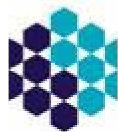
# Memorandum of Understanding.

*Investigating patient or client safety incidents*
*(Unexpected death or serious untoward harm):*



Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

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NORTHERN IRELAND
COURT
SERVICE

hseni
CONTROLLING RISK TOGETHER

***Promoting liaison and effective communications***
*between the Health and Personal Social Services,*
*Police Service of Northern Ireland, Coroners Service,*
*and the Health and Safety Executive for Northern Ireland.*

*February 2006*

## FOREWORD

The Department of Health, Social Services and Public Safety is committed to putting patient and client safety at the forefront of everyday practice. Patient and client safety incidents may involve failures by systems or individuals. Openness in reporting and investigating safety incidents will ensure that lessons are learnt for the future.

Patient and client safety incidents involving unexpected death or serious untoward harm and requiring investigation by the police, coroners and/or the Health and Safety Executive for Northern Ireland (HSENI) are rare. When such incidents happen they need to be handled correctly for the sake of public safety. Where the nature of an incident raises real questions about the possibility of criminal proceedings, the police and/or HSENI may be involved in the investigation. The coroner will investigate unexpected or unnatural deaths.

The threshold for a detailed investigation by the police or HSE is usually set at a high level. This means that their investigations should take place only where there is clear evidence or reasonable suspicion of a criminal offence having been committed.

In situations where the same incident is subject to investigation by a number of separate organisations, it is essential that there is clarity of roles and responsibilities, effective liaison and communication between all parties involved. This memorandum seeks to ensure effective arrangements are in place for incidents of this nature.

This memorandum is intended to help:

- prompt early decisions about the actions and investigation(s) thought to be necessary by all organisations and a dialogue about the implications of these;

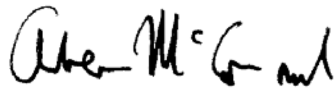
- provide an efficient and effective approach to the coordination of the investigation(s);

- save time and other resources of all the organisations concerned.

All guidance in this memorandum will defer to the overarching principle of the protection and preservation of life.

The memorandum is supported by other operational guidelines produced by the respective organisations.

We commend the memorandum to you.



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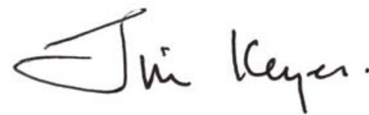

Jim Keyes

Chief Executive

Health and Safety Executive for
Northern Ireland

## INTRODUCTION

1. This memorandum has been agreed between the Department of Health Social Services and Public Safety (DHSSPS) on behalf of the Health and Personal Social Services (HPSS), the Police Service of Northern Ireland (PSNI), the NI Court Service (Coroners Service Branch) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from the HPSS in Northern Ireland.

2. For the purposes of this memorandum an HPSS patient or client is defined as: 'A person receiving health and/or personal social services under The Health and Personal Social Services (Northern Ireland) Order 1972'.

3. The memorandum focuses on investigation by DHSSPS[1], HPSS, PSNI, HSENI and Coroners in HPSS organisations. The principles and practices promoted in the document could be applied to other locations where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care commissioned by the HPSS. It sets out the general principles for the HPSS, police, coroners and HSENI to observe when liaising with one another.

4. The purpose of the memorandum is to promote effective working relationships between the organisations. The memorandum will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the police, coroners or HSENI separately or jointly. This may be the case when an incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

5. Other causes of patient or client death (such as industrial diseases) should be referred to the coroner (see Appendix 1). These would not require investigation of the HPSS organisation or its employees under this memorandum.

6. Similarly, some accidents to patients or clients are required to be reported to HSENI by HPSS organisations under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 (RIDDOR). HSENI will normally investigate all reportable fatal accidents under RIDDOR that '*arise out of or in connection with work',* but not accidents to patients that arise from medical treatment or diagnosis. (see Appendix 2)

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[1] DHSSPS Pharmacy Branch Inspection and Investigation Team have statutory responsibility under various legislative frameworks including the Medicines Act, Misuse of Drugs Act and Pharmacy Order.

**Roles and responsibilities of the organisations and other relevant bodies**

7. HPSS organisations, DHSSPS, the police, coroners and the HSENI have various roles and responsibilities in relation to investigating patient or client safety incidents in the HPSS. These are as follows:

8. HPSS organisations have a responsibility, among other things, to ensure the safety and well being of patients or clients and staff and to investigate when things go wrong. This responsibility is placed upon every HPSS Chief Executive as well as upon the Board of their organisation and is a critical component of corporate and clinical and social care governance. In discharging this responsibility, HPSS organisations must conform to national and local policies and procedures, and should ensure that the requirements of this memorandum operate effectively alongside procedures and protocols established or under development in the areas of child protection and the protection of vulnerable adults.

9. The police, who also have a duty to uphold public safety, may investigate all criminal offences and, in doing so, will seek to balance matters of public safety against the need to prosecute. The types of patient or client safety incident that should prompt an HPSS organisation at some stage to seek the involvement of the police are those that display 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, in a serious safety incident, including as a result of failure to follow safe practice or procedure or protocols.

10. HSENI is responsible for the enforcement of the Health and Safety at Work (Northern Ireland) Order 1978 (HSWO). It seeks to ensure that risks to people's health and safety from work activities are effectively controlled. Generally speaking, HSENI does not seek to apply the HSWO to matters of clinical judgement or to the level of provision of care. Although HSENI is responsible for enforcing work-related health and safety legislation in a large variety of settings including hospitals and nursing homes, District Councils have this responsibility where the main activity is the provision of permanent or temporary residential accommodation e.g. statutory residential homes and residential homes. If the HPSS organisation is unsure who to report work-related health and safety issues to, they should contact HSENI for advice.

