOR

2 Franklin Street, Belfast, BT2 8DQ
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Your Ref:
AD-0615-13
AD-0646-13

Our Ref:
HYPB04/06

Date:
24th September 2013

Mrs Dillon
Solicitor to the Inquiry
Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam,

RE: DEPARTMENTAL AND ADDITIONAL GOVERNANCE SEGMENT

I refer to your letter of 5th August 2013 (AD-0646-13) and now enclose a paper prepared by the Belfast Trust dealing with the issues raised in your aforementioned correspondence.

I trust that this is in order.

Yours faithfully

JRBolton

Joanna Bolton
Solicitor Consultant

Why and in what way have reports of children's deaths to the Coronial Service changed since Claire's death in 1996 and Lucy's death in 2001 [sic]?

The Belfast HSC Trust developed a comprehensive guidance entitled 'Guidance on Actions to be taken after a patient's death' which has been in operation since July 2010 (see attached Appendix 1). This guidance is available on the Trust's intranet.

As indicated in the Trust's Quality and Safety Initiatives paper (furnished to the Inquiry on 6th September 2013) (page 16) the Trust can demonstrate a positive approach to the reporting of unexpected/unexplained deaths as Serious Adverse Incidents to the Health and Social Care Board (HSCB). The HSCB reporting template requires the Directorate to confirm if the Coroner has been informed. This enables the Trust's Corporate Governance team, who oversee the submission of the SAI reports to the HSCB; to go back to the Directorate to query why a decision has been taken not to report a death to the Coroner and to escalate this to the Medical Director if required.

A key development in this area in recent years has been the development of the Belfast HSC Trust's 'Morbidity and Mortality Policy' as referenced at page 42 to 43 of the Trust's Quality and Safety Initiatives paper submitted to the IHRD.

The establishment of the role of Medical Adviser within the Coroner's Office is another significant development in recent years and has been welcomed by the Trust. This enables clinicians to discuss queries with a medical practitioner and to make informed decisions as to whether or not to report deaths to the Coroner. In addition, HMCO log these queries as well as formal referrals.

How does the Trust become aware of issues arising from the treatment of children in other hospitals in Northern Ireland and elsewhere in the UK which are relevant to practice in the RBHSC?
And
Is there a system for it to become aware?

The system by which matters pertaining to governance issues are managed is in line with the Belfast HSC Trust's Assurance Framework which is detailed in the Trust's Quality and Safety Initiatives paper (page 6 and Appendix 1). In relation to learning from issues and/or good practice the proposed Learning from the 'Experience Steering Group' will, as a high level subcommittee of Trust Board, enhance existing arrangements for the sharing of learning (page 25). The purpose of the 'Experience Steering Group' is to provide information to the 'Assurance Committee' around the effectiveness of structures and processes established to support learning from the events and experiences of our service users and staff. The Learning

from 'Experience Steering Group' will bring together aspects of the assurance framework agenda in order to realise continuous improvement in safety and quality.

In the case of issues or learning arising from Serious Adverse Incidents (SAIs) please refer to the sections of the Trust's Quality and Safety Initiatives Paper entitled 'Reporting Serious Adverse Incidents' (pages 18 to 22) and 'Learning from adverse incidents and other significant events' (pages 25 to 27). All of the Trusts in Northern Ireland are required to report SAIs to the Health and Social Care Board (HSCB) in the manner described and in line with extant guidance. [1] The HSCB and Public Health Agency (PHA) produce regular generic learning reports which are disseminated to all of the Trusts (see Appendix 2 attached).

These learning reports are received by the Chief Executive's Office and circulated throughout the organisation, including the Children's Hospital, as described in the Trust's Quality and Safety Initiatives paper in the section entitled 'Dissemination of External Standards and Guidelines' (pages 38 to 39) and in Appendix 34. The learning report is also discussed at the 'Serious Adverse Incident Review Board' (see pages 18 and 19) and in relevant Directorate Governance meetings. The Directorate Governance meeting is described on page 7 of the Quality and Safety Initiative paper.

In addition, the HSCB/PHA may wish to disseminate a learning letter for a specific issue which requires regional action. A sample learning letter has been attached (see Appendix 3). These letters are disseminated and monitored as described in the 'External Standards and Guidelines' section of the Quality and Safety Initiative Paper (page 38) and in Appendix 14.

Issues may also arise from formal and informal networks or other sources and these and the system for dissemination are described in the RBSHC Communication Strategy at Appendix 16 of the Quality and Safety Initiative Paper.

The RQIA undertake a number of thematic reviews and hygiene inspections (announced and unannounced) annually. They will generally produce a report which reflects issues and best practice for the region as well as specific reports for individual trusts. These reports provide an additional resource for learning. RQIA reports are disseminated via the Chief Executive's Office to Directors for information/action and are reviewed by the Assurance Committee of Trust Board.

[1] www.hscboard.hsci.net/consult/Policies Procedure for the reporting and follow up of SAI April 2010.

Belfast Health and Social Care Trust

Reference No: SG 04/09

Title:	**Guidance on actions to be taken after a patient's death**		
Author(s)	**Ms Nicki Patterson** **Co-Director Nursing Workforce Planning and Development** [redacted] **Dr JR Johnston, Co-Chair Standards and Guidelines.** **Dr Ann Harper, RJMH**		
Ownership:	**Dr AB Stevens, Medical Director**		
Approval by:	**Standards and Guidelines Committee**	**Approval date:**	**14/09/2011**
Operational Date:	**July 2010**	**Next Review:**	**July 2013**
Version No.	**3**	**Supercedes**	**2**
Links to other policies			

Version Record

Date	Version	Author	Comments
05/08/2011	V2.1	CM	Addition of-responsibility to inform relatives of cause of death, - record coroner referred in patient's notes.
14/12/2011	V2.2	CM	Update of Appendix 2 following comments from a Serious Incident Investigation.
07/03/2012	V2.3	CM	Update Appendix 2 following HSC Board letter (6/02/2012) requesting improved timeliness to GP being informed of deaths
1/5/2012	V2.4	JRJ	New format; After S&G on 4/4/12
14/5/2012	V2.5	JRJ	Hyperlinks updated; update 4.18

Guidance on actions to be taken after a patient's death

1.0 INTRODUCTION / PURPOSE OF POLICY

This policy provides guidance on the steps that need to be taken after a patient dies:-

- **confirmation and verification of death, stillbirth.**
- **when and how to liase with the coroner's services.**
- **completion of medical certificates.**
- **cremation certification**

1.1 Purpose

The purpose is to:

- provide guidance to medical and nursing staff on verifying life extinct and to ensure the appropriate steps are then taken.
- ensure that all deaths are reported and recorded in accordance with the Coroner's office.
- ensure that staff deal with the death of a patient in a caring, compassionate and professional manner.
- comply with DHSSPSNI circulars HSS(MD) 3/2008, 8/2008, 10/2008.

2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all staff that have a role in verifying and recording life extinct, death certification and reporting deaths to the coroner's office.

It applies to a variety of settings: wards, ICU/CCU, emergency department and community.

The current position in law is that there is no statutory definition of death in the United Kingdom. The definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe[2].

When a person dies, a number of steps need to be completed to allow confirmation, certification and legal registration of the death. These steps are:

A. Verifying life extinct.
B. Certifying the medical cause of death or
C. Referral to the Coroner.
D. Registering the Death.
E. Obtaining a burial or cremation order.

3.0 ROLES/RESPONSIBILITIES

Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

Doctors are responsible for completing a Medical Certificate and Cause of Death (MCCD). The doctor completing the MCCD must have been involved in the care of the patient, but need not have verified death or have seen the body of the deceased.

Those verifying and certifying death must be aware of the roles of Health and Social Care, the Police Service of Northern Ireland and the Coroner's Office in the process of dealing with death.

4.0 KEY POLICY PRINCIPLES

A. Verifying life extinct.

4.1 This first step has no formal legal term and is referred to in a number of ways including recognition of life extinct, verification of death, pronouncing death, confirming death.

4.2 In order to verify life extinct, cessation of circulatory & respiratory systems and cerebral function must be confirmed and documented in the patient's notes - appendix 1.

Further details of the process for confirming death are given in appendix 3 and from the "A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008)".

4.3 Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

Further requirements regarding these roles are provided in the circular - HSS(MD) 8/2008 - *Verifying and recording life extinct by appropriate professionals* and its guideline.

