C.10 SUBMISSION TO IHRD IN RESPECT OF DEATH CERTIFICATION IN NORTHERN IRELAND

Deaths that must be reported to the Coroner

1. Under the Coroners Act (Northern Ireland) 1959 there is a statutory duty on a wide category of professionals (including doctors) and the public to provide information to the Coroner.

2. Under section 7 of this Act, 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.

Who reports a death to the Coroner?

3. The duty to report a death to the Coroner is imposed on doctors, Registrars of Deaths, funeral undertakers and every occupier of a house or mobile dwelling and every person in charge of any institution or premises in which a deceased person was residing. This contrasts with the position in England and Wales where only the Registrar of Deaths is under a statutory duty to report such deaths to the Coroner.

Who can complete the Medical Certificate of Cause of Death?

4. Registered Medical Practitioners have a legal duty to provide, without delay, a medical certificate of cause of death (MDDC) 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.

5. This is a statutory legal duty on all doctors set out in the Births and Deaths Registration (Northern Ireland) Order 1976, independent of any employment contract.

6. In hospital, it is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified.

7. The narrative below outlines the main documents providing guidance in relation to death certification in Northern Ireland and provides information on the key issues and events leading to the process of reform.

The Work of the Coroner in Northern Ireland (Published by the Northern Ireland Court Service, 1993) (Republished in 1995)

8. This leaflet comprised answers to questions relating to the role of the Coroner, including:
   - What is a Coroner?
   - How and when is a death reported to the Coroner?
   - Is the inquest a trial?
   - Does the Coroner have any other functions in relation to a death?

The Work of the Coroner's Office – Courts Charter (Published by NI Court Service, 2000)

9. This is a leaflet was published by the NI Court Service in relation to work of the Coroner's Office. It primarily uses the information contained within the 'Work of the Coroner' leaflet and adds information in relation to what the public can expect when they come to court or make a complaint.

Death Certification and Investigation in England Wales and Northern Ireland – The Report of a Fundamental Review, 2003 (Luce Review)

10. In 2003, a report was delivered following a review of death certification and investigation in England, Wales and Northern Ireland. The review, chaired by Tom Luce, investigated the existing system and made recommendations including those in relation to death certification, death investigation and delivery of the Coroner's service.

11. The report made 7 specific recommendations for Northern Ireland.

Shipman Inquiry – Third Report: Death Certification and the Investigation of Deaths by Coroners (July 2003)

12. The Shipman Inquiry was set up in 2001 and was tasked with investigating the extent of Dr Harold Shipman's unlawful activities, enquiring into the activities of the statutory authorities and other organisations involved, and making recommendations on the steps needed to protect patients for the future.

13. The 3rd report of the Shipman Inquiry focused entirely on death certification and the investigation of death by the Coroners.

14. Chapter 17 makes recommendations specific to Northern Ireland.

Publication of Shipman Inquiry Fourth Report – Regulation of Controlled Drugs in the Community (July 2004)

15. This report not only looked at matters pertaining to the Shipman Case, but also focussed on looking at ways to improve and modernise the security of controlled drugs. It outlines Dr Shipman's use of several drugs and how he acquired them. The report also lists what it called "the systematic

shortcomings" of the procedures for the inspection and monitoring of controlled drugs.

Publication of Shipman Inquiry Fourth Report – Regulation of Controlled Drugs in the Community (July 2004) - Government Response (December 2004)

16. The Government fully agreed that the existing systems of control for controlled drugs needed strengthening but that systems should not be so onerous as to get in the way of good patient care. It recommended the following:
    - The Chief Executive of every NHS organisation would have a statutory duty of quality;
    - There would be explicit standards of care for every patient;
    - There would be assessment against performance of these standards;
    - Local systems of clinical governance to ensure review of clinical healthcare and skill level;
    - Improved disciplinary procedures; and
    - Plans for a 5 year revalidation of all doctors.

The Coroners Service of Northern Ireland - Proposals for Administrative Redesign (2004)

17. This consultation paper set out proposals for the redesign of the Coroners Service in Northern Ireland following publication of the Luce Review.

Reforming the Coroner and Death Certification Service – A Position Paper Published by the Home Office (2004)

18. This paper constitutes the Government's response to the Luce Review and Shipman Inquiry and contains the outline proposals for reform.

