FROM THE MINISTER FOR HEALTH,
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Dear Alastair

JUSTICE BILL 2014 – DHSSPS WRITTEN SUBMISSION FOR 28 JANUARY 2015

Please find attached a written submission paper for the Committee (Appendix 1) which summarises the Department's position on the proposals by the Attorney General to amend the Coroners Act (NI) 1959 through the Justice Bill.

As previously advised Dr Paddy Woods, Deputy Chief Medical Officer, Mr Fergal Bradley, Director of Safety, Quality and Standards Directorate and Mr David Best, Head of Learning, Litigation and Service Framework Development Branch will be attending the evidence session on behalf of the Department on Wednesday 28 January 2015.

I trust this is helpful.

Jim Wells MLA
Minister for Health Social Services and Public Safety

Appendix 1

Written Submission from DHSSPS to Justice Committee

Attorney General's proposal to amend the Coroners Act (Northern Ireland) 1959 through the Justice Bill

Background

1. The Department first became aware of the amendment from the Attorney General (AG) following correspondence from the Committee in April 2014. At that time the AG was seeking powers, through the Legal Aid and Coroners' Court Bill, to obtain information or documentation for consideration when deciding whether to direct an inquest. Full details of the proposed amendment were not provided and this was indicated in the Department's response.

2. Further correspondence was received on 30 April 2014 which provided the original proposal of 5 March 2014 as well as amended text from the AG dated 30 April. The amended text appears to broaden the scope of his intentions to seek information or documentation on any death where health or social care has been provided at any time.

3. The current position is that, under Section 14(1) of the Coroners Act (NI) 1959, where the AG has **reason to believe** that a deceased person has died in circumstances **which in his opinion** make the **holding of an inquest advisable** he may **direct any coroner** to conduct an inquest into the death of that person. This would indicate that the AG already has the power to direct an inquest and therefore it is not clear what value the proposed amendment would add.

4. The Department has indicated in previous responses that there is no objection in principle to the AG having the power to access the information necessary to allow him to discharge his functions under section 14 of the Coroners Act. There is however, a need for greater policy clarity as to the precise intent of the

provision and how it would be used in practice. The Departments concerns will be addressed under four broad headings:

(i) The rationale for the provision
(ii) The scope of the provision
(iii) The implications of the provision
(iv) Alternatives to the provision

(i) Rationale for the provision

5. Legislation is deemed necessary when there is a need to regulate, authorise, sanction, grant, declare or to restrict practices. The essential starting point in the development of any legislation is a clearly defined policy direction. The Department does not believe this has been provided and remains to be convinced that the additional powers being sought by the AG are necessary.

6. Originally the AG indicated in his proposed amendment of 5 March, that he had experienced difficulties in getting access to information on hospital deaths to allow him to exercise his power under section 14.

7. Our understanding from contact we have had with the Trusts is that the AG does on occasion make requests for information on hospital deaths and where possible this information is provided as requested.

8. Under section 14 of the Coroners Act, the AG can currently direct the coroner to conduct an inquest into the death of a person if he has reason to believe that the deceased person died in circumstances which in his opinion make holding an inquest advisable.

9. In order to exercise his power all that is required is for the AG to have a reason to believe that the circumstances of the death make the holding of an inquest advisable. The use of these words and phrases seem to import a wide degree of discretion and a low threshold for taking action and the wording does not envisage the AG having to carry out an investigative role to determine whether to direct the conducting of an inquest.

10. The AG also stated in his evidence session to this Committee in May last year that it was from his own experience and from media interest that there is a concern that unexpected deaths occurring in hospital, in particular are not, in all cases, being reported to the Coroner. He added that at present it is largely the decision of doctors as to whether those matters are referred onwards to the Coroner.

11. Section 7 of the Coroners Act, states that a death should 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. The duty to report arises if that death falls within a set of clearly defined criteria which includes as a result of violence or misadventure or by unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or in such circumstances as may require investigation (including death as a result of the administration of an anaesthetic).

12. The medical practitioner attending the deceased must make a decision on whether the death falls within any of the defined criteria. If it does, or if there are any doubts or concerns surrounding the circumstances of the death, it should be reported to the Coroner immediately.

13. If a death occurs in a hospital and meets the criteria outlined in The Coroners Act, it will be reported to the Coroner for consideration. However, there will be occasions when a death may be reported to the Coroner sometime after the date of death. This can happen when information comes to light that may not have been apparent at the time of death. There is a perception that these are 'late reports', however, this is not the case as the Coroner will be informed once such information becomes apparent.

14. The AG's proposals may have been as a result of his understanding following media reports that there may have been deaths in hospital including Emergency Departments where there was no report to the Coroner.

15. Last year, Edwin Poots commissioned a look back exercise to review all Emergency Department Serious Adverse Incidents. The exercise covered three aspects, one of which related to the engagement by HSC Trusts with the Coroner.

16. This exercise indicated that Trusts are complying with the statutory requirement to report deaths to the Coroner and are doing so in a very timely fashion. The information supplied by HSC Trusts for this look back exercise has been independently validated by the RQIA, and from this it is evident that doctors are meeting their statutory obligation to report deaths to the Coroner when required.