4.4 Following the verifying of life extinct, the practitioner needs to determine the next steps, which will depend on the circumstances of the death (appendix 2).

Although most deaths, even sudden deaths, are not suspicious, it is important that the professional who has verified life extinct considers the general circumstances of the death.

4.5 Where there are concerns about the death, the body and the area around it should be secured and not disturbed, the Police should be contacted and they will direct how the death should be handled.

4.6 There are some special circumstances concerning the diagnosis and confirmation of death e.g. brain-stem death in ventilated patients, where these artificial interventions are sustaining cardiorespiratory function in the absence of a patient's ability to breathe independently. A code of practice designed to address these issues - A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008) outlines current practice.

B. Certifying the medical cause of death, stillbirth.

4.7 Death certification provides a permanent legal record of the cause and facts of death, allows registration, enables a family to arrange disposal of the body and settle their estate.

A doctor who had treated the patient in the last 28 days for a natural illness that caused their death may issue a Medical Certificate of Cause of Death (MCCD).

4.8 All doctors completing medical certificates of cause of death or cremation forms and doctors and midwifes completing stillbirth forms should be aware of when and how to complete the forms and when deaths should be referred to the coroner.

4.9 All staff should refer to the DHSSPSNI guidance on Medical Certification and Cause of Death (MCCD), when completing a death certification / liaising with the Coroner. This can be found at the link below:

http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf

An expected death can be defined as: "a death where the patient's demise is anticipated in the near future". In such cases the doctor will be able to issue a medical certificate as to the cause of death.

Where there is a death in suspicious circumstances or a sudden /unexpected death nursing and medical staff must be familiar with the necessary steps required to deal with this situation – outlined in appendix 2. These procedures should be handled in a sensitive and knowledgeable way.

4.10 Registered Medical Practitioners have a legal duty to provide, without delay, a certificate of cause of death if, to the best of their knowledge, that person died of natural causes for which they had treated that person in the last 28 days.

4.11 Any alterations to the MCCD must be initialled by the doctor.

4.12 Because Registrars need to be assured that the doctor completing a MCCD is fully registered and because they sometimes need to contact the doctor to clarify issues before registering the death, the MCCD should contain a

- legible printed name,
- signature
- GMC number beside your signature and
- contact details. Difficulty contacting the doctor can lead to delay in funeral arrangements and distress for families.

4.13 It is good practice to either make a note in the clinical record of the details recorded on the MCCD, or keep a copy of the MCCD in the patient's records.

4.14 It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Foundation level doctors should not complete medical certificates of cause of death unless they have received training.

4.15 If a doctor cannot complete an MCCD, either because the cause of death was not natural or because they were not treated in the final 28 days of life, then the death must be referred to the Coroner. If a doctor contacts the Coroner's Office out of hours *they should listen to the full range of options* on the recorded message before selecting one as the most appropriate option may not be clear until the message is complete.

A doctor who had not been directly involved in the patient's care at any time during the illness from which they died cannot certify the cause of death, but should provide the coroner with any information that may help to determine the cause of death.

If a MCCD cannot be completed because no doctor involved in the patient's care is on duty (as may happen at weekends) then the duty doctor may contact the Coroner's office and, after agreement, complete a pro-forma which will allow the death to be

registered under the "Form 14 – **Pro-forma system**" (page 29 of *Working with the Coroner's Service for Northern Ireland)*.

If the Coroner agrees this approach, you will be asked to draft a completed but unsigned MCCD giving the cause of death as agreed and a signed clinical summary letter explaining the circumstances of the death (including any relevant investigations and results). These are both to be faxed through to the Coroner's office (both originals should then follow in the post).

It is also good practice to inform the patient's GP if death occurs in hospital.

4.16 **Recording Healthcare Associated Infections (HCAI)**
The level of healthcare associated infections (HCAI) remains a matter of concern to clinicians and the public.

The Health Service depends on accurate information gained from death certificates to record changes in mortality associated with infections. Trends which are identified can highlight new areas of concern, or monitor changes in deaths associated with certain infections.

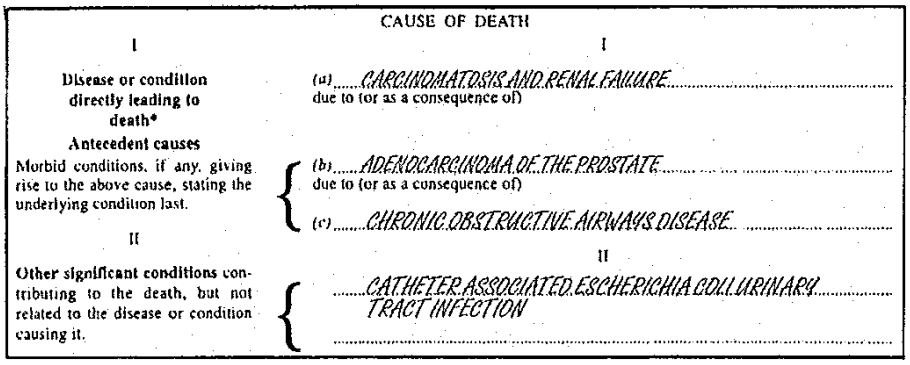
Families may be surprised if an infection the patient was being treated for, such as MRSA or Clostridium Difficile, is not mentioned on a death certificate.

It is a matter of clinical judgement if a HCAI was the disease
i. directly leading to the death [record at part I (a)],
ii. was an antecedent cause [record at part I (b) or I (c)] or
iii. was a significant condition not directly related to the cause of death [record at part II].

A. If a health care associated infection was part of the sequence leading to death, it must be recorded on part I of the MCCD and all the conditions in the sequence of events back to the original disease being treated should be included.

CAUSE OF DEATH	
I	I
Disease or condition directly leading to death*	(a) *CLOSTRIDIUM DIFFICILE PSEUDO MEMBRANOUS COLITIS* due to (or as a consequence of)
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.	(b) *MULTIPLE ANTIBIOTIC THERAPY* due to (or as a consequence of)
	(c) *COMMUNITY ACQUIRED PNEUMONIA WITH SEVERE SEPSIS*
II	II
Other significant conditions contributing to the death, but not related to the disease or condition causing it.	*POLYMYALGIA RHEUMATICA*
	OSTEOPOROSIS

B. If a patient had a HCAI which was not part of the direct sequence but which was thought to contribute to their death it must be mentioned in part II.



CAUSE OF DEATH

I		I
Disease or condition directly leading to death*	(a)	CARCINOMATOSIS AND RENAL FAILURE due to (or as a consequence of)
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.	(b)	ADENOCARCINOMA OF THE PROSTATE due to (or as a consequence of)
	(c)	CHRONIC OBSTRUCTIVE AIRWAYS DISEASE
II		II
Other significant conditions contributing to the death, but not related to the disease or condition causing it.		CATHETER ASSOCIATED ESCHERICHIA COLI URINARY TRACT INFECTION

C. If the HCAI is thought not to be contributory to a patient's death it is important not to record it on the MCCD.

The recommended sequence should be:-

1. **Discuss** if it is appropriate to include HCAI on MCCD with a consultant before completion.
2. **Inform** family where HCAI appears on certificate. (also explain, in cases where it is non-contributory and therefore not on the MCCD, why it does not.)
3. **Inform** ward manager/nurse in charge that MCCD with contributory HCAI has been issued.
4. **Assist** ward manager/nurse in charge in completion of incident report form and ensure that causes of death as they appear on the death certificate are recorded on the incident form.

For further guidance on this topic refer to

- Guidance on Death, Stillbirth & Cremation Certification. DHSSPSNI, 2008.
- HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
- Consultant advice.

C. Referral to the Coroner.

4.17 There is a general requirement under section 7 of the Coroners Act (NI) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.

Notification to the coroner and any discussions with the coroner should be recorded in the patient's notes.

For information regarding the Coroner's office refer to the Coroners Service for Northern Ireland – June 2011.

4.18 Therefore, before you proceed with completing a MCCD ask yourself this question – *Does this Death have to be reported to the coroner?*

Death is reported to the Coroner in the following situations:

- a doctor did not treat the person during their last illness;
- a doctor did not see or treat them in the 28 days before they died;
- the cause of death was sudden, violent or unnatural such as an accident, or suicide;
- the cause of death was murder;
- the cause of death was an industrial disease of the lungs such as asbestosis; or
- the death occurred in other circumstances that may require investigation.

