Western Health and Social Care Trust

Memorandum of Understanding – Patient Safety Incidents Policy June 2021

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Policy Code: MED21/002

Title:	Liaison and Effective Communications with the Police Service of Northern Ireland (PSNI), Coroners Service for Northern Ireland and the Health & Safety Executive Northern Ireland (HSENI) when Investigating Patient Safety Incidents Involving Unexpected Death and Serious Untoward Harm			
Author(s)	Regional Working Group on Adverse Incidents			
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1.0 INTRODUCTION/PURPOSE OF POLICY

1.1 Background

On 15 March 2013, the Department of Health issued a revised Memorandum of Understanding for Investigating Patient Safety Incidents involving unexpected death and serious untoward harm.

1.2 Purpose

The purpose of this policy is to promote effective relationships with the Police Service of Northern Ireland (PSNI), Coroner's Office and the Health & Safety Executive (HSENI), and improve appropriate information sharing and co-ordination to save time and other resources when joint or simultaneous investigations are required into a serious incident that caused unexpected death or serious untoward harm. **This is likely to be the case when an incident has occurred from, or involved, criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work related death.**

2.0 SCOPE OF POLICY

2.1 The Trust has a responsibility to ensure the safety and well-being of patients or clients and staff and to investigate when things go wrong, occasionally involving other agencies.

2.2 Some accidents to patients or clients have a requirement to be reported to HSENI by the Trust, under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Northern Ireland 1997. HSENI will normally investigate all reportable incidents 'arising out of or in connection with work' but not accidents that arise from medical treatment or diagnosis.

2.3 In situations where the same incident is subject to investigation by a number of separate organisations, it is essential there is clarity of roles and responsibilities by effective liaison and communication between all parties involved.

3.0 ROLES AND RESPONSIBILITIES: TRUST STAFF AND OTHER RELEVANT BODIES

3.1 It is the responsibility of all line managers to ensure this policy is brought to the attention of relevant staff. Staff must familiarise themselves with, and adhere to, the contents of this policy. This policy should be read in conjunction with the Trust's Adverse Incident Policy.

3.2 In cases where more than one organisation may have an involvement in investigating any particular incident it is the responsibility of the relevant Director responsible for the incident (or nominee) to liaise with each of the organisations.

3.3 The PSNI may investigate all criminal offences. The types of incident the Trust will report to the PSNI are those that display any one or more of the following characteristics: -

- Evidence or suspicion that the actions leading to harm were intended;
- Evidence or suspicion that adverse consequences were intended;
- Evidence or suspicion of gross negligence and/or recklessness including as a result of failure to follow safe practice or procedure or protocols.

3.4 The HSENI is responsible for the enforcement of the Health and Safety at Work (Northern Ireland) Order 1978 (HSWO). Generally the HSENI does not seek to apply the HSWO to clinical judgment or to the level of provision of care. However, HSENI is responsible for enforcing work related health and safety legislation in a large variety of settings including nursing homes and hospitals. District councils have this responsibility for residential facilities within the Trust area.

3.5 Coroners have a responsibility under the Coroners Act (Northern Ireland) 1959 to investigate the cause and circumstances of deaths reported to them. Appendix 1 sets out guidelines on reporting deaths to the Coroner.

3.6 Other organisations may also investigate patient or safety incidents locally and/or nationally. These include the Health and Social Care Board (HSCB), the Regulation and Quality Improvement Authority (RQIA), Northern Ireland Adverse Incident Centre (NIAIC) and professional regulatory bodies.

3.7 In line with the Regional Procedure for Reporting and Follow Up of Serious Adverse Incidents (November 2016) – section 3.5.1, the Trust should consider invoking the Memorandum of Understanding when reviewing a serious adverse incident that involves any of those organisations noted above.

3.8 Trust Board: is responsible for seeking assurance that a robust system is in place for the effective management of incidents relevant to this policy.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

4.1.1 **Preliminary Meeting:** An initial meeting between the Trust and relevant parties to collate initial information about the incident.