17. It is not entirely clear whether the rationale behind these proposals is due to a lack of information being provided to the AG from Trusts, a belief that deaths are not being reported to the Coroner, a misunderstanding of the SAI process or indeed, some other reason. Before accepting the AG's proposals, it would be important to have more policy clarity before legislation of this nature is introduced.

(ii) SCOPE

18. Secondly, the Department has concerns that the scope of the AG's proposed powers is ambiguous. He stated in March 2014, that his principal focus of concern was deaths in hospitals or where there was a suggestion of medical error. However, through the amendment submitted in April 2014 and during his evidence session in May 2014, he appears to broaden rather than restrict the scope of the power. He would, if his amendment is accepted, have the power to request any document or any other information from any person who provided health and social care to the deceased.

19. This could therefore relate to any death, not just deaths in hospital or where there was a suggestion of medical error. The wording leaves the scope of his powers very open and could therefore equally apply to deaths in residential homes, the death of an individual who may have been receiving private counselling or all deaths in a particular hospital, hospital ward, or GP practice.

20. In April 2014, the AG advised that his proposal would give him powers to obtain information, for example, about Serious Adverse Incidents (SAIs). There appears to be some misunderstanding regarding the purpose of the SAI process. The SAI Reporting System was first introduced in 2004 and has been revised and refined over the years. Its purpose is to ensure an agreed approach to reporting, managing, analysing and learning from adverse incidents and to prevent reoccurrence in as far as possible.

21. Primarily, the SAI system operates to identify and promote **learning and improvement**. It does not exist to investigate deaths or attribute blame or fault – that is the role of other agencies and processes. The health and social care system aspires to a 'no blame' culture or a 'just' culture in which staff can be open without fear of inappropriate reprisal.

22. Not all SAIs relate to deaths as the SAI criteria are much broader than deaths. The Department has on a number of occasions amended the definition of an SAI on the basis of exploring different opportunities for learning by focussing on different types of incident. The Department reserves the right to continue to change the focus of SAI investigations in the future on the basis of exploring other opportunities for learning and improvement.

23. The SAI reporting system is fundamentally dependent on a culture of openness and learning rather than one of blame, recognising that when things go wrong and a patient is harmed that the reasons are often complex and rarely simply the result of individual failing. The Department considers that openness, transparency, blame and fear, are multi-dimensional issues that cannot be improved directly by legislation, rules or procedures alone.

24. The culture of blame with regard to SAIs has been fuelled by the misrepresentation of the SAI system as one whereby Trusts investigate themselves and by inference as part of a system of cover ups.

25. The statutory requirement to report a death to the Coroner (as clearly defined in section 7 of the Coroners Act (NI) 1959), exists entirely separately from the SAI process. In addition to the Coroners Act, there are a range of other statutory requirements on HSC bodies to report certain incidents to external organisations such as Professional Regulatory Bodies, the Health and Safety Executive, or the Police Service of Northern Ireland. Whilst such incidents may also meet the criteria to be reported and investigated as an SAI, the SAI process is not a portal to reporting incidents to these external agencies.

26. The scope of the AG's policy context is conflicting and unclear. We suggest that if the proposed amendment is supported in principle, then it should be rewritten to precisely indicate which deaths in particular it relates to. The Department would also support the view of the Lord Chief Justice outlined in the written submission, dated 9 April 2014, where as in England and Wales the AG should make an application to direct an inquest through the High Court as this would provide the Coroners with a greater understanding of why an inquest was being directed.

(iii) IMPLICATIONS OF PROPOSAL

27. Whilst the AG has said that he "does not believe" his proposed amendment will burden the health service, no evidence has been provided to support his supposition and there are concerns that his proposals may have negative implications for the health and social care sector in a number of ways.

Accessing information

28. It is unclear at this stage, what information the AG will be seeking. The proposal suggests that any person who has provided health or social care to the deceased would be required to "produce any document or give any other information" that he would require. This would need to be more clearly defined.

29. There are many people, both administrative and professional, within the HSC who are responsible for updating and maintaining information on patients. This can range from patients or client notes, x-rays, prescribed drugs or outpatient appointments to name but a few. Under the current proposal any of this

information may need to be provided and whilst most of this will relate to the deceased and not be affected by the Data Protection Act, other information may relate to family and friends as well as to medical staff and may be subject to confidentiality or data protection restrictions.

30. When a unexplained death occurs there may already be a number of "investigations" to ascertain the cause of death. This can include action by the Trust through the SAI process, action by the Coroner, the RQIA, the Health and Safety Executive or the PSNI. These investigations may be happening simultaneously and all require documentation to be produced to help to inform the circumstances surrounding the death.

31. There is a real concern that adding a further investigation by the AG would place an additional administrative burden on HSC staff which has the potential to direct much needed resources away from frontline services.

Openness and transparency

32. Another implication of the proposed legislation is the summary conviction element, which applies if a person fails without reasonable excuse to provide the relevant documentation or information. The Department believes that a potential conviction could actually discourage openness and transparency if something has gone wrong.