A death in hospital should be reported if:

- there is a question of negligence or misadventure about the treatment of the person who died;
- they died before a provisional diagnosis was made and the general practitioner is not willing to certify the cause; or
- the patient died as the result of the administration of an anaesthetic.

From: Coroners service for Northern Ireland – June 2011

For help, refer to appendix 4 and/or
Guidance on Death, Stillbirth & Cremation Certification. **DHSSPSNI, 2008.**

4.19 Notification to the Coroner of the death of a child must be done by a Consultant.

4.20 Whenever a patient dies, a doctor who is familiar with their medical history and who is able to give an explanation of why death occurred should speak to family members. This will provide an opportunity for the family to express any concerns before a Medical Certificate of Cause of Death (MCCD) is completed.

If the family is unhappy with the care and treatment the deceased received it is advisable to report the death to the coroner with particulars of the family's concerns. A written record of these concerns should always be made and retained with the medical records.

4.21 A foundation level doctor must consult a more senior colleague before reporting a death to the coroner.

4.22 A death occurring in hospital during the night does not usually need to be immediately reported to the coroner. The body should be moved to the mortuary for overnight storage and the coroner's office contacted promptly the following morning.

A coroner is always on call and can be reached if necessary out-of-hours. Where there is a need to obtain consent for the transplantation of organs or some other complicating factor arises, the death should be reported to the coroner as soon as possible. In cases where death may have resulted from a crime or foul play the doctor should immediately inform the police and allow them to take the matter forward with the coroner.

4.23 The office of the Coroners Service for Northern Ireland is at:

- May's Chambers, 73 May Street, Belfast BT1 3JL.
- Tel: 028 9044 6800; Fax 028 9044 6801.
- Website: www.coronersni.gov.uk
- E-mail: coronersoffice@courtsni.gov.uk
- the office is staffed weekdays 9.00am – 5.00pm,
- weekends and public holidays 9.30am – 12.30pm
- (except Christmas Day when the office is closed)
- outside normal office hours a recorded message will provide contact details for the duty coroner or messages may be left on the telephone answering machine.

NB: If a doctor contacts the Coroner's Office out of hours *they should listen to the full range of options* on the recorded message before selecting one as the most appropriate option may not be clear until the message is complete.

4.24 **Hospital Post-Mortem Examinations**

In some cases, where the nature of the terminal illness is unclear, or the cause of death is uncertain, but there are no concerns that the death was not due to natural causes, a hospital post-mortem examination may be requested.

The decision to request a hospital post-mortem examination in an adult should be taken by a senior doctor, e.g. ST3 grade or above. Any request for a hospital post-mortem on a child must be made by a consultant.

In these cases, the next of kin must be counselled and made conversant of the reasons why a post-mortem examination would be desirable and written consent must be obtained. Information books and consent forms are available for neonatal, paediatric and adult examinations - Post Mortem Examinations DHSSPS(NI).

4.25 **Definition of a maternal death – ICD code 9/10.**

A **maternal death** is defined as a death of woman while pregnant or within 42 days of the end of the pregnancy (includes delivery, ectopic pregnancy, miscarriage or termination of pregnancy) from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

However, a maternal death can effectively be any death which occurs during or within one year of pregnancy, ectopic pregnancy or abortion as it can be directly, indirectly, coincidentally related to the pregnancy or late.

A **Direct** death is defined as a death resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

An **Indirect** maternal death is defined as a death that resulted from previously existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy. These include cases of self harm as consequence of postnatal depression.

A **Coincidental (fortuitous)** death is defined as a death that occurs from unrelated causes which happen to occur in pregnancy or puerperium, i.e. some malignancies, domestic violence, road traffic accidents, etc.

A **Late** death is defined as a death that occurs between 42 days and one year after miscarriage or delivery that is due to **direct or indirect** maternal causes.

4.26 For detailed guidance please refer to the BHSCT policy on "management of a maternal death" - http://intranet.belfasttrust.local/Policies%20and%20Procedures/Management%20of%20a%20Maternal%20Death.pdf

4.27 When the death is directly related to the pregnancy the attending doctor cannot issue a death certificate without first referring to the Coroner.

4.28 **Centre for Maternal and Child Enquiries" (CMACE)**
It is a statutory requirement that all health professionals provide information and participate in confidential inquires and that Maternal deaths are reported to the CMACE (Centre for Maternal and Child Enquiries) i.e. the Maternal Mortality Enquiry. It is commissioned and monitored by the National Patient Safety Agency (NPSA).

ALL maternal deaths (direct, indirect or coincidental) which occur during pregnancy or within 42 days of delivery should be reported to the CMACE Regional Manager.

In addition, the following deaths should be notified if they occur from 42 days to 6 months following delivery, termination or abortion:

- Direct Deaths
- Deaths due to peripartum cardiomyopathy
- Deaths due to suicide.

4.29 CMACE in Northern Ireland is commissioned by the DHSSPS through the Public Health Agency for Northern Ireland and can be contacted through:-
Regional Manager: Dr Jackie McCall

Address:
Public Health Agency (PHA)
[redacted]

Phone:
[redacted] or [redacted]

Fax:
[redacted]

Email: [redacted]

D. Registering the Death.

4.30 The family (or certain other people) will provide the person's details to the local registrar, with either the MCCD or the Coroners form giving the cause of death.

E. Obtaining a burial or cremation order.

4.31 The registrar or coroner can issue a burial or cremation order.

4.32 Cremation
When a body is to be cremated there are a series of special medical forms to be completed by different, independent doctors, to provide reassurance that the death does not require further investigation. If the death has not been referred to the coroner,

and a MCCD - certificate of cause of death has been completed, the medical forms are Forms B, C and F.

Cremation forms are not required for coroner's cases where a pro-forma has been agreed (they will issue burial or cremation orders in this instance) or where there is to be a coroner's post-mortem.

4.33 Form B
This should be completed by a registered medical practitioner who has attended the deceased during his last illness. It is often the same doctor who completed the MCCD.

Foundation level doctors should NOT complete cremation Form B unless they have been trained to do so.

Form C
The doctor completing cremation Form C should:

- be a registered medical practitioner of not less than 5 years standing
- be independent of the doctor who completed Form B. The legal requirement is that the doctor completing Form C should not be a relative, partner or assistant of the doctor who completed Form B. It would be good practice that the doctor completing Form C should not have been directly involved in the patient's care;
- not be related to the deceased.

Form F
This is completed by the Medical Referee for the Cremation Authority.

Stillbirth
Stillbirth forms can be completed by a medical practitioner who was present at the birth, or who examined the body.

Foundation level doctors should not complete stillbirth forms without discussion with a more senior colleague.

A registered midwife who was present at the birth or examined the body can also complete the stillbirth certificate.

5.0 IMPLEMENTATION OF POLICY

6.0 MONITORING

Monitoring of MCCDs will be done by checking the concurrent entry of death certification details onto a new IT system to be introduced in 2012.

7.0 EVIDENCE BASE / REFERENCES

1. DHSSPSNI guidance on death, still birth and cremation certification – 2008.
2. A code of practice for the diagnosis and confirmation of death. Academy of Medical Royal Colleges. 2008.
3. DHSSPSNI circulars

References, including relevant external guidelines:

1. Guidance on Death, Stillbirth & Cremation Certification. Part A DHSSPSNI, 2008.
2. Guidance on Death, Stillbirth & Cremation Certification. Part B DHSSPSNI, 2008.

3. A code of practice for the diagnosis and confirmation of death. Academy of Medical Royal Colleges, 2008.
4. HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
5. HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.
6. Guidelines for Verifying Life Extinct (PDF 62 KB)
7. HSS(MD) 10/2008. Enhanced monitoring arrangements for deaths where C.DIFFICILE or MRSA infection is mentioned on the death certificate.
8. Coroner's Service for Northern Ireland - June 2011.
9. *Working with the Coroner's Service for Northern Ireland*

8.0 CONSULTATION PROCESS

Endorsement of regionally and nationally consulted documents
Coroner Office

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Verification of Life Extinct
Appendix 2: Protocol for actions to be taken after a death in Hospital
Appendix 3: Diagnosing and confirming death after cardiorespiratory arrest
Appendix 4: Deaths that must be reported to the coroner

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

SIGNATORIES

Date: March 2012
Name: Nicki Patterson
Title:
Co-Director Nursing Workforce Planning and Development

Name: Dr A B Stevens **Date: March 2012**
Title:
Medical Director

Appendix 1

VERIFICATION OF LIFE EXTINCT

Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

In order to verify life extinct, cessation of

- circulatory system
- respiratory system
- cerebral function

must be confirmed and documented in the patient's notes with a name and signature.