Memorandum of Understanding on Investigating Patient or Client Safety Incidents (Unexpected Death or Serious Untoward Harm) between DHSSPS, PSNI, NSENI and NICTS (February 2006)

19. Patient and client safety incidents involving unexpected death or serious untoward harm and requiring investigation the police, Coroners and/or the Health and Safety Executive for Northern Ireland are rare. When such incidents do happen they need to be handled correctly for the sake of public safety.

20. In situations where the same incident is subject to investigation by a number of separate organisations, it is essential that there is clarity of roles and responsibilities, effective liaison and communication between all parties involved.

21. In recognition of this, the Department developed a Memorandum of Understanding (MoU) to improve appropriate information sharing and co-ordination when joint or simultaneous investigations are required into a serious patient/client incident involving unexpected death or serious untoward harm.

22. The MoU was intended to help:
    - Prompt early decisions about the action and investigation(s) thought to be necessary by all organisations and a dialogue about the implications of these;
    - Provide an efficient and effective approach to the co-ordination of the investigation(s); and
    - Save time and other resources of all the organisations involved.

Improving Patient Safety: Building Public Confidence – A Response by DHSSPS to the Recommendations Contained in the Shipman Inquiry – November 2006

23. In response to the recommendations contained in the Shipman Inquiry Reports 3, 4 and 5 the Department produced the document “Improving Patient safety: Building Public Confidence”.

24. In relation to death certification the DHSSPS response describes changes to improve the verification and recording of the fact of death and completion of the death certificate on the cause of death, referrals to the Coroners Service, registration of deaths and investigations of unexpected deaths. In addition, it recognises the need to work with other government departments, agencies and establishments to further promote appropriate post mortem examinations and compliance with the Human Tissue Act.

Learning from Tragedy, Keeping Patients Safe – Overview of the Governments Action Programme in response to the Recommendations of the Shipman Inquiry – February 2007

25. This document contains the Government’s Action Plan in response to the Shipman Inquiry. It outlines the main themes of the Inquiry’s reports, the developments which had already occurred, and the Government’s action programme.

26. It sets set out recommendations in relation to both reform of the Coroners’ system and death certification. Main actions relating to reform of the Coroners’ system included:

- The introduction of a draft Coroners’ Bill in June 2006 which outlined: new powers for Coroners to obtain and summon witnesses, ensuring Coroners have better medical support and advice; introducing a new Chief Coroner and a Coronial Council, and the ability of bereaved people to contribute more to Coroners’ investigations;

●The introduction of a new Medical Advisor to the Chief Coroner; and

●The setting aside of funding to provide Coroners with advice at local level.

27. Improvements in the process for death certification focused on the creation of a rigorous, unified system covering both burials and cremations. The proposal was that the medical certificate of cause of death (MCCD) would be subject to scrutiny by a Medical Examiner for both burials and cremations. This Medical Examiner would have full access to medical records and would be empowered to discuss the circumstances of the death with the doctor signing the MCCD and the family of the deceased. The Medical Examiner would then be able to refer the case to the Coroner for further investigation if he/she was not satisfied**.**

Northern Ireland Medical Certificate of Cause of Death as prescribed in accordance with the Births and Deaths Registration (NI) Order 1976 – Revised Notes 1974 – Re-issued in October 2007

28. The Northern Ireland Medical Certificate of Cause of Death (MCCD) is the certificate to be signed by a registered medical practitioner who has been in attendance during the last illness of the deceased person. The format has been amended various times since it was introduced. The General Register Office (GRONI) issued a revised version in October 2007**.**

Workshop held to consider Death Certification – February 2008

29. In order to consider Death Certification in Northern Ireland in the context of the Shipman Inquiry and Luce Review the Department convened a workshop in February 2008 to consider the options for reform.

30. Amongst the conclusions from the workshop was the need to improve accuracy of death certification.

Guidance on Death, Stillbirth and Cremation Certification – September 2008

31. The MCCD provides a permanent legal record of the fact of death. It is essential that it is completed accurately. In its response to the recommendations contained in the Shipman Inquiry, the Department undertook to develop guidance on the completion of MCCDs.

