Fisher, Ruth

From: Dunlop, Colin
Sent: 16 November 2004 12:57
To: Carnew, Sholto
Cc: Hamilton, Andrew; Sullivan, Dean; Browne, Andrew; Neagle, Heather; McCaw, Darren; McCarthy, Miriam; Fisher, Ruth
Subject: PQ 3594 04 Mr John Hume

Importance: High

Follow Up Flag: Follow up
Flag Status: Red

Sholto,

Draft attached.

Draft PQ 3594 04 JOHN HUME 16...

Thanks.

Colin

PQ 3594/04

DATE FOR ANSWER: 17 November 2004

16 November 2004

Mr John Hume (Foyle): To ask the Secretary of State for Northern Ireland, what the procedures are for (a) notification and (b) investigation of deaths in hospital which may have resulted from medical treatment; and at what stage the Chief Medical Officer should be informed. (198612)

Angela Smith

All deaths that are not due to natural disease must be referred to the Coroner. The Coroner will investigate all such deaths, which will include circumstances such as:

- sudden or unexpected deaths;
- deaths where the cause of death is unknown or a doctor is unable to issue a medical certificate stating the cause of death (death certificate);
- all unnatural deaths (including accidents, suspected suicide or suspicious deaths;
- deaths thought to be due to negligence;
- deaths occurring during surgery or anaesthesia; and
- deaths from any cause other than natural disease.

The Coroner will decide on the need for a post mortem examination and subsequently if an inquest is required. The coroner's investigation is supported by the Police Service for Northern Ireland.

A Safety in Health and Social 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. This includes a requirement for all HPSS organisations and Special Agencies to have nominated a senior manager at Board level who will have overall responsibility for the reporting and management of serious adverse incidents within the organisation. In addition, if the senior manager considers that the incident is likely to:

- be serious enough to warrant regional action to improve safety or care within the broader HPSS;
- be of public concern; or
- require an independent review,

then he/she is required to provide the Department with a brief report within 72 hours of the incident being discovered. These reports are shared with the Chief Medical Officer and other professional and administrative staff as appropriate.

Furthermore, 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".

BACKGROUND NOTE TO PARLIAMENTARY QUESTION NO. 3594/04

1. It is thought that this PQ arises from the death of Lucy Crawford in April 2000 and the recent UTV Insight programme.

2. The primary route for the investigation of deaths, which are not due to natural disease, is through the Coroner's office. These will include circumstances such as:

- sudden or unexpected deaths;
- deaths where the cause of death is unknown or a doctor is unable to issue a medical certificate stating the cause of death (death certificate);
- all unnatural deaths (including accidents, suspected suicide or suspicious deaths;
- deaths thought to be due to negligence;
- deaths occurring during surgery or anaesthesia; and
- deaths from any cause other than natural disease.

3. All deaths that are not due to natural disease must be referred to the Coroner. It will then be for the Coroner to decide on the need for a post mortem examination and subsequently if an inquest is required. Should the Coroner decide that such an examination is necessary, then this would be undertaken by a pathologist who works to standards set by the Royal College of Pathologists. The coroner's investigation is supported by the Police Service for Northern Ireland, who gather notes and statements, identify the body and present evidence at the Inquest.

4. Any doctor who has concerns about a death should inform the Coroner. Junior doctors are also able to discuss any concerns that they may have about a death with more senior colleagues.

5. 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.

6. 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 took place on 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:

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

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DHSSPS