The documentation recording the examination undertaken and verifying life extinct should be completed and put in the patient's notes.
(**N.B** This applies whether Doctor or Nurse verifies death).

Life extinct must always be verified by examining all of the following systems:

1. Cessation of circulatory system e.g.
   - No pulses on palpation.
   - No heart sounds (verified by listening for heart sounds or asystole on an ECG tracing)

2. Cessation of respiratory system e.g.
   - No respiratory effort observed
   - No breath sounds (verified by listening for one full minute)

3. Cessation of cerebral function e.g.
   - Pupils dilated and not reacting to light
   - No reaction to painful stimuli

Certain situations can make the clinical confirmation of life extinct more difficult, in particular, **drowning, hypothermia, drug overdose and pregnancy.**

In these situations active resuscitation should continue until an experienced doctor has verified life extinct.

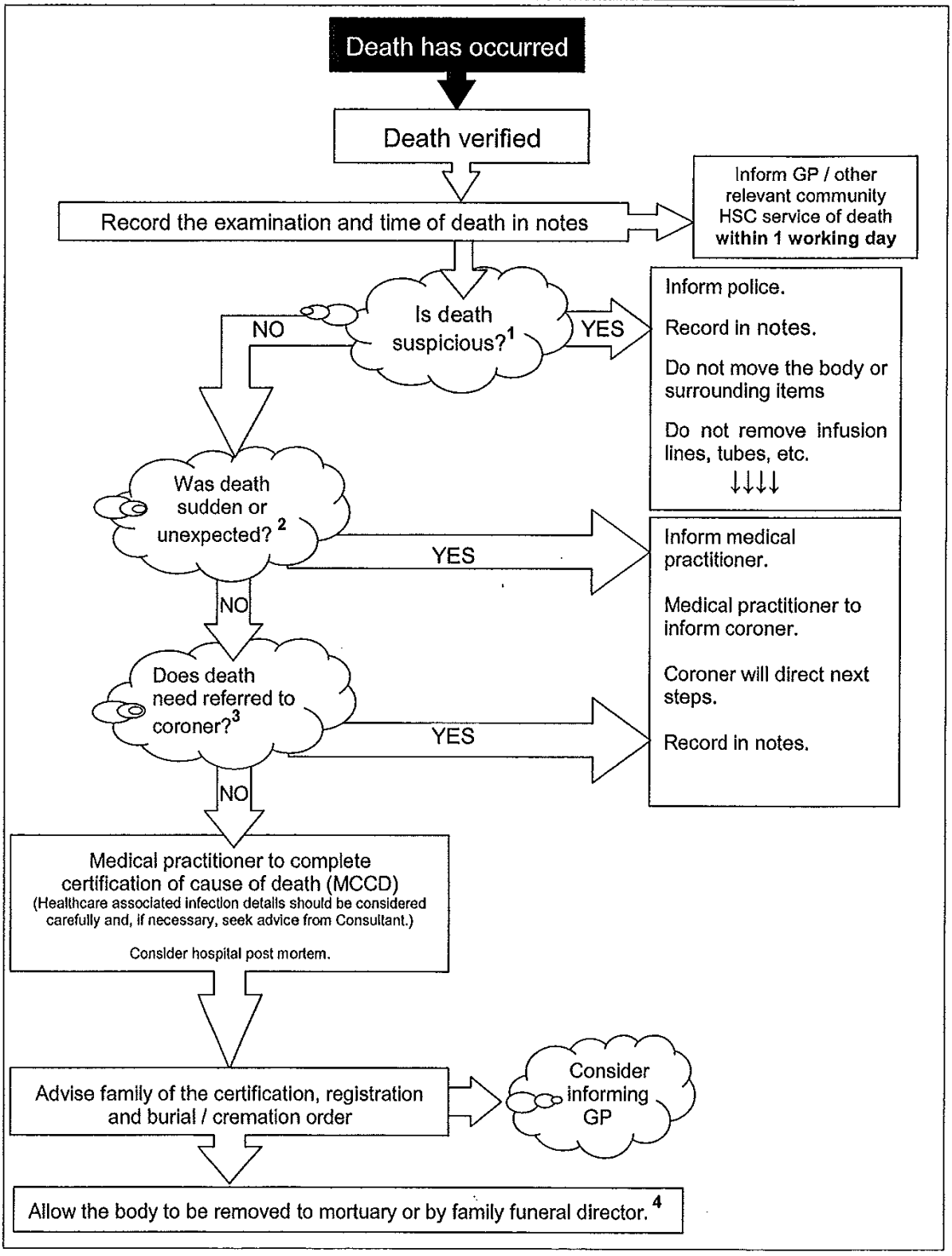
There are some special circumstances, including brain-stem death in ventilated patients, where medical consultants will be involved in verifying life extinct under more detailed protocols. See appendix 3.

From:
HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.

Guidelines for Verifying Life Extinct (PDF 62 KB)

Appendix 2

PROTOCOL FOR ACTIONS TO BE TAKEN AFTER A DEATH IN HOSPITAL



Standards and Guidelines Committee – Guidance on actions to be taken after a patient's death – V3 – May 2012

Notes for Appendix 2

1. **Death involving suspicious circumstances** e.g. injuries, apparent suicide, and scene of death raises concerns about break-in, fire, struggle.
   The body must not be moved. Do not disturb the scene.
   There must be immediate contact with the Police and the appropriate medical practitioner (GP, Out-of-Hours Service or hospital medical staff).
   The Police or medical practitioner must contact the Coroner.
   The body will require Post Mortem examination by State Pathology.
   The Police will arrange transfer to a mortuary.

2. **Sudden/unexpected death without suspicious circumstances** e.g. person found dead at home or initial resuscitation is unsuccessful but circumstances do not raise concerns. Contact the appropriate medical practitioner who must contact the Coroner. The coroner may direct a post mortem examination either by a hospital pathologist or by State Pathology. If the coroner is content that post mortem examination is not required a pro-forma letter to the coroner can be completed by the doctor, and the body released to the family's funeral director. If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the persons normal GP is available to discuss the case) the body should be taken to the designated hospital mortuary. The Police will arrange transfer to a mortuary on behalf of the coroner.

3. **Death related to specific conditions which need referred to the Coroners Service.** In addition to suspicious and unexpected deaths there is a statutory requirement to refer to the Coroner any death as outlined in appendix 4. e.g. Industrial disease such as asbestosis or mesothelioma, during or shortly after an anaesthetic, any injury, including fractures, neglect.

   Contact the appropriate medical practitioner who must contact the Coroner. The coroner may direct a post mortem examination either by a hospital pathologist or by State Pathology. If the coroner is content that post mortem examination is not required a pro-forma letter to the coroner can be completed by the doctor, and the body released to the family's funeral director. If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the persons normal GP is available to discuss the case) the body should be taken to the designated hospital mortuary. The Police will arrange transfer to a mortuary on behalf of the coroner.

4. **Paediatric deaths**
   In certain paediatric cases, parents have the opportunity to take the body of their child home prior to the funeral and where appropriate this choice should be offered. The GP must be informed that this is happening.

Appendix 3

DIAGNOSING AND CONFIRMING DEATH AFTER CARDIORESPIRATORY ARREST

Whilst dying is a process rather than an event, a definition of when the process reaches the point (death) at which a living human being ceases to exist is necessary to allow the confirmation of death without an unnecessary and potentially distressing delay. This is especially so within a primary or secondary care environment, where clear signs that are pathognomonic of death (hypostasis, rigor mortis) are present. However, in the absence of such signs, we recommend that the point after cardiorespiratory arrest at which death of a living human being occurs is identified by the following conditions:

- The simultaneous and irreversible onset of apnoea and unconsciousness in the absence of the circulation

- Full and extensive attempts at reversal of any contributing cause to the cardiorespiratory arrest have been made. Such factors, which include body temperature, endocrine, metabolic and biochemical abnormalities, are considered under section [5]

- One of the following is fulfilled:
  - — the individual meets the criteria for not attempting cardiopulmonary resuscitation[8]
  - — attempts at cardiopulmonary resuscitation have failed
  - — treatment aimed at sustaining life has been withdrawn because it has been decided to be of no further benefit to the patient and not in his/her best interest to continue and/or is in respect of the patient's wishes via an advance decision to refuse treatment

- The individual should be observed by the person responsible for confirming death for a minimum of five minutes [9,10] to establish that irreversible cardiorespiratory arrest has occurred. The absence of mechanical cardiac function is normally confirmed using a combination of the following:
  - — absence of a central pulse on palpation
  - — absence of heart sounds on auscultation

  These criteria will normally suffice in the primary care setting. However, their use can be supplemented in the hospital setting by one or more of the following:
  - — asystole on a continuous ECG display
  - — absence of pulsatile flow using direct intra-arterial pressure monitoring
  - — absence of contractile activity using echocardiography

- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest

- After five minutes of continued cardiorespiratory arrest the absence of the pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure should be confirmed

- The time of death is recorded as the time at which these criteria are fulfilled.

