FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Jim Wells MLA

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

Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
Tel: 028 90 520642
Fax: 028 90 520557
Email: private.office@dhsspsni.gov.uk

Mr Alastair Ross MLA
Chairman
Committee for Justice
Room 242
Ballymiscaw
Parliament Buildings
Stormont
BELFAST
BT4 3XX

Our Ref: AGY/123/2015

Date: 25 February 2015

Dear Alastair

REVIEW OF THE HANDLING OF SERIOUS ADVERSE INCIDENTS BETWEEN 1 JANUARY 2009 AND 31 DECEMBER 2013.

On 28 January 2015, Departmental Officials attended the Justice Committee to give evidence in relation to the Attorney General's proposed amendment to the Coroner's Act (Northern Ireland) 1959 through the Justice Bill. At that evidence session, the Committee was advised that information regarding the "Look Back" Exercise of Serious Adverse Incidents (SAIs) would be provided to the Committee.

From the 1417 Serious Adverse Incidents reported during 1 January 2009 to 31 December 2013, there were 777 cases where a death was associated with the SAI. Of the 777 cases only 18 (2.3%) were reported to the Coroner more than 3 days after the date of death, see table 1.

Table 1

	Number of deaths	Number reported to the Coroner more than three days after date of death
2009	119	3
2010	123	3
2011	152	3
2012	174	5
2013	209	4*
	777	**18**

*Includes 3 Stillbirths (not a statutory requirement to report at time of death)

It is important to clarify that in respect of these 18 cases, the timescales involved ranged from as little as 5 days after the death to 5 years. In almost all cases the deaths were reported as a result of additional information or considerations not available at the time of death. The requirement to report relates to the point in time when a Trust has knowledge that a death should be reported. In most cases this decision will be taken at the time of death, in a minority of cases this may be sometime later when further information comes to light.

There are a number of other reasons why additional time may elapse before a death is reported to the Coroner. A case may have been complex in nature, for example where a patient has transferred between two hospitals, the medical professionals involved may take more time before being able to identify that a case needs to be referred resulting in a small delay. In some cases, further information may only come to light at a later date for example as part of a look back exercise, an SAI investigation, a complaint investigation, information from GPs, from another Trust if care was provided in more than one location or from some other third party.

It should also be noted that 3 of the 18 cases referred to were stillbirths. The Trusts, in those instances, complied entirely with the guidance as it existed at the time as there was no statutory requirement to report these cases to the Coroner at that time. The duty to report to the Coroner in the case of a stillbirth only came into effect following a Court of Appeal ruling in November 2013.

Whilst giving evidence to the Justice Committee the Attorney General referred to a number of NHSCT cases that had not been reported to the Coroner at the time of death and that, following his intervention, 4 cases were now being investigated. These cases were all identified as a result of an exercise undertaken by the Trust itself which they reported to the Department. The Department had advised the Trust to review these cases against the statutory requirement to report deaths. We believe that some of these 4 cases relate to stillbirths, which at the time when they occurred did not require reporting to the Coroner but which would be routinely reported now.

In their report, the RQIA have independently verified the quality of the information provided by the Trusts for the SAI look back exercise, which included detailed information on notification to the Coroner if a death occurred.

In his evidence to the Committee, the Attorney General acknowledged the pressure currently placed on the Coroner's Service. In a large proportion of cases considered by the Coroner there is a knock on effect of requests for information, witness statements etc. from Health and Social Care Bodies who provide information to assist the Coroner in discharging his duties. The Committee will be generally aware of the pressures on the Health system. The Attorney General's proposals would place additional pressure on the same Health and Social care bodies.

Mortality and Morbidity Review system

As you are aware, the Department is currently taking forward a number of initiatives to strengthen and enhance public assurance and scrutiny of the death certification process. One of these initiatives is the roll-out of a Regional Mortality and Morbidity Review system. The introduction of this system will ensure that all deaths in hospital are accurately recorded, reviewed, monitored and analysed. This will provide additional scrutiny through peer review; 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 to the Coroner and as part of serious adverse incident investigations.

The introduction of an Independent Medical Reviewer, similar to that being introduced in Scotland from May 2015, is also being considered. The appointment of an Independent Medical Reviewer would provide additional safeguards and assurances. Within the proposals currently being considered the Medical Reviewer, who will be an appropriately clinically qualified professional, would have the power to examine the health records of the deceased, seek the views of the medical practitioner who completed the Medical Certificate of Cause of Death and make enquiries of any other person who may have information, for example, a family member, carer or a nurse.

The Independent Medical Reviewer would also have the power to refer cases to the Coroner for further investigation should there be any reason to do so.

I hope you find this information useful.

Jim Wells MLA
Minister for Health Social Services and Public Safety