4.1.2 **Incident Co-ordination Group (ICG):** This group is set up to provide strategic oversight of a patient safety incident or direct safety incident involving multiple investigations.

4.2 Preliminary Meeting and Commissioning an Incident Coordination Group (ICG) Coordination of investigatory activities, responsibility and investigation and documenting the ICG

4.2.1 Where more than one organisation is involved, the Director responsible for the incident (or nominee) will make arrangements with the relevant organisations to attend a preliminary meeting.

4.2.2 The purpose of this meeting will be for a Trust representative to brief the various parties on the circumstances so that they can decide where responsibility for investigation lies.

4.2.3 The Director responsible for the incident (in conjunction with the Assistant Director is the named Trust contact to facilitate ongoing communication and liaison.

4.2.4 The preliminary meeting is to be followed by an incident coordination group (ICG) meeting. The purpose of this is to provide strategic oversight of a patient safety incident involving multiple investigations. It allows each organisation to identify actions to be taken that do not prejudice the work of other organisations e.g. legal proceedings. The information that may be shared will be constrained by the requirements of any criminal investigation and disclosure restrictions.

4.2.5 The Trust should continue to ensure patient safety but not undertake any activity that might compromise subsequent statutory investigations. If in doubt the Trust's Assistant Director will seek legal advice and consult with the PSNI, Coroner, HSENI or other investigating bodies.

4.2.6 Those attending the ICG should be sufficiently senior to take decisions concerning the management of the incident. Police representation would be at the level of Detective Chief Inspector. The Trust's representation will be the Director responsible for the incident supported by the **Assistant Director of the area where the incident occurred.**

4.2.7 The statutory investigating bodies will come to an early decision about the nature of the incident and where responsibility for investigation should lie e.g. the PSNI and HSENI may conclude they have no further role in the matter. On some occasions the Trust may have to investigate further and if more information or evidence is found, another ICG meeting may have to be convened.

4.2.8 On some occasions the incident may cause concern about wider patient safety. In such circumstances the ICG needs to discuss if the necessary further investigation can be conducted to avoid the danger of prejudicing the police, coroner and/or HSENI investigation e.g. by interviewing members of staff who may subsequently give evidence at court. The PSNI have the authority to prevent the Trust from undertaking an investigation until its investigation is completed in the event that it might prejudice their investigation. However, this should not prevent the Trust from ensuring that immediate learning is undertaken.

4.2.9 The Trust is responsible for minuting the ICG meeting(s) and circulating them to other members. If the Trust has been excluded the ICG must agree who will minute the meeting.

4.3 Securing and Preserving Evidence

4.3.1 The safeguarding of physical, scientific and documentary evidence may be critical to understanding what happened in a serious incident and promote a

satisfactory investigation. Destruction of evidence may prevent or delay adequate safety measures being put in place and may lead to a more complex investigation. Documentation should be secured in line with the Trust's policy on securing records and any Trust Policy on the handling of forensic items.

4.3.2 Where a criminal offence is suspected, failure to retain evidence may mean that legal proceedings are undermined. Even in incidents where concerns arise after a long time period every effort to secure and preserve all available evidence should be made.

4.3.3 A record should be kept by **Assistant Director responsible for the incident** and receipts obtained when Trust documents, records or other items are passed to other agencies.

4.4 Sharing Information

4.4.1 There will be a need for organisations in the ICG to share information for the purposes of coordinating multiple investigations.

4.4.2 There are a number of factors to take account of when making judgments about information sharing including: -

- The nature and degree of risk;
- The purpose;
- Consent;
- Justification for breach of patient/client confidentiality;
- Current law and guidance; and
- Confidentiality agreements.

4.4.3 Where necessary, the Assistant Director will seek legal advice on information sharing.

4.5 Supporting Those Affected

4.5.1 The organisations should agree and follow a liaison strategy for each incident, agreed at the first meeting and reviewed at subsequent meetings. This should include keeping the relevant affected parties informed.