Appendix 4

DEATHS THAT MUST BE REPORTED TO THE CORONER

The duty to report arises if a medical practitioner has reason to believe that the deceased died directly or indirectly:

1. As a result of violence, misadventure or by unfair means;

2. As a result of negligence, misconduct or malpractice (e.g. deaths from the effects of hypothermia or where a medical mishap is alleged);

3. From any cause other than natural illness or disease e.g.:

   - homicidal deaths or deaths following assault;
   - road traffic accidents or accidents at work;
   - deaths associated with the misuse of drugs (whether accidental or deliberate);
   - any apparently suicidal death;
   - all deaths from industrial diseases e.g. asbestosis.

4. From natural illness or disease where the deceased had not been seen and treated by a registered medical practitioner within 28 days of death;

5. Death as the result of the administration of an anaesthetic (there is no statutory requirement to report a death occurring within 24 hours of an operation – though it may be prudent to do);

6. In any circumstances that require investigation;
   - the death, although apparently natural, was unexpected;
   - Sudden Unexpected Death in Infancy (SUDI).

7. Doctors should refer to the Registrar General's extra-statutory list of causes of death that are referable to the coroner.

   - Industrial diseases or poisoning and other poisonings
     - A. Industrial lung diseases
     - B. Other industrial diseases
     - C. Industrial poisoning
     - D. Other poisonings

   - Death resulting from an injury
     - A. Injury
     - B. Indirect injury
     - C. Birth injury
     - D. Operation / anaesthetic

For further detail go to:
http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf

Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

October 2012 – March 2013

June 2013

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SECTION 1

1.0 INTRODUCTION

An adverse incident is defined as, any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation,[1] arising during the course of the business of an HSC organisation / Special Agency or commissioned service. Appendix A of this report sets out the criteria of a Serious Adverse Incident (SAI).

These incidents occur in all health systems and can be the result of system failures, human error, intentional damaging act, rare complications or other causes.

An organisation with a culture of safety will not only report these incidents but will have a process in place by which learning from these incidents is shared both locally and regionally.

This report identifies key regional learning, action taken and proposed arising from SAIs reported during the period 1 April 2012 to 30 September 2012.

The aim is to improve the care and treatment of patients and clients, to improve safety and ensure effective management of the incident.

2.0 BACKGROUND

Responsibility for management of SAI reporting transferred from the DHSSPS (Department) to the Health and Social Care Board (HSCB) working in partnership with the Public Health Agency (PHA), with effect from 1 May 2010.

In April 2010, following consultation with key stakeholders, the HSCB issued the procedure for the 'Reporting and Follow up of Serious Adverse Incidents' for full implementation on 1 May 2010. The procedure sets out the arrangements for reporting, managing, investigating and reviewing of all SAIs occurring during the course of business of an HSC organisation, Special Agency or commissioned service. It also sets out the arrangements of how SAIs are managed within Primary Care Services in conjunction with the adverse incident system in place within the HSCB Integrated Care Directorate.

The procedure details arrangements for internal management of SAIs by HSCB and PHA staff, supported by an additional internal protocol in relation to the nomination and role of a HSCB/PHA Designated Review Officer (DRO).

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

3.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

The arrangements for managing SAIs reported to the HSCB/PHA include:

- Regional reporting system to the HSCB for all SAIs.
- The nomination of a DRO to review and scrutinise reports.
- Regional SAI Review Group meeting held on a bi-monthly basis to consider reports, identify learning and agree actions.
- Escalation if required in respect of:
  -timescales for receipt of SAI and Investigation reports
  -assurances for action being taken forward by reporting organisations following the investigation.

In addition, the HSCB Senior Management Team receives and considers all SAIs on a weekly basis.

4.0 SAIS REPORTED DURING PERIOD OCTOBER 2012 – MARCH 2013

During the period 1 October 2012 to 31 March 2013, the HSCB received 204 SAI notifications. This represents an increase on the previous six months (April 2012- Sept 2012) when 141 SAIs were reported to HSCB. A breakdown of these SAIs by reporting organisation and programme of care is detailed at Appendix B.

5.0 DE-ESCALATION OF A SAI

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, it is recognised that SAI reports can be based on limited information at the time of reporting and further investigation may identify that the incident no longer meets the criteria of a SAI.

In such instances a request can be submitted, by the reporting organization, to de-escalate the SAI, however, the decision to approve the de-escalation will be made by the HSCB/PHA Designated Review Officer.

During the reporting period seven (7) SAI notifications received were de-escalated.

6.0 DUPLICATE SAI REPORTING

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, on occasions a notification may be received from one or more organisations relating to the same incident. In such instances, a lead organisation will be identified to take forward the investigation and follow and the duplicate notification will be closed.

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

The purpose of any adverse incident reporting system is to improve patient safety. A key aim of the SAI reporting and learning process is to reduce the risk of recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is core to achieving this and to ensure these lessons are embedded in practice and the quality of care provided.

The Regional SAI Review Group analyses reports and comments received from DRO's to identify opportunities for learning across organisations and makes recommendations for change to drive improvements for patients and services across the HSC.

Opportunities for learning can be identified in a number of ways:

- Through individual investigations and Root Cause Analysis (RCA)
- Aggregation of similar incidents over time identifying common themes and trends.
- Systematic reviews of areas of concern.

Both providers and the Regional SAI Review Group have a role in not only identifying actions but ensuring changes are made to practice, for example, training or dissemination of information and in implementing and sustaining these changes to practice.

The Regional SAI Review Group also commission specific thematic reviews to identify trends and patterns across commissioned provider organisations and ensure wider implications and key learning points are disseminated across the HSC.

There are many barriers to learning achieving outcomes as identified in 'An Organisation with a Memory'.[2]

- An undue focus on the immediate event rather than on the root cause of problems
- A tendency towards scapegoating and finding individuals to blame rather than acknowledging and addressing deep rooted organisational problems
- Lack of corporate responsibility
- Organisational culture

In meeting its objectives the Regional SAI Review Group will be exploring new methods of learning to maximise the impact on patient safety.

[2] An Organisation with a memory (2000) Department of Health England.

2.0 DISSEMINATION OF LEARNING INITIATIVES

The following initiatives were identified as part of the SAI review process and relate to learning from trends, reviews and individuals cases. Some of these initiatives may relate to learning identified and reported in the previous report as part of ongoing work.

2.1. PHYSIOLOGICAL EARLY WARNING SCORES

A Regional Learning Event was undertaken to disseminate shared learning in relation to Physiological Early Warning Scores (PEWS) in health care. The Senior Management Team (SMT) recommended a review to identify the number and type of SAIs relating to issues surrounding the identification and response to deteriorating patients in the clinical setting to inform and decide whether any further action is required.

An analysis of incidents between the 1 May 2010 and 19 July 2012 was undertaken and a number of recommendations made, for example, Trusts should continue ongoing work on PEWS as set out in HSS (MD)17/2010 and confirm their commitment to a regional approach to the use of PEWS in the identification and management of the deteriorating patient.

The findings from the PHA/HSCB thematic review in relation to PEWS have been presented to HSC Trust Senior Nurses and shared with Education providers.

The PHA, through the Safety Forum, was tasked by DHSSPS to coordinate a regional approach to the use of PEWS. A National Early Warning Score (NEWS), which is currently being rolled out in England, has been considered by the regional group for use in Northern Ireland and is scheduled to start on August 2013. An online package for training is available for use with this tool.

2.2. GP MENTAL HEALTH REFERRAL FORMS TO SECONDARY CARE

The SAI process has identified an issue regarding patient risk information on the GP mental health referral forms to secondary care. These forms do not have a 'don't know' option in the section regarding forensic history, which would highlight to other professionals that this part of the patient history/information requires further exploration.

