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FACTSHEET

Adverse events and coronial investigations—what to expect

Accident or otherwise, every doctor will encounter an adverse event at some point during their career - so it pays to face it prepared. This fact sheet contains everything you need to know about the process of adverse events, the types of investigations that follow and your role within them.

What happens after an adverse event?

Once an adverse event has occurred, it will normally result in a formal notification to your hospital or practice management. This is then usually followed by an investigation and a final report of findings and recommendations.

There are two kinds of investigations:

- An investigation initiated by the hospital or practice.
- A coronial investigation and possible inquest (in the case of a patient death).

Sometimes, both types of investigations are performed. For example, many cases which are referred to the coroner are also investigated by the hospital itself.

If this happens, any coronial inquest will also look at the conduct of the hospital investigation and its findings, as well as the extent to which recommendations have been implemented.

Adverse event investigations

Hospital or practice-initiated investigations are also called "root cause", "sentinel", or "serious event" investigations. They all entail an investigation into what happened, why it happened and recommendations to make it less likely to happen again.

For less serious events, these investigations will likely be lead internally, usually by a clinical director. However, other authority figures can front the investigation as well, as long as they don't have any personal or clinical interest in the outcome.

For more serious events, including investigations into patient deaths, the investigations are more robust and more structured. Typically, the investigator is an external appointment with appropriate qualifications, and there is often more than one investigator, so that a range of clinical expertise may be brought to bear on the investigation.

Increasingly, district health boards are adopting the London Protocol, or a variation of it, for the investigation of serious adverse events. This makes investigations more comprehensive and rigorous, but also ensures that the process isn't centred on attributing personal blame and focuses on reducing future occurrences of the same problems.

Some adverse event investigations are approved by the Minister of Health as a "protected quality assurance activity". Amongst other things, this means that good faith participation in the activity is immune from civil or disciplinary liability, and any document brought into existence, or any information generated "solely" for the purpose of the activity, can't be produced in any court proceeding or in any other investigation (including any HDC investigation).

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Coronial investigations

An investigation by the coroner is a fact-finding exercise in which the coroner is both investigator and adjudicator, assisted by the Police.

In addition, the coroner has extensive powers to request information, such as requiring the production of a report from the patient's doctor. Additionally, the coroner may seek the assistance of experts.

Under the Coroners Act 2006, certain patient deaths are required to be reported to the coroner. This includes:

- A death which was "medically unexpected" and which occurred during, or apparently as the result of, a medical procedure.
- A "medically unexpected" death that occurred while the patient was affected by an anaesthetic.
- The death of a woman which occurred while the woman was giving birth, or which appears to have been a result of the woman being pregnant or giving birth.

In this context the phrase "medically unexpected" is defined to mean a death which:

> *"...would not reasonably have been expected by a health practitioner who was competent to carry out the procedure, or administer the anaesthetic, in question and had knowledge of the dead person's medical condition before the procedure began."*

Not all cases referred to the coroner are the subject of coronial investigation. Where the death is determined to be from natural causes, the case will be closed without an enquiry being opened.

The coroner may also postpone opening an enquiry and ultimately, may decide not to open one, if the death is already being investigated by another agency.

About 75 per cent of coroners' investigations are conducted as hearings on the papers. The remainder proceed to a coroner's inquest: a public hearing presided over by the coroner, in which evidence is produced through witnesses (much like in regular court).

Cases which proceed to inquest are generally those where there is a dispute about critical issues of fact, or where the public interest warrants a public hearing, or where the coroner, the family of the deceased, or other interested parties, seek to have issues tested through the cross-examination of witnesses.

In essence, the three purposes of a coronial investigation are:

1. To establish as far as possible when and where the person died, and the causes and circumstances of the death.
2. To make recommendations or comments, but only for the purpose of reducing the chances of further deaths occurring in similar circumstances.
3. To determine whether it is in the public interest that the death should be investigated by another authority (for example the Police, the Medical Council, or the Health and Disability Commissioner).

While coronial investigations are not about attributing blame to individuals, establishing the cause and circumstances of death can require adverse findings or comments.

In these cases, the person who is the subject of comment is entitled to know what the coroner proposes to say beforehand, and the opportunity to respond. In most cases, such a person will have the opportunity to view and comment on the coroner's draft findings.

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Your role in adverse event investigations

Should you be asked to participate in an adverse event investigation, you will very likely be obliged to do so, either through your contract of employment or simple ethical duty.

Under section 40 of the Coroners Act, a coroner may, by written notice, require a doctor who attended upon a deceased person before death, to provide a written report containing such information as is specified in the notice. Such information may include the deceased's "health information".

This can be a difficult situation to navigate, both legally and ethically.

What you should do

If you receive a request to participate in an adverse event investigation or in a coronial investigation, you should:

- Contact your indemnifier (i.e. NZMII) immediately.
- Collect all relevant information to give to your indemnifier or any legal counsel provided by it. This should include the patient's (relevant) clinical notes and records. You should err on the side of including more, rather than less; make sure that you include relevant referral letters, reports to primary providers and similar.
- Prepare a draft report, cross-referenced as appropriate with the clinical notes and records.

Your report begins with a brief description of your medical qualifications and experience, and a description of relevant circumstances surrounding the case. This is where you should describe any extenuating circumstances, such as an unusually high workload, or other factors (for example the end of a period of night duty) which may be relevant to the care you were able to provide.

Otherwise, your report should be a factual narrative of what happened. It should be as objective as possible, with as little emotion or opinion as possible.

You should describe what you did and what you observed, usually in chronological order. While this may entail describing what others had done before you or were doing at the same time, generally you should refrain from commenting upon the involvement of others. You will also need to explain any significant elements or actions that aren't included in your clinical notes.

Finally, your report should address any questions specifically asked of you.

If you have indemnity cover, do not provide your report without first notifying your indemnifier and having the report reviewed. We are here to help you and have a wealth of experience with this type of inquiry.

NZMII are here to help!

Contact us if you have any questions about your medical indemnity cover:

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