4.6 Communications

4.6.1 A strategy will be agreed by all relevant parties for dealing with the media, patients/clients and relatives. The organisations should take a common approach to communication although in the event of legal proceedings this may not be practicable. Legal advice will be sought by the Trust, as required.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

5.1.1 This policy will be disseminated to all relevant Operational and Corporate Directorates and will be available on the Trust's intranet site.

5.2 Resources

5.2.1 The Medical Directorate will be responsible for organising awareness and/or training sessions for all relevant managers and staff in relation to this policy, as appropriate.

5.3 Exceptions

5.3.1 This policy is applicable to all service areas within the Trust.

6.0 MONITORING

6.1 An audit of the implementation of this policy will be undertaken on a 3 year basis by the **Medical** Directorate.

7.0 EVIDENCE BASE / REFERENCES

- Memorandum of Understanding: Investigating Patient Safety Incidents Involving Unexpected Death and Serious Untoward Harm: Promoting liaison and effective communications between the Health and Social Care, Police Service of Northern Ireland, Coroners Service for Northern Ireland, and the Health & Safety Executive for Northern Ireland [HSS(MD) 8/2013 – 15 March 2013
- https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf
- https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/mou-patient-client-safety-incidents.pdf
- HSENI Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) NI 1997
- Guidelines for Notifying the Coroner of a Death - https://www.health-ni.gov.uk/sites/default/files/publications/health/Guidelines%20for%20Notifying%20the%20Coroner%20of%20a%20Death.pdf

8.0 CONSULTATION PROCESS

- Via the Regional Working Group consultee list.

9.0 APPENDICES / ATTACHMENTS

- Appendix 1 – Reporting Deaths to the Coroner

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

SIGNATORIES

_____ **Date:** _____

APPENDIX 1

DEATHS THAT MUST BE REPORTED TO THE CORONER

The duty to report arises if a medical practitioner has reason to believe that the deceased person (to include a fetal demise in utero, beyond the legal limit for viability (24 weeks) and considered to be 'then capable of being born alive') died directly *or* indirectly,

- as a result of violence, misadventure or by unfair means;

- as a result of negligence, misconduct or malpractice (e.g. where a medical mishap is alleged);

- from any cause other than natural illness or disease, for example;
    - O homicidal deaths or deaths following assault;
    - O road traffic accidents or work-related accidents;
    - O injury, direct or indirect (including birth injury);
    - O deaths associated with the misuse of drugs (whether accidental or deliberate);
    - O any apparently suicidal death; or
    - O all deaths from industrial or occupational disease e.g. asbestosis.

- from natural illness or disease if the deceased had not been seen and treated for it by a registered medical practitioner within 28 days prior to death; or

- in other circumstances that may require investigation; for example,
    - O the death, although apparently natural, was unexpected;
    - O Sudden Unexpected Death in Infancy (SUDI);
    - O as the result of an operation, following a procedure or where a person has had an accident or adverse incident in the hospital environment;
    - O as the result of the administration of an anaesthetic, e.g. hypoxia, circulatory failure, drug reaction, (there is no statutory requirement to report a death occurring within 24hours of an operation – though it may be prudent to do so).

Doctors should also consider the Extra-statutory list of causes of death that are referable to the Coroner. If in doubt, seek advice from the Coroner's Office.

1. Industrial diseases or poisoning and other poisonings

A. Industrial lung diseases e.g. asbestosis, pneumoconiosis, extrinsic allergic alveolitis.
B. Other industrial diseases e.g. mesothelioma, leptospirosis.
C. Industrial poisoning e.g. heavy metal, chemicals.
D. Other poisonings e.g. Food poisoning, Tetanus.

2. Death resulting from an injury

A. Injury e.g. Asphyxia, Drowning, Intracranial Haemorrhage.
B. Indirect injury e.g. pneumonia following a fractured femur.
C. Birth injury.
D. Operation / Anaesthetic.