A scoping exercise in Mental Health Services in HSC Trusts indicated that there is a variation in referral practices not only across HSC Trusts, but also by teams within HSC Trusts. Therefore identifying a need to standardise these forms regionally and a Safety and Quality Learning Letter has been developed and will be communicated to HSC Trusts.

2.3. INADVERTANT ATTACHEMENT OF OXYGEN TO NASOGASTRIC TUBE

In two recent SAIs, green oxygen tubing was attached to the side vent of a Salem Sump nasogastric tube to prevent leakage of stomach contents. Subsequently, staff attached an oxygen supply to the green oxygen tubing, leading to a flow of oxygen

directly into the patient's stomach. This resulted in major complications for both patients who needed further extensive surgery. A Safety and Quality learning Alert was disseminated to all HSC Trusts and RQIA for distribution to independent providers, identifying the following learning:

- oxygen tubing should never be connected to a Salem Sump nasogastric tube;
- extra care should be taken when attaching an oxygen supply in patients who have a nasogatric tube if they have to receive oxygen;
- no equipment other than that identified as compatible in the manufacturer's instructions should be used to facilitate drainage or prevent leakage from a Salem Sump nasogastric tube.

Responses from HSC Trusts indicate they are compliant with the actions required as identified on the learning alert.

2.4. IMPORTANCE OF TAKING ACTION ON X-RAY REPORTS

A Safety and Quality Alert Letter was distributed to HSC Trusts and RQIA following two recent SAIs, where two patients experienced several months delay in diagnosis of serious conditions because abnormal chest x-ray findings, and suggested CT scans, were not actioned by a number of Consultants and other medical staff during inpatient/outpatient care. There were many factors which contributed to these incidents occurring and the learning alert set out the following actions:

- Radiologists should make it easier for other staff to 'pick-up' abnormal results from the many results they review daily, by reporting the suspected findings and urgency of follow-up action, clearly and precisely, as recommended by the Royal College of Radiologists;
- Radiologists should ensure that referring clinicians know about important abnormal results, by communicating directly to the referring clinician, all critical, urgent and significant unexpected findings as defined by the Royal College of Radiologists. That communication should be documented;
- to avoid patient harm Radiologists should fix all transcription errors on x-ray reports;
- Consultants, Middle Grade and Junior Medical staff should remember that their review of x-ray and lab results is a critical step in patient care. It should not be viewed as a routine task in otherwise busy days. Every result is important and the doctor who has read a result is responsible for arranging follow-up actions;
- Consultants, Middle Grade and Junior Medical staff where practicable, should review x-ray and lab results in a quiet area to minimise the risk of being interrupted or distracted;
- Consultants, Middle Grade and Junior Medical staff should always document in the patient's records, the actions taken to follow-up on an abnormal result;
- Consultants, Middle Grade and Junior Medical should remember that each ward round, the discharge summary, the discharge letter and each outpatient review are important opportunities to review a patients test results.

Action/ recommendations for HSC Trust and Independent Providers:

HSC Trusts have provided confirmation that they have addressed the following risks/actions to minimise the possibility of reoccurrence:

- patients are at higher risk if they are not cared for in the appropriate clinical setting e.g. medical outliers;
- if medical staff review patient x-rays and lab results in a busy ward area, they are more likely to be interrupted or distracted and therefore the risk of not taking appropriate action increases;
- if patient x-ray and lab results are reviewed by a doctor who is not part of the day-time Consultant team looking after a patient e.g. where a surgical junior doctor reviews results for medical outliers on the surgical ward, the risk of not taking appropriate action increases;
- policies should be precise about who is responsible for communicating abnormal x-ray results directly to the referring clinician, and in what circumstances, and should reflect Royal College of Radiologists' guidance.

2.5. WRONG SITE SURGERY

Analysis of a SAI identified that a wrong procedure was undertaken on a patient in a Day Procedure Unit (DPU). No checks were performed before the procedure although the patient did complete a consent form. A number of opportunities were missed to confirm the patient's identity and procedure. A Quality and Safety Learning Alert was circulated to all the HSC Trusts and independent providers, identifying the learning to prevent reoccurrence and requesting the following:

- all relevant staff, including student staff, are made aware of the identified learning;
- all DPU and theatre staff have been provided with formal written procedures to check a patient's identity and procedure, prior to starting the procedure. This can be through a surgical safety checklist, or its equivalent;
- all DPU and theatre staff are trained to use the formal procedures regularly;
- all DPU and theatre staff audit their adherence to those written procedures – adherence should be 100%.

Confirmation has been requested by 31May 2013 and an update on progress will be available in the next SAI Learning Report.

2.6. PATIENT SELECTION AND INTRAPARTUM CARE IN MATERNITY UNITS

A number of similar learning points have been identified from two recent SAIs in Maternity Care Services, in which one baby died and another suffered harm.

Escalation and appropriate action was delayed due to:

- not taking account of the entire clinical picture of the woman and her baby. CTG tracings and risk factors for pregnancy and labour were not considered together;

- failure to recognise pathological CTG tracings and escalate appropriately;
- lack of clarity in communication between members of the multidisciplinary team.

Each HSC Trust is currently addressing issues highlighted in the Safety and Quality Learning letter issued and confirmation of actions will be reviewed again in June 2013.

2.7. MANAGEMENT OF HEAD INJURY

There have been two recent reports of death in patients who presented to Emergency Departments (ED), following head injury. A Safety and Quality Alerts letter was circulated to all HSC Trusts and RQIA. The learning identified that medical and nursing staff in EDs, general surgery and other specialities should take account of the following when assessing and monitoring patients with head injury:

- ensure staff know and apply the contents of the Trust's policy on assessment and treatment of head injury, including frequency of observations, indications for CT scanning and medical reviews;
- take particular care when assessing a head injury in a patient who has also taken alcohol and/or drugs. It is particularly important that scheduled observation times are adhered to and that scores are accurately recorded;
- at times of staff handover, whether a shift change or moving the patient from one ward area to another, ensure the nursing staff who are new to the patient are made aware of their clinical condition and responsiveness;
- if transferring a patient to another location, record the patient's observations immediately prior to transfer, and again on admission to the new clinical area;
- take action on a deteriorating PEWS score in line with Trust policy;
- document in the patient's chart what action, if any, was taken in response to a request to assess a patient with a change in PEWS score;
- if a patient has a deteriorating Glasgow Coma Scale (GCS) and needs urgent CT, seek anaesthetic advice early as the patient may need airway management during imaging and/or immediate surgery afterwards.

Following dissemination of a Safety and Quality Learning Alert, all HSC Trusts have indicated compliance or are developing guidance in response to the alert.

2.8. APPROPRIATE COMMUNICATION

Following the occurrence of a SAI in Mental Health Service, HSC Trusts were issued with a learning letter from the Director of Social Care and Children.

The recommendation related to the failure of staff to check that a patient with whom they were communicating by letter could actually read. In this instance the fact that the patient could not read was clearly recorded in the individual patient notes.

The learning letter requested that this issue was highlighted to the HSC Trusts' Mental Health Services and specifically that HSC Trusts reinforce the need in each case for staff to establish the appropriate communication methods for individuals.

2.9. PSEUDOMONAS OUTBREAK

The emergence of Pseudomonas Aeruginosa in Neonatal intensive care units was a significant development across Health and Social Care in Northern Ireland. Recommendations from the Regulation Quality Improvement Authority (RQIA) review required significant work to be taken forward across HSC organisations to implement new working arrangements and practices. A Regional Workshop was held on Thursday 25th April 2013, at New Mossley Mill Newtownabbey, to identify any learning from a regional perspective. This event had participation from relevant personnel, across HSC in Northern Ireland and had input from an independent facilitator from Public Health England.

SECTION 3

NEXT STEPS

1.0 REVIEW OF COMPLAINTS AND SAIS REPORTED IN RELATION TO CARE AND TREATMENT OF OLDER PEOPLE

Following discussions at the Regional SAI Review Group and subsequently with the chair of the Regional Complaints Group, it has been agreed to conduct an analysis of SAIs and complaints relating to care and treatment of older people. *(An Older Person is defined as someone 65 years and over).*

A group has been established within the PHA/HSCB to examine SAIs and Complaints reported within the period April 2011 – March 2012, to identify themes, patterns and trends and roll out any learning arising from this in depth analysis.

The methodology for this thematic review will be:

- A review of Older People complaints identifying themes;
- A review of Older People SAIs identifying themes;
- Focus group to elicit first-hand experience of health and social care by older people;
- A cross-reference of the information gathered above with patient experience reports.

