PQ 3292/04		
DATE FOR ANSWER: 02 November 2004		
		28 October 2004

Mrs Iris Robinson (Strangford): To ask the Secretary of State for Northern Ireland, what plans he has to introduce more rigorous methods of investigating hospital deaths in the Province; and if he will make a statement. (194642)

Angela Smith

A Safety in Health Care Steering Group was established by my Department following the publication of the consultation document entitled "Best Practice, Best Care" in April 2001. In July it issued interim guidance (HSS (PPM) 06/04) to the HPSS and special agencies on the reporting and management of serious adverse incidents.

My Department has also established a multi-agency group comprising Departmental officials and representatives from the Police Service of Northern Ireland, the Health and Safety Executive (HSE), and the Coroners' service to develop a memorandum of understanding for the investigation of death and serious incidents in hospitals. This will take account of a recent memorandum of understanding issued for consultation in England and Wales: "Investigating patient safety incidents (unexpected death or serious untoward harm): a protocol for liaison and effective communications between the NHS, Association of Chief Police Officers and HSE", which can be viewed at:

http://www.dh.gov.uk/assetRoot/04/08/48/61/04084861.pdf

BACKGROUND NOTE TO PARLIAMENTARY QUESTION NO. 3293/04

1. It is thought that this PQ is related to PQ 3292/04, also tabled by Iris Robinson, which probably relates to the death of Lucy Crawford in the Children's Ward at the Erne Hospital in April 2000.

2. The Department has taken steps to ensure that there is proper reporting and follow-up of severe adverse incidents and near misses. The Safety in Health and Social Care Steering Group was established by the Department in response to the "Best Practice, Best Care" consultation paper published by the Department in April 2001. Its remit was to develop a strategic approach to the reporting, recording and investigation of adverse incidents and near misses and the promotion of good practice to minimise risk. In addition to the existing local and national reporting systems, both mandatory and informal, Interim Guidance HSS (PPM) 06/04 was issued to the HPSS and Special Agencies on 7 July. It provides detailed guidance on the reporting and management of serious adverse incidents and near misses, pending the issue of more comprehensive guidance on safety that will be issued once the work currently being undertaken by the Department on the strategic review of the reporting, recording and investigation of adverse incidents and near misses has been concluded.

The Steering Group commissioned a report by Deloitte and subsequently reported to the Departmental Board on 10 September. The Steering Group obtained the Board's agreement to improve definitions and coding; develop a safety framework; and produce a business plan for the creation of a safety unit.

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3. A further group has been established, which comprises Departmental officials, the Police Service of Northern Ireland, the Health and Safety Executive, and the Coroners' Service. Its first meeting is scheduled for 29

October. The group is tasked with drawing up a memorandum of understanding for the investigation of deaths and serious incidents that occur in hospitals. This will take account of a recent memorandum of understanding issued for consultation in England and Wales: "Investigating patient safety incidents (unexpected death or serious untoward harm): a protocol for liaison and effective communications between the NHS, Association of Chief Police Officers and HSE", which can be viewed at:

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