Management and Resources

33. The Department also has concerns as to how the proposals will be managed and resourced or the potential risks and their impact. As the suggested amendment relates to "*any* person who has provided health or social care to a deceased person", it will relate not only to medical practitioners and nurses, but to carers, pharmacists, therapists, dentists, allied health professionals, counsellors, healthcare assistants and home helps etc. It covers such a wide spectrum of individuals and organisations in the HSC, that as already stated, the service may not be able to cope with the additional burden.

Penalties

34. The Department has concerns that the criteria for establishing the exact circumstances under which someone would be guilty of such an offence has yet to be defined, e.g. the precise mechanisms for ascertaining non compliance; the person or authority who would determine when a criminal offence has taken place; if the penalty would be issued to an individual or to the governing organisation.

35. If applied to individuals, a criminal offence could result in appearances at Professional Regulatory Bodies which could well have a detrimental affect on professional and healthcare workforces.

Consultation

36. The Department is concerned that no formal public consultation has been carried out on the legislative proposals. There will be many HSC organisations, professionals and healthcare workers, who will not have had an opportunity to comment on how these proposals will be applied and the implications for them and their work practices.

(iv) ALTERNATIVES TO PROPOSAL

37. The Department is already taking forward a number of initiatives and programmes of work, which are designed to provide greater scrutiny around the processes for certifying death in Northern Ireland.

38. In April 2012, the NI Executive considered two options following a review of death certification. The first option was the implementation of a series of enhancements to the existing assurance arrangements for death certification with a view to strengthening and improving the current process. The second option was the introduction of a Medical Examiner/Reviewer, a medically qualified person with the appropriate specialism and expertise, who would carry out a basic independent review of non-reportable deaths.

39. The Executive agreed that Option 1 be implemented as soon as practicable and that an evaluation of this option be undertaken over a two year period in order to inform a decision on whether the introduction of a Medical Examiner/Reviewer should go ahead.

40. Work is well underway on the implementation and evaluation of the enhancements under Option 1. These include the development and implementation of a Regional Mortality and Morbidity Review System (RM&MRS). In April last year, Edwin Poots, gave the go ahead for this system to be rolled out across all hospitals in NI over the next two to three years. The RM&MRS will allow for the accurate recording, reviewing, monitoring and analysis of all deaths occurring in hospitals, thereby facilitating identification of poor care management, learning form errors, openness and transparency and improvements in patient safety and care. The Technical Specification for the system is currently being developed in conjunction with the Belfast HSCT, the Southern HSCT and the Regional Health and Social Care Board.

41. This will not only allow for the quality assurance of all hospital based deaths, but will provide further assurance and oversight in line with existing statutory responsibilities and will ensure that learning from the mortality and morbidity of patients is shared. The suitability and adaptation of this system to both Primary Care and the wider community will also be considered in order to capture equitable information on all deaths. The Department will also continue to work closely with the Coroner to monitor the timeliness of reporting and to address any concerns he may have.

42. Under Option 2, the appointment of a Medical Examiner/Reviewer, it is envisaged that there might be 2 levels of independent scrutiny of deaths that are not be required to be reported to the Coroner. Level 1 scrutiny would involve, for example, the review of a random selection of approximately 10% of non-reportable deaths including completion of the Medical Certificate of Cause of Death (MCCD) and discussion with the certifying doctor. Level 2 scrutiny would provide further scrutiny including examination of medical records and discussion with families or interested parties.

43. These arrangements would be similar to those being introduced in Scotland in May 2015; however this would be subject to the full development of the proposals and NI Executive approval.

44. Under the AG's proposal it appears that cases would be selected on an ad hoc basis, whereas the Medical Examiner/Reviewer would systematically scrutinize the cause of death, in a way that is robust, proportionate and consistent.

45. In addition to proportionate and effective independent scrutiny of MCCDs, it is anticipated that medical examiners would provide medical advice to Coroners and advice to certifying doctors. They would work with HSC colleagues to use the information they collect to support clinical governance and they would assist in training doctors and other healthcare professionals on the appropriate certification of death.

46. The Department is taking a systematic approach to all of this work, as it is based on research, evidence, statistical data and stakeholder engagement including liaising with the other UK administrations. We are therefore of the opinion that the comprehensive initiatives which the Department is already undertaking to supplement extant statutory and legal processes, will adequately provide the level of assurance that is necessary to ensure that information regarding deaths is being appropriately recorded, reported and analysed. Whilst the AG's proposals are well intended, there is some duplication of resources which we believe make them superfluous to requirements.

SUMMARY

47. In summary, the Department, in principle, has no objection to the AG having the power to access the information necessary to allow him to discharge his functions under section 14 of the Coroners Act (NI) 1959. However, as outlined in the paper above there are real concerns surrounding the rationale, the scope and the implications of the AG's proposals, which can be expanded on further during the evidence session.

48. The Department also understands that a full review of Coronial legislation is likely and as the AG's proposed amendments relate to the Coroners Act (Northern Ireland) 1959, it would seem more appropriate for his proposals to be considered under the review of that original legislation.