The Coroner’s Inquest: Patient Safety Issues

Medicolegal investigation of sudden, unexplained, violent or unnatural death

Coroner's Inquiry

- Medicolegal Investigation
- Doctor/lawyer
- Garda support
- Support from medical profession
- Relatively high autopsy rate
- Public hearing (inquest)

Some Indicia of the Coroner System

- Comprehensive death investigation
- Check on death certification
- Information in relation to mortality
- Public information on health and safety matters
- Independent investigation

Reportable Deaths

- Sudden death
- Unexplained death
- Difficulty with certification
- Certain healthcare acquired infections
- Death in prison/custody
- Unnatural death
- Violent death
- Suspicious death
- Homicide

Deaths Reportable to Coroner

- Rules of Law
- Rules of Practice
- Reportable Deaths for Maternity Hospitals (Dublin District Coroner)

(see handout)

Unnatural deaths (Rules of Law)

- road traffic collision
- accident in the home, workplace, or elsewhere
- any physical injury
- fractures in the elderly
- drowning
- hanging

Unnatural deaths

- drug overdose or drug abuse (including alcohol)
- neglect, including self-neglect
- burns or carbon monoxide poisoning
- starvation/malnutrition
- exposure and hypothermia
- firearms injuries
- occupational disease
- food poisoning

Death of Foetus

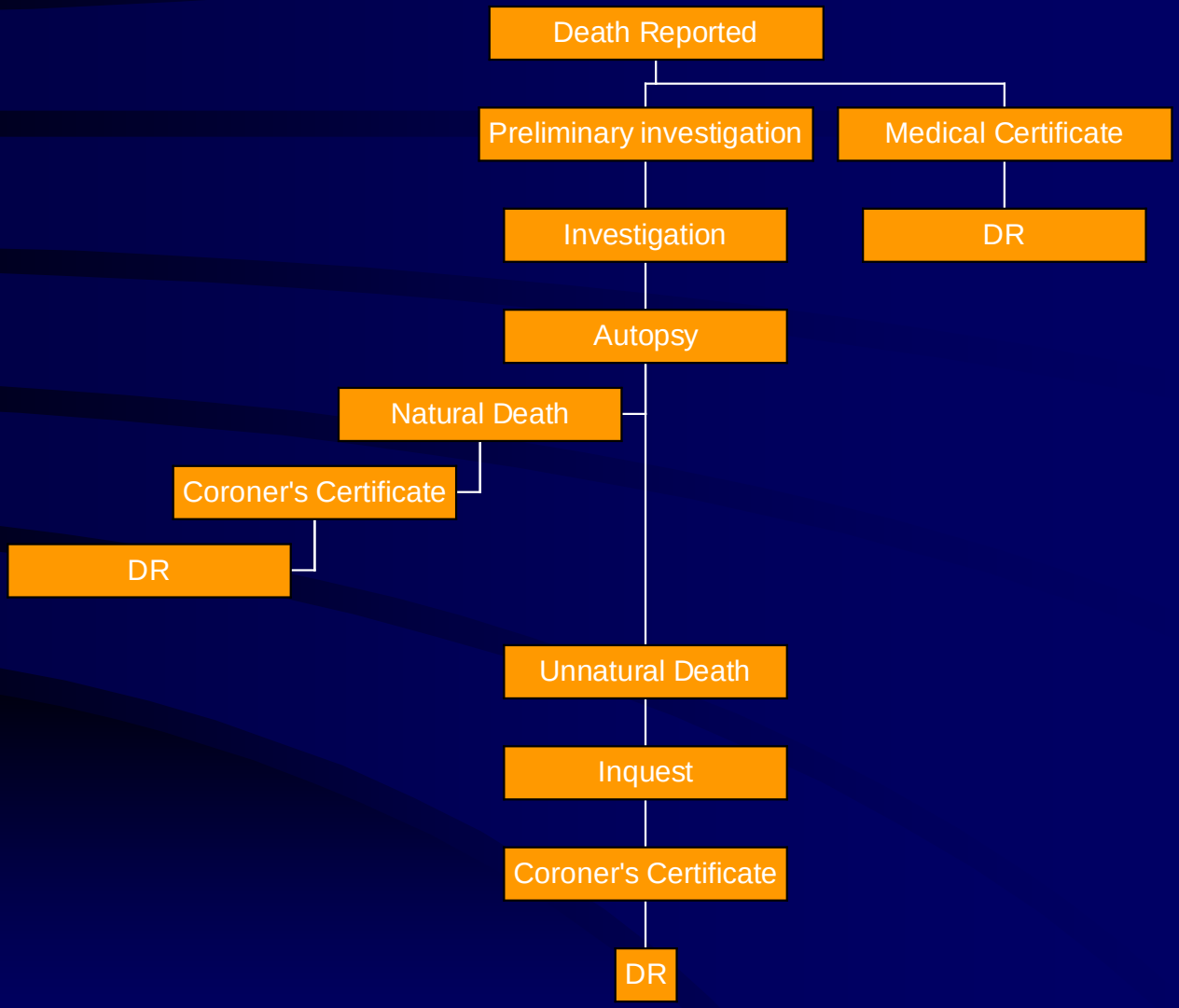
- Abortion / attempted abortion;
- Injuries to foetus in utero;
- Alleged negligence / mismanagement
- Hypoxic encephalopathy