32. The guidance was developed in conjunction with DHSSPS, GRONI, Clinicians and Coroners and was distributed by CMO to HSC Trusts and General Medical Practitioners. It was developed for the purposes of raising awareness of the importance of accurate and timely recording of death certification and provides a step-by-step guide to completing the various certificates and details on reporting cases to the Coroner.

Establishment of Inter-departmental Working Group – Nov 2008

33. As the 3rd Report and the Luce Review had highlighted significant weaknesses in the death certification processes in England and Wales (and Northern Ireland in the Luce Review) an Inter-Departmental Working Group was established in November 2008 comprising members from key authorities within the death certification process in Northern Ireland to consider the future strategic direction of the death certification process.

34. The objectives of the working group was to:

- Develop a proposal for the future direction of death certification in Northern Ireland and present this for public consultation;
- Take responsibility for ensuring thorough planning, identification and address of associated risks and delivery of the proposal within agreed timescales; and

- Engage stakeholders to give guidance on the practical implications of the proposal.

35. This group reported to an Inter-departmental steering Group jointly chaired by DHSSPS and GRONI.

Working with the Coroners Service for Northern Ireland – Best Practice Guide – September 2009

36. This guidance was published by the Coroners Service for Northern Ireland. It outlines the role of the Coroner in Northern Ireland and gives guidance to a number of groups on working with the Coroners Service more effectively.

Review of Memorandum of Understanding- Investigating patient/client safety incidents (unexpected death or serious untoward harm) – July 2010

37. Since the Memorandum of Understanding had first been published in 2006, health and social care services were significantly re-structured following the Review of Public Administration. These developments meant that in certain practical aspects the MoU was in need of revision.

38. In addition analysis of investigations into serious safety incidents which occurred within HSC organisations since the MoU had been issued suggested that the recommended protocols had not been consistently adhered to. In light of this the Department instigated a review.

39. In July 2010, CMO issued a request for nominations from representative organisations to join a working group, chaired by DHSSPS to review the working of the MoU first issued in February 2006.

Public Consultation on the Review of Death Certification in Northern Ireland – December 2010

40. In December 2010, the Interdepartmental Working Group produced proposals to enhance the existing arrangements for death certification in Northern Ireland, with a view to strengthening and improving the process.

41. A consultation document was jointly issued by DHSSPS, DOE and DFP. The document set out two options for the future.

42. Option 1 would see an enhancement of existing arrangements and would include:

- Adding the doctor's General Medical Council and the deceased's Health and Social Care number to the existing MCCD to facilitate improved statistical analysis;
- Improving death certification training for registered medical practitioners;
- Incorporating death certification practice as part of the appraisal of registered medical practitioners;
- Developing a set of system standards and improved guidance on certifying death across organisations;
- Building on learning from other established death reporting systems; and
- Health and Social Care Trusts undertaking an analysis of MCCD completion by hospital based doctors under existing governance arrangements.

43. Option 2 was a more comprehensive model incorporating all the enhancements of Option1 alongside the introduction of the new post of Medical Examiner to carry out a basic scrutiny of all non-reportable deaths.

Report to the Inquiry into Hyponatraemia-Related Deaths – B Dolan: April 2011

44. In April 2011, Bridget Dolan produced a report for the Inquiry in respect of issues related to coronial law.

45. The report looked at several issues including the reporting of hospital deaths to the Coroner, dissemination of information from Coronial inquiries.

46. She highlighted that in contrast to the position in England and Wales, under the Coroners Act (Northern Ireland) 1959, there is a statutory duty on a wide range of professionals and the public to provide information to a Coroner.

47. In relation to the introduction of a Medical Examiner for Northern Ireland, she outlined the position regarding the ongoing consultation and did not give any opinion.

Revised version of Northern Ireland Medical Certificate of Cause of Death (MCCD) issued by GRONI (late 2011)

48. GRONI issued a revised version of the MCCD with space to include the printed name of the doctor and their GMC registration number.

Guidance on Death, Stillbirth and Cremation Certification – April 2012

49. In April 2012, the Department issued a letter re-iterating the guidance on Death, Stillbirth and Cremation Certification first issued in September 2008. It advised practitioners of their responsibilities to maintain their competence by updating their knowledge and reflecting on their practice and drew particular attention to the section on deaths that must be reported to the Coroner.

