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]
Dublin District Coroner Statistics 2015

• Deaths reported – 5297
• Autopsies ordered – 1857
• Inquests held – 615
Death Notification Form Part 1
MCCD

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

II. Other significant conditions ........................................

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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.”
“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
• COD: Mechanical obstruction of airway by food bolus (choking)/inquest
• 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
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Coroner Service
Website: www.coroners.ie