December 2014

Paper describing the communication pathways between the Coroners' Office, Northern Ireland and the Public Health Agency / Health and Social Care Board

Background

In Northern Ireland there is a statutory legal duty on all registered medical practitioners to provide, without delay, a certificate of cause of death if that person died of natural causes for which they had treated that person in the last 28 days (except for deaths reportable to the Coroner)[1]. There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 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. The Coroner will then seek to establish the cause of death by making whatever inquiries are necessary to do this eg ordering a post mortem examination, obtaining witness statements and medical records, or holding an inquest.

Within Northern Ireland the duty to report a death to the Coroner arises if a medical practitioner has reason to believe that the deceased died directly or indirectly:

- as a result of violence, misadventure or by unfair means;
- as a result of negligence, misconduct or malpractice (eg deaths from the effects of hypothermia or where a medical mishap is alleged);
- from any cause other than natural illness or disease eg
    - 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 apparent suicidal death;
    - All deaths from industrial diseases eg asbestos.

- from natural illness or disease where the deceased had not been seen and treated by a registered medical practitioner within 28 days; death as the result of the administration of an anaesthetic;
- In any circumstances that require investigation
- Of any cause of death listed on the Registrar General's extra-statutory list of causes of death[2].

[1] Births and Deaths Registration (Northern Ireland) Order 1976

[2] Available from DHSSPS Guidance on Death, Stillbirth and Cremation Certification (http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf)

Approximately 280 – 300 deaths are referred to the Coroners' Office every month, and 10-12 progress to a Coroner's Inquest. Whilst most of these deaths will not have implications for practice within Health and Social Care Northern Ireland (HSCNI), some will identify issues and/or regional learning for HSCNI.

Commissioners and Providers of Health and Social Care want to ensure that there is a systematic process in place for safeguarding service users, staff and members of the public, as well as property, resources and reputation. As part of this commitment, HSC organisations undertake to investigate serious adverse incidents (SAIs) and any regional learning identified is disseminated by PHA / HSCB to other organisations. In many cases, deaths of HSC patients reported to the Coroners' Office will also be subject to the formal Serious Adverse Incident (SAI) investigation and follow up processes but there may be instances when this is not the case.

This paper details the communication pathway between PHA / HSCB and the Coroners' Office, considering individual cases and any patterns / trends / areas of concern identified by the Medical Officer of the Coroners' Office.

Investigating patient or client safety incidents Memorandum of Understanding[3]

A memorandum of understanding (MoU) has been agreed between the Department of Health, Social Services and Public Safety (DHSSPS), on behalf of HSC, the Police Service of Northern Ireland (PSNI), the Coroners Service for NI and the Health and Safety Executive for NI (HSENI). The MoU focuses on high level communication between the organisations to ensure appropriate organisations to be involved in the investigation are identified and the lead investigating body determined. The MoU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by PSNI, Coroners Service or HSENI separately or jointly.

This paper outlines the communication between the Coroners' Office and the Public Health Agency / Health and Social Care Board in situations without the MoU.

Coroner's Findings

The findings from a Coroner's Inquest which may have implications or learning for Health and Social Care, will be forwarded by the Coroners' Office to HSCB via seriousincidents@hscni.net. HSCB will review the Coroners' findings through the same process for reviewing SAI Investigation Reports. This will enable HSCB/PHA to identify issues, themes that may require specific action or learning that requires dissemination regionally, if this has not already been identified via other routes eg notification of a SAI.

[3] http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

Deaths referred to Coroner

Primary Care

If the Coroners' Office requires further information about a death in primary care or clarification of information provided, the Coroners' Office will liaise directly with the individual GP. If this is not satisfactory, the Coroners' Office will escalate the issue to the Assistant Director for General Medical Services, Director of Integrated Care, Health and Social Care Board.

Patterns / trends identified by the Coroners' Office

The Medical Officer for the Coroners' Office may identify patterns or trends in the deaths notified to them eg similar issues across different geographical areas, medication use etc which may highlight a need for regional learning or concerns about an individual's practice.

Potential Regional learning / action required

If the Medical Officer for the Coroners' Office identifies a pattern or trend in cases reviewed by the Medical Officer, HSCB/PHA will be informed if appropriate (through seriousincidents@hscni.net).

Individual Practitioner

If the Coroners' Office identifies a concern about the practices of an individual, this will be reported to the employing organisation for investigation and follow up. If the concerns relate to a GP, Dr Margaret O'Brien Assistant Director Integrated Care, Health and Social Care Board will be informed.

HSCB/PHA Learning Letters

The key aim of reporting and follow up of Serious Adverse Incidents (SAIs) within HSC is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of this learning is via Learning letters / Newsletters. Cases referred to, and investigated by, the Coroners' Office may also be reported and investigated as an SAI. Therefore any learning / trends identified by HSC through this mechanism may be relevant to the Coroner's investigation. Consequently HSCB Alerts Office will copy the Coroners' Office into all Learning Letters issued to the HSC.