50. HSC organisations were reminded of their responsibility to promote good practice and governance by monitoring or regular audit of compliance with the guidance.

Review of Death Certification Processes in Northern Ireland - Executive Approval of Recommendations from – April 2012

51. Following consultation on the proposals to reform the death certification process, the NI Executive was asked to agree the recommendations of the Interdepartmental Working Group, namely:

- That implementation of Option1 should begin as soon as was practical, with a view to moving to Option 2 at a later date if this is considered necessary following evaluation of Option 1.

52. On 5th April 2012 the NI Executive agreed to the recommendations made by the Working Group.

Revised Memorandum of Understanding: Investigating Patient or Client Safety Incidents (Unexpected Death or Serious Untoward Harm) – March 2013

53. In March 2013 the revised Memorandum of Understanding was issued.

54. It had been updated to improve appropriate information sharing and co-ordination when joint or simultaneous investigations are required into a serious patient/client safety incident occurring within a Health and Social Care (HSC) setting.

Establishment of Death Certification Implementation Working Group – August 2013

55. A Death Certification Implementation Working Group has been established to review the current position on death certification and take forward the implementation of Option 1. The first meeting is arranged to take place on 4th October 2013.

56. In spring 2013, the Belfast HSC Trust launched a computerised system which records details of mortality & morbidity (M&MR) of its patients which are analysed and reviewed. This system will be evaluated with a view to roll out across NI as part of the implementation of death certification reforms.

Revised Memorandum of Understanding: Investigating Patient or Client Safety Incidents (Unexpected Death or Serious Untoward Harm) - Strategic and Decision Making Group

57. The revised Memorandum of Understanding issued in March 2013 provided for the establishment of a Strategic and Decision Making Group. The purpose of this group is to provide strategic oversight of a patient safety incident investigation involving the PSNI, Coroners Service and/or HSENI and RQIA.

58. The first bi-annual meeting of this group has been arranged to take place on 8th October 2013 when the use and dissemination of the MoU will be considered.

Death Certification documents provided

1. The Coroners Act (Northern Ireland) 1959
2. The Work of the Coroner in Northern Ireland (Published by Northern Ireland Court Service, 1993) (Republished in 1995)
3. The Work of the Coroner's Office – Courts Charter
4. Death Certification and Investigation in England Wales and Northern Ireland – The Report of a Fundamental Review 2003 (LUCE Review)
5. Shipman Inquiry – Third Report: Death Certification and the Investigation of Deaths by Coroners (Summary) (July 2003)
6. Publication of Shipman Inquiry Fourth Report – Regulation of Controlled Drugs in the Community (Summary) (July 2004)
7. The Coroners Service of Northern Ireland Proposals for Administrative Redesign (2004).
8. Reforming the Coroner and Death Certification Service – A Position Paper Published by the Home Office (2004).
9. Publication of Shipman Inquiry Fourth Report – Regulation of Controlled Drugs in the Community (July 2004) - Government Response (December 2004)
10. Memorandum of Understanding Investigating Patient or Client Safety Incidents (Unexpected Death or Serious Untoward Harm) (February 2006)
11. Improving Patient Safety: Building Public Confidence – A Response by DHSSPS to the Recommendations Contained in the Shipman Inquiry – November 2006
12. Learning from Tragedy, Keeping Patients Safe – Overview of the Governments Action Programme in response to the Recommendations of the Shipman Inquiry – February 2007
13. Northern Ireland Medical Certificate of Cause of Death as prescribed in accordance with the Births and Deaths Registration (NI) Order 1976 – Revised Notes 1974 – Re-issued in October 2007
14. Circular HSS (MD) 10/2008 Enhanced monitoring arrangements for deaths where C. Difficile or MRSA Infection is mention on the Death Certificate. (March 2008)

15. Guidance on Death, Stillbirth and Cremation Certification – September 2008
16. Working with the Coroners Service for Northern Ireland – Best Practice Guide – September 2009
17. Report to the Inquiry into Hyponatraemia-Related Deaths – B Dolan: April 2011
18. HSS (MD) 11/2011 Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust
19. Revised version of Northern Ireland Medical Certificate of Cause of Death (MCCD)
20. Revised Memorandum of Understanding: Investigating Patient or Client Safety Incidents (Unexpected Death or Serious Untoward Harm) – March 2013