From the Chief Medical Officer
Dr Michael McBride

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Action:

Chief Executives of HSC Trusts
Medical Directors of HSC Trusts
(for onward distribution to All Hospital Doctors)

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Your Ref:
Our Ref:
Date: 18 April 2014

Dear Colleague

REPORTING DEATHS TO THE CORONER

I was recently copied into correspondence emanating from the Senior Coroner for Northern Ireland to the HSCB Chief Executive. In a letter dated 2 April 2014, Mr John Leckey expresses concerns about deaths reported to the coroner under section 7 of the Coroners Act (NI) 1959, which may be linked to Serious Adverse Incident reports.

The Senior Coroner has requested that all relevant staff within Health and Social Care organisations, be reminded of the circumstances in which they have a duty to report deaths to the coroner.

I would draw your attention to the Guidance on Death Stillbirth and Cremation Certification which was issued by the Department in September 2008. This can be found at the following link:

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

My letter HSS (MD) 14/2012 - http://www.dhsspsni.gov.uk/hss-md-14-2012.pdf re-iterated that guidance and drew particular attention to the Section - “Deaths and the Coroner”.

In view of the Coroners request, I would therefore ask you to remind all staff that 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 duty to report 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 (e.g. deaths from the effects of hypothermia or where a medical mishap is alleged);

- 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).

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

- 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);

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

The duty to report is also imposed on 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.

The Coroner's concerns may be linked to recent media reports about Serious Adverse Incidents and possible delays in treatment that may have contributed to a patient's death. With this in mind I would also ask you to remind staff that referral to the coroner needs to be considered when subsequent information comes to light as a result of investigations involving complaints, review exercises or SAIs. If there are concerns at any stage of an investigation regarding the factual correctness of information supplied to the Coroner, or if the Coroner has not been informed, then the death should be immediately reported to the Coroner through the proper processes.

It is also essential that there should be full engagement with the families or carers of the bereaved, so that they are fully informed of any subsequent information that is reported or supplied to the Coroner. I would remind you of the need for complete candour in these circumstances and of the importance of open and meaningful engagement with families and carers.

It is the responsibility of organisations to promote good governance through the regular monitoring and audit compliance with relevant policies, guidance and statutory duties, to ensure the provision of high quality, person centred health and social services across Northern Ireland.

I would ask you to confirm receipt of this letter and that you have complied with my request to remind all staff of their statutory duty under Section 7 of the Coroners Act (Northern Ireland) 1959, by 9 May 2014.

Yours sincerely

DR MICHAEL McBRIDE
Chief Medical Officer

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