In parallel with this thematic review the RQIA have also undertaken a review of the care of older people in acute hospital wards. As both organisations' work is related a Professional Practice Workshop to share the learning from the review of SAIs, complaints and the RQIA review, affecting older people was held on 17 May 2013.

The following themes were discussed at the Learning Event:

- Advocacy (recognising that most complaints are not made by older people themselves)
- Falls
- Privacy and Dignity
- Misdiagnosis and delay in commencement of treatment
- Staff attitude and behaviour and staff communication with patients, service users and families.

The outcome from the workshop and follow up actions for improvement will be included in the next SAI Learning report.

2.0 REVIEW OF THE PROCEDURE FOR REPORTING AND FOLLOW UP OF SAIS

During 2012/13 the HSCB/PHA undertook to carry out a review of the 2010 Procedure for Reporting and Follow up of SAIs and as a result a series of events and meetings were held. These have included meetings with HSC Trusts, in order to identify and resolve issues which have proved problematic in relation to the current procedure.

A group of HSCB/PHA staff involved in the SAI process are currently taking forward the outcome of these events, and a number of sub groups have been established to review particular aspects of the procedure. During the last 6 months subgroups have reviewed and amended specific elements of the procedure, which have subsequently been approved by the SAI Project Team. In addition to this work, further aspects of the procedure were identified as being relevant to the review and as a result additional subgroup meetings have been arranged to consider these issues and where relevant make the necessary amendments.

It is anticipated the draft procedure will be shared with HSC Trusts and DHSSPS in early summer with formal issue in September 2013 for implementation on 1 October 2013.

3.0 REGIONAL ADVERSE INCIDENT AND LEARNING (RAIL) SYSTEM

The PHA working closely with the HSCB and all other HSC Organisations has a responsibility to ensure the Regional Adverse Incident Learning (RAIL) System is successfully designed, implemented and evaluated. The aim of the project is to implement agreed proposals for an integrated system that will support a culture of learning from adverse incidents and the effective implementation of that learning across the HSC and Primary Care services.

The RAIL Outline Business Case (OBC) has been amended and resubmitted for appraisal following review, with departmental colleagues, of the options to deliver the pilot. The OBC recommends a phased approach to the implementation of the RAIL system, with the first phase being a 12-18 month pilot to test and refine the system in practice, and determine the staffing, processes and system infrastructure required for RAIL to operate effectively in the longer term. It is intended that the RAIL system will be fully operational subject to positive evaluation of the pilot phase, and approval of a future separate business case for the recurrent long term staffing and infrastructure.

4.0 PROGRESS WITH IMPLEMENTING MENTAL HEALTH REVIEW RECOMMENDATIONS

On 24 January 2013 the PHA and HSCB held the second Mental Health SAI Learning Event in New Mossley Mill, Newtownabbey.

The workshop brought together key stakeholders from across Northern Ireland to explore and share the learning from serious adverse incidents and suicides in the Mental Health programme of care. Representatives attending the event included

Service Users, Carers, Advocates and HSC Trust staff involved in the delivery of Mental Health Services.

The aim of the event was three fold:

- to provide an understanding of the trends emerging from SAI reports submitted by HSC Trusts;
- to provide an opportunity to update those present on the actions previously identified and to consider the lessons learnt from a regional perspective;
- to facilitate discussions regarding the sharing of information, as well as the process for managing SAIs.

Service user engagement was a key element throughout the day with valuable input from the service users and carers in attendance.

As a result the PHA and HSCB have identified a number of actions to be taken forward by the Mental Health Services within HSC Trusts, the PHA and HSCB.

Feedback from the day was positive with all participants expressing the value of the information presented and the opportunity for discussion.

Review of Mental health IEAP and application of DNA practice standards.

- Lessons from HSCB and PHA DNA Audits are now being embedded into new regional care pathways. This includes revised/new guidance for mental health services in respect of those persons disengagement prematurely and/or do not attend care appointments. A standard has also been developed in relation to embedding Assertive Outreach as a function of core mental health services. The care pathway is still in draft and work with service user/carer on refining the requirements continues, this includes embedding their perspective on how DNA management and assertive outreach can be more effectively managed by the HSC. The plan is that this care pathway should be operational from September 2013.
- Service Improvement Managers will be re-auditing DNA practices in June 2013 with an interim report available early July 13

5.0 FRANCIS REPORT

The HSCB and PHA contributed to a number of seminars which provided some opportunities to hear directly from Robert Francis QC about the Mid Staffordshire experience. The purpose was to share the key recommendations from the Inquiry and to explore with colleagues the key lessons and how we further develop and build progress in our own patient safety and quality journey.

A further half day workshop has been arranged on 5 June 2013, to consider the implications of the Francis Report for governance arrangements in the HSC.

SECTION 4

CONCLUSION

Within this reporting period, a number of learning letters were issued. The six HSC Trusts are positively responding to the interim arrangements for disseminating and implementing change as a result of learning from SAIs. Until agreement is reached on a Regional learning system, the current arrangements enable and support regional learning arising from SAI investigations. Furthermore the arrangements facilitate engagement with HSC Trusts on SAI data analysis, and provide opportunities to collectively agree solutions to improve reporting and dissemination of lessons learned.

Over the next six months further action will be taken forward, to implement and develop reporting systems to further enhance safety and quality processes. Learning outcomes as a result of specific reviews will be disseminated locally, regionally and where appropriate nationally, in order to improve both safety and quality and ultimately the care and treatment of patients and clients.

APPENDIX A

DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation, [3] arising during the course of the business of an HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

SAI CRITERIA

- serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self harm*) of :
  - A service user
  - A service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two [4] years)
  - A staff member in the course of their work
  - A member of the public whilst visiting an HSC facility.

- Unexpected serious risk to a service user and/or staff member and/or
  - member of the public

- Unexpected or significant threat to provide service and/or maintain business
  - continuity

- Serious assault (*including homicide and sexual assaults*) by a service user
  - on other service users,
  - on staff or
  - on members of the public

  Occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years).

- Serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

[3] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

[4] Mental Health Commission 2007 UTEC Committee Guidance

APPENDIX B

ANALYSIS OF SAI ACTIVITY OCTOBER 2012 – MARCH 2013

The HSCB has **received 204 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[5] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 below provides an overview of all SAIs reported by organisation and includes **year on year comparison** of activity for the same **reporting period 1 October to 31 March**.

TOTAL SAI ACTIVITY	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	42	49
BSO	2	0
HSCB	3	1
NHSCT	24	48
NIAS	0	4
NIBTS	0	2
PCARE	16	15
SEHSCT	15	34
SHSCT	25	25
VOL	1	0
WHSCT	17	26
Totals:	**145**	**204**

SAI DE-ESCALATION

SAI reports submitted can be based on limited information at the time of reporting. If on further investigation the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate.

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation provides information on why the incident does not warrant further investigation under the SAI process. This information is considered by the HSCB/PHA Designated Review Officer prior to approving any de-escalation. During the reporting period **seven (7) SAI notifications** received were subsequently **de-escalated**.

TOTAL DE-ESCALATED	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	2	1
HSCB	1	0
NHSCT	2	3
PCARE	7	2
SEHSCT	1	0

[5] Source- HSCB DATIX Information System

TOTAL DE-ESCALATED	Oct 11 - Mar 12	Oct 12 - Mar 13
SHSCT	2	0
WHSCT	1	1
Totals:	16	7

DUPLICATE SAI NOTIFICATIONS

A notification may be received from one or more organisation but relating to the same incident.

TOTAL DUPLICATE	Oct 11 - Mar 12	Oct 12 - Mar 13
WHSCT	0	1
Totals:	0	1

SAI ANALYSIS BY PROGRAMME OF CARE

SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

De-escalated and duplicate SAI notifications have been **excluded** from the analysis in the remainder of this report.

ACUTE SERVICES

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	17	16
BSO	0	0
HSCB	0	0
NHSCT	3	9
NIAS	0	3
NIBTS	0	0
PCARE	0	0
SEHSCT	0	8
SHSCT	6	5
VOL	0	0
WHSCT	1	2
Totals:	27	43

Current period: Forty three (43) incidents were reported. The top five groups related to the following classifications/categories, with less than 5 incidents being reported in any one category.

Classification/category

- Admission
- Unexpected /unexplained deaths
- Cancer- Dx failed or delayed
- Arteries and veins
- Communication between staff, teams or departments

There were no major themes emerging from the SAIs. The largest groups (n=4) associated with this category was relating to 'Admissions' and 'unexpected/unexplained deaths'

MATERNITY & CHILD HEALTH

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	1	4
BSO	0	0
HSCB	0	0
NHSCT	0	0
NIAS	0	1
NIBTS	0	1
PCARE	0	0
SEHSCT	0	0
SHSCT	2	2
VOL	0	0
WHSCT	2	0
Totals:	5	8

Current period: Eight (8) SAIs relating to maternity and child health were reported.

FAMILY & CHILD CARE

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	2	2
BSO	0	0
HSCB	0	0
NHSCT	3	10
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	1	1
SHSCT	1	3
VOL	0	0
WHSCT	0	1
Totals:	7	17

Current period: Seventeen (17) SAIs were reported relating to the following classifications. The largest groups (n=6) related to 'Abuse' and 'Self harm in primary care'

- **Classification/category:**
  - Abuse by the staff to the patient or patient to patient or other

- Self harm in primary care, or not during 24hour care
- Discharge
- Environmental matters

OLDER PEOPLE SERVICES

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	0	1
BSO	0	0
HSCB	0	0
NHSCT	3	3
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	0	4
SHSCT	0	3
VOL	0	0
WHSCT	3	2
Totals:	**6**	**13**

Current period: Thirteen (13) SAIs were reported relating to older people services, with less than three incidents being reported in any one category. The largest group (n=2) related to 'Slips, trips, falls and collisions'

MENTAL HEALTH

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	15	23
BSO	0	0
HSCB	0	0
NHSCT	11	19
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	12	18
SHSCT	11	12
VOL	1	0
WHSCT	8	16
Totals:	**58**	**88**

Current period: Eighty-eight (88) SAIs relating to adult mental health services were reported.

- 71 related to suspected/attempted suicides* or unexpected deaths

The remaining reported incidents related to the following classifications:

- **Classification/category:**
  - Discharge
  - Health and Safety
  - Abuse - other
  - Financial loss
  - Medication error

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

LEARNING DISABILITY SERVICES

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	1	1
BSO	0	0
HSCB	0	0
NHSCT	0	1
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	0	2
SHSCT	1	0
VOL	0	0
WHSCT	0	0
Totals:	2	4

Current period: Four (4) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	0	1
BSO	0	0
HSCB	0	0
NHSCT	0	0
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	0	1
SHSCT	0	0
VOL	0	0
WHSCT	0	0
Totals:	0	2

Current period: Two (2) SAIs relating to physical disability and sensory impairment services were reported.

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

	Oct 11 - Mar 12	Oct 12 - Mar 13
HSCB	1	1
WHSCT	1	0
NHSCT	0	2
PCARE	9	13
Totals:	**11**	**16**

Current period: Sixteen (16) SAIs relating to Primary Health and Adult Community were reported relating to the following classifications.

- **Classification/category:**
  - Administration or supply of a medicine from a clinical area
  - Preparation of medicines / dispensing in pharmacy
  - Medication error during the prescription process
  - Adverse events that affect staffing levels
  - Cancer - Dx failed or delayed
  - Information Technology
  - Abuse - other
  - Infrastructure or resources - other
  - Test results / reports

The largest group (n=5) related to the administration or supply of a medicine from a clinical area

CORPORATE BUSINESS

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	3	0
BSO	2	0
HSCB	1	0
NHSCT	2	1
NIAS	0	0
NIBTS	0	1
PCARE	0	0
SEHSCT	1	0
SHSCT	1	0
VOL	0	0
WHSCT	1	3
Totals:	**11**	**5**

Current period: Five (5) SAIs were reported relating to the following classifications:

- **Classification/category:**
  - Fires, fire alarms and fire risks
  - Patient's case notes or records
  - Environmental matters
  - Infrastructure or resources - other
  - Security incident related to Premises, Land or Real Estate

HEALTH PROMOTION AND DISEASE PREVENTION

	Oct 11 - Mar 12	Oct 12 - Mar 13
BHSCT	1	0
BSO	0	0
HSCB	0	0
NHSCT	0	0
NIAS	0	0
NIBTS	0	0
PCARE	0	0
SEHSCT	0	0
SHSCT	1	0
VOL	0	0
WHSCT	0	0
Totals:	**2**	**0**

Current period: No reported incidents

Health and Social Care Board

[redacted]

Tel: [redacted]

To: Trust Chief Executives
Trust Medical Directors
Trust Directors of Nursing
Trust Directors of Pharmacy
Trust Governance Leads
General Practitioners
Community Pharmacists
For appropriate cascade to clinical staff

28 June 2012

Dear Colleague

Regional learning from a serious adverse incident (SAI) – flushing of a central line with the incorrect strength of heparin sodium injection

The occurrence of a Serious Adverse Incident (SAI) is being brought to the attention of GPs, Community Pharmacists and Health and Social Care Trusts. The SAI occurred in 2009 following the discharge of a baby with a central IV line from hospital. The central IV line was to remain in place and its patency maintained by flushing with heparin sodium flushing solution.

Heparin sodium flushing solution was not supplied at discharge and the GP was asked to prescribe it. However, the GP had not received any discharge information about the patient and in a subsequent communication was advised to prescribe the branded product Hepsal®, a product that was not listed in the clinical system as it had been discontinued earlier in 2009. In addition, the GP did not receive specific information about the dose to be administered in order to allow a clinical check to take place.

The GP incorrectly prescribed heparin sodium injection 1000 units/ml instead of the 10 units/ml flushing solution. This was dispensed by the pharmacist and the line was flushed in the community with 2000 units of heparin sodium instead of 20units. Fortunately, there was no harm caused to the baby.

Following the incident, correspondence was issued to prescribers in primary care and community pharmacists to advise them to take extra care when prescribing and dispensing heparin sodium products[1].

More recently, medicines safety newsletters on reducing the risks with heparin flushes have been issued in primary care[2] and Trusts[3].

Further discussions have also taken place with primary care clinical system suppliers to put additional safeguards in place to reduce the risk of a prescriber selecting the heparin sodium injection instead of the flushing solution.

The review of the SAI identified important lessons to be learned and the following actions have been recommended.

Action for Trusts, GPs and Community Pharmacists

- Discharge planning should include timely communication with all parties including GPs and other non-acute Trust staff who are required to contribute to the patient's ongoing care and treatment plan in the community.
- All patients being discharged from hospital who require medications (including heparin) should be given a supply by the hospital in accordance with the 28 day discharge policy.
- Heparin sodium flushing solutions must always be referred to using the generic name of the medicine. Procedures, guidelines, prescription charts and discharge documents must not refer to the discontinued branded products Hepsal® or Canusal®.
- Prescriptions and instructions to administer heparin sodium flushing solutions should provide clear dosing information e.g. dose, volume, frequency.
- GPs and community pharmacists should take care when selecting products for prescribing and dispensing and ensure that the correct strength of product is selected. If there is any ambiguity about the

intended strength, this should be clarified directly with the prescriber.

Trusts are requested to provide an assurance to **alerts.hscb** [redacted] by 30th July 2012 that these recommendations have been actioned.

If you have any queries regarding this letter, please contact Deirdre Quinn on [redacted] or [redacted]

Yours sincerely

Sloan Harper

Dr Sloan Harper
Director of Integrated Care

cc: Mr J Brogan, Head of Pharmacy and Medicines Management, HSCB
Dr M O'Brien, Head of General Medical Services, HSCB
Ms M Hinds, Chair Regional SAI Group
Dr C Harper, Director of Public Health, Public Health Agency
Ms A Madill, Governance Manager, HSCB

[1]HSCB Medicines Safety Alert - Learning from Adverse Events: Heparin. April 2010
http://www.hscboard.hscni.net/medicinesmanagement/Medicines%20Safety%20Alerts/002%20No2%20Learning%20from%20Adverse%20Events%20Heparin%20-%20April%202010%20PDF%20184Kb.pdf

[2]HSCB Medicines Safety Matters Vol 2 Issue 2 May 2012 – Prescribers and Community Pharmacists
http://www.hscboard.hscni.net/medicinesmanagement/Medicines%20Safety%20Matters%20Newsletter/index.html#P-1_0

[3]Medication Safety Today Issue 33 November 2010
http://www.medicinesgovernanceteam.hscni.net/newsletters/newsletters/MST%2033.pdf