11. Coroners have a responsibility under the Coroners Act (Northern Ireland) 1959 to investigate the cause and circumstances of deaths in cases reported to them that appear to be unexpected or unexplained, a result of violence, the result of an accident, a result of negligence, or a result of any cause other than natural illness or disease. Appendix 1 sets out guidelines on reporting deaths to the coroner.

12. Other organisations may also have a role in investigating patient or client safety incidents at local or national level. These include the HPSS Boards, HPSS Regulation and Improvement Authority (known as Regulation & Quality Improvement Authority), the Northern Ireland Adverse Incident Centre (NIAIC), and professional regulation bodies (see Appendix 3 for details).

**Co-ordination of investigatory activities**

13. In cases where more than one organisation may have an involvement in investigating any particular incident, **it is the responsibility of the HPSS organisation to report to each of these as is appropriate**. The criteria for reporting to each of these organisations under the Memorandum are contained in Appendix 3.

14. Where there may be more than one organisation involved in investigation of the incident, the HPSS organisation should make arrangements with all the relevant organisations to attend a Preliminary Meeting. The purpose of this meeting will be for a HPSS organisation representative to provide initial information on the circumstances of the incident so that the various parties can determine where responsibility for investigation lies. A contact will be established at senior management level in the HPSS organisation for liaison purposes to facilitate ongoing communications and liaison.

15. This Preliminary Meeting should be followed with a meeting of an Incident Co-ordination Group (ICG). The purpose of an ICG is to provide strategic oversight of a patient or client safety incident involving multiple investigations. It allows all organisations to set out their needs so that actions can be agreed that do not prejudice the work of each organisation e.g. legal proceedings, or the phasing, extent and timing of further HPSS investigations. Clearly, the information that may be shared will be constrained by the requirements of any criminal investigation and disclosure restrictions.

16. Where investigations are required by HSENI, it will be necessary to restrict membership of the ICG to preserve the independence and impartiality of any HSENI investigation. In such cases the HPSS organisation will not be a member of the ICG. When HSENI is not involved in the investigation of an incident, the ICG may include HPSS organisation membership at the discretion of the other organisations involved.

17. The purpose of the ICG is to provide strategic oversight of a patient or client safety incident involving the HPSS and the police, coroner and/or HSENI. It is a forum for communicating, exchanging information and coordinating multiple investigations.

18. Until the Preliminary Meeting, the HPSS organisation should continue to ensure patient or client safety, but not undertake any activity that might compromise any subsequent statutory investigations. If in doubt about this matter, the organisation should seek legal advice and consult as appropriate the police, coroner, the HSENI, DHSSPS Pharmacy Branch or other investigating bodies.

19. It is also critical that any relevant physical, scientific and documentary evidence is secured and preserved safely.

20. The police, coroner, HSENI or DHSSPS may also request a Preliminary Meeting in response to a complaint or in response to other concerns which would require investigation of an incident under the terms of this memorandum.

21. Those who attend on behalf of the organisations on the ICG should be sufficiently senior to take decisions concerning the management of the incident. They must also have sufficient skills, experience and training to deal with immediate concerns that may arise. Police representation should normally be at the level of Detective Chief Inspector or above. HSENI representation will normally be at Inspector level. HPSS management representation would normally be at director level, possibly supported by the appropriate senior professional.

22. The preliminary meeting of the organisations should consider matters under the following headings:

    - nature of the incident(s);
    - reasons for meeting, including an explanation from the organisation responsible for requesting the meeting;
    - summary of HPSS actions to date, including the outcome of any internal or external investigation or root cause analysis;
    - public safety concerns;
    - safety of HPSS systems and the need for continuity of patient or client care during any investigation;
    - the need for HPSS organisation to take remedial action;
    - needs of and support to patients, clients, relatives and HPSS staff;
    - information to other interested parties;

- need to inform DHSSPS;
- need to inform professional regulatory bodies; and
- need to inform other investigating bodies ( see Appendix 3);

- handling communications with patients, clients, relatives, carers, staff, other organisations and the media;

- composition of ICG; and

- future handling and coordination, including the appointment of a liaison officer from each organisation.

23. The ICG should then consider:

    - role and responsibilities of each organisation represented;

    - next steps to be taken (except where this would jeopardise any police/coroner/HSENI investigations or subsequent legal proceedings);

    - the extent of further, immediate HPSS investigations and how these may need to be constrained in subject matter or format by the needs and requirements of the police, the coroner and/or HSENI;

    - securing and preserving evidence; and

    - sharing information.

24. The precise nature of what is discussed at the Preliminary Meeting and by the ICG will be determined by local circumstances including the nature of the incident. However all the above issues should be considered even if some are covered in more detail than others.

**Responsibility for investigating**

25. Where possible, the statutory investigating bodies will come to an early view about the nature of the incident and where responsibility for any future investigation lies. For instance, the police and HSENI may conclude that they have no further role in the matter. On some occasions it may be decided that the HPSS organisation should investigate further and if more information or evidence comes to light convene another meeting of the ICG to discuss its findings. This will provide an opportunity for the police and/or HSENI to decide if they need to conduct their own investigation or if some other course is appropriate.

26. There will be occasions when the incident may raise important concerns about wider patient or client safety. In such circumstances, the conduct of any further HPSS investigations will need to be discussed by the ICG so that the necessary further investigation by the

HPSS can be conducted in such a way as 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.

27. Where more than one organisation is involved in investigating an incident primacy of investigations must be considered by the ICG.

**Documenting the Incident Coordination Group**

28. A written record of each meeting of the ICG should be made. This should set out matters discussed, decisions reached, and the actions agreed by each member. Where possible milestones should be agreed and further meetings of the ICG should be scheduled to correspond with these. The HPSS organisation normally has responsibility for preparing the written