From the Chief Medical Officer
Dr Michael McBride

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Mr John Leckey LL.M
Senior Coroner for Northern Ireland
May's Chambers
73 May Street
Belfast
BT1 3JL

Your Ref:
Our Ref:
Date: 18 April 2014

Dear Mr Leckey

SERIOUS ADVERSE INCIDENTS AND REPORTING OF DEATHS

Thank you for copying me into your letter to the HSCB Chief Executive on 2 April 2014, in which you expressed concerns about deaths, reported under section 7 of the Coroners Act (NI) 1959, which may be linked to Serious Adverse Incident reports.

I wish to advise you that further to your concerns, I have written to HSC Trust Chief Executives, reiterating extant Guidance on Death, Stillbirth and Cremation Certification issued by the Department in 2008, drawing particular attention to the section on Deaths and the coroner. I have asked them once again to remind all medical staff, relevant professionals and any other staff involved in reporting deaths to the coroner, of their statutory duties under Section 7 of the Coroners Act (NI) 1959. I have also emphasized the need for complete candour in these circumstances and of the importance of open and meaningful engagement with families/carers. A copy of my letter is enclosed.

You may also be aware that the Minister for Health, Social Services and Public Safety made a statement to the Assembly on 8 April 2014. In his statement, Minister highlighted the need for openness and transparency and in particular, the need for meaningful engagement with patients, clients and families, which includes in the event of a Serious Adverse Incident, giving them the opportunity, if they wish, to participate in the Serious Adverse Incident investigation. The statement may be accessed at:

http://www.dhsspsni.gov.uk/statement080414

I would also draw your attention to a number of pieces of work that the Department has initiated to strengthen the completion of MCCDs and the reporting of deaths in hospital to the coroner.

HSC Trusts will review all Serious Adverse Incidents between 1 January 2009 and 31 December 2013 and provide a report to the Department by September 2014. This will include in cases where patients/clients have died, confirmation or otherwise, that the statutory requirement to inform the Coroner has been complied with where this was appropriate. Trusts have also been reminded that where failures to report cases to the Coroner's office are identified, they should ensure that the proper reporting process is complied with.

In his statement on 8 April, Minister also gave the go-ahead for the phased regional implementation of an enhanced assurance process for all deaths in hospitals in Northern Ireland. This Mortality and Morbidity Review System (M&MRS) which is being developed by the Belfast Trust will be rolled out across Northern Ireland hospitals over a three year period and will record, review monitor and analyse all hospital deaths.

This system used effectively will provide additional scrutiny of the Death Certification process; enhance a culture of learning across Trusts; improve reporting of Serious Adverse Incidents where a death has occurred; act as an additional safeguard to ensure that deaths are appropriately reported to the Coroner; and improve the quality of information provided both to the Coroner and as part of Serious Adverse Incident notifications.

Rolling out this system will help to ensure that the causes of death are accurately recorded, reviewed and analysed thereby facilitating the identification of poor care management, learning from errors, openness and transparency, and improvements in patient safety and care.

This will not only provide a means by which to quality assure information on deaths at hospital level but will provide additional assurance and oversight in line with statutory responsibilities and ensuring the identification and sharing of learning from all deaths that occur in our hospitals.

I trust that this approach assuages your concerns.

Yours sincerely

DR MICHAEL McBRIDE
Chief Medical Officer

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Eddie Rooney
Dr C Harper
Michael Bloomfield
Fergal Bradley
Dr Donnelly
David Best