Rules of practice

- BID (DOA)
- death in A&E department
- death within 24 hours of admission/or operation
- certain deaths in a hospital department
- maternal death
- recent transfer from nursing home, mental hospital
- where there is any doubt as to the cause of death

"The coroner service is a public service for the living, which, in recognising the core value of each human life, provides a forensic and medicolegal investigation of sudden death having due regard to public safety and health epidemiology issues"

[RCS 2000]


Death Reported
Preliminary investigation
Medical Certificate
Investigation
DR
Autopsy
Natural Death
Coroner's Certificate
DR
Unnatural Death
Inquest
Coroner's Certificate
DR

Dublin District Coroner Statistics 2015

- Deaths reported – 5297
- Autopsies ordered – 1857
- Inquests held – 615

Death Notification Form Part 1 MCCD

I.	I
Disease or condition directly leading to death	(a)……... …… due to (or as a consequence of)
Antecedent causes	(b)…… due to (or as a consequence of) (c)……
II.	II
Other significant conditions	……

Medical Certificate of Cause of Death

No unnatural cause of death

Check on death certification

- Registrar of Deaths has a statutory duty to report certain deaths to the coroner
- Close working relationship with Registrars Office (on a day to day basis)
- Copy of Medical Certificate Cause of Death (MCCD) requested

Issues

- proximate causes
- unclear terminology
- complications of operation or medical procedure
- fractures in elderly
- alcohol related death
- mesothelioma
- malnutrition/dehydration

Incomplete Certification

- cardiomegaly
- healthcare acquired infection
- pulmonary fibrosis
- intra-cranial haemorrhage
- multiorgan failure
- HIV and hepatitis
- spongiform encephalopathy
- “acute kidney injury”

DNF Part 1 MCCD

I (a) Lower respiratory tract infection

(b) Acute on chronic subdural haemorrhage

I(a) Portal vein thrombus

(b) Alcoholic cirrhosis

(c) Hepatitis C

DNF Part 1 MCCD

I(a) Bronchopneumonia

(b) Dementia

(c) Immune resistant encephalopathy

II Vertebral fractures

DNF Part 1 MCCD

I (a) Out of hospital cardiac arrest

(b) Coronary artery disease

Hepatitis C

II Intravenous illicit drug abuse

Deaths Under Medical Care

- Clinically unexplained
- May be attributable to a therapeutic or diagnostic procedure
- Occurs during administration of general or local anaesthesia
- Unexpected with regard to clinical condition of the patient
- Associated with allegations of lack of care (or serious concerns).

Deaths Under Medical Care

- Associated with medical/surgical treatment
- Invasive diagnostic /therapeutic procedure
- Death that may be due to a medication/ADR/drug interaction/ anaphylaxis
- Any non medical injury sustained in hospital

Coroners Autopsy

- Autopsy authorisation forms should provide information on the case
- Discuss case with supervising consultant
- If death occurred in hospital case notes, A&E notes etc. should be consulted
- Identify known or suspected infection risks
- If further information is required contact the clinical team or coroner’s office
- Conflict of interest

Coroners Autopsy

- Confirm identification
- Coroner authorisation form
- *(Hospital organ retention/information forms)*
- Summary of case

Coroners Autopsy

- All tubes, airways, lines or drains remain in situ
- Includes the endotrachael tube, iv cannulae, catheters, wound drains, electrodes, etc.
- Where equipment failure may be an issue retain or isolate for technical examination
- Hospital laboratory to retain all specimens especially blood and urine

Medical procedures/perioperative issues

- CVP lines or catheters
- chest drains
- PEG tubes
- cardiac pacemaker insertion, angioplasty, stents (including covered stents)
- portacaval shunts (TIPS)
- ERCP
- coiling of berry aneurysm

Pre-inquest review

- autopsy report
- medical reports
- issues and concerns/legal submissions (interested parties)
- medical/nursing witnesses
- case notes/x-rays/scans
- ? expert report

- Eastern Health Board v Dublin City Coroner [2001] IESC96

EHB v Dublin City Coroner

- "…the prohibition on any adjudication as to civil or criminal liability should not be construed in a manner which would unduly inhibit the inquiry. That would not be in accord with the public policy considerations relevant to the holding of an inquest to which I have referred."

EHB v Dublin City Coroner

- “It is clear that the inquest may properly investigate and consider the surrounding circumstances of the death, whether or not the facts explored may, *in another forum*, ultimately be relevant to issues of civil or criminal liability.”

Inquest
Public Policy Considerations

(i) to determine the medical cause of death;

(ii) to allay rumours or suspicions;

(iii) to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;

(iv) to advance medical knowledge;

(v) to preserve the legal interests of the deceased person's family, heirs or other interested parties.

Inquest

- Establish the cause of death
- Establish the circumstances surrounding death
- Co-morbid conditions
- Medical/surgical treatment

(what role did the procedure play in the cause of death?)

- COD: Left sided haemothorax/inquest
- Insertion of CV line/internal jugular vein
- Guide wire perforation
- Complication of procedure

- COD: Disseminated cytomegalovirus (CMV) infection/inquest
- Stem cell transplant
- Conditioning chemotherapy and pre-inquest tests
- Post-transplant G globulin and steroids for GvHD
- Review pre-testing protocol/pre-emptive CMV testing

- COD: septic shock/acute pancreatitis/inquest
- Post total knee replacement
- Post-op wound infection and cellulitis
- Vancomycin resistant enterococcus (VRE)

- COD: lethal level of Lamotrigine/inquest
- Sodium valproate
- Lamotrigine levels
- HPRA/GCK
- Product characteristics documentation

- COD: Acute subdural haemorrhage/inquest
- fall in longstay unit
- multiple risk factors
- history of falls at home (4 in recent months)
- ambulant with zimmer frame
- risk assessment
- on medication with cognitive issues

- warfarin anticoagulation/prolonged INR
- single room/posey alarm removed
- fell in bathroom/three days later fell in corridor (unescorted)
- suboptimal environment (floor uneven, handrails etc.)
- supervision
- protocols/procedures

- <u>COD: Mechanical obstruction of airway by food bolus (choking)/inquest</u>
- Cognitive impairment, Parkinsonism and depressive illness
- Admitted following a fall at home through ED
- Prior assessment by Speech and Language therapy identified saliva management issues and choking episodes
- Issues: diet and supervision at meal times

Self harm in hospital

- Hanging/Self-inflicted stab wounds
- Risk assessments
- Access to knives and ligatures etc.
- Hospital protocols/guidelines/practices

Perinatal death

- Hypoxic-ischaemic encephalopathy
- Maternal/placental/cord/fetal abnormality
- Management of labour
- Cardiotocography/ Oxytocin (Syntocinon) augmentation / electronic fetal monitoring/ timing of hypoxic event
- Consultant cover/review guideline

- Academic research, hospital projects, health research groups.
- National Drug Related Death Index (HRB)

(alcohol, road traffic collisions, fires and self harm)

- Road Traffic Safety
- Airport Emergency Procedures/Repatriation
- Forum on End of Life
- Medical Management of Organ Donation and Diagnosis of Brain Death 2010 (ICSI)
- Standards and Recommended Practices for Postmortem Examination [HSE]
- CEMD (Confidential Enquiry into Maternal Death)
- Sudden Cardiac Death – Molecular Autopsy
- Protection and Welfare of Children
- Major Emergency Consolidation Programme 2011-current

Dublin District Coroner

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Coroner Service

Website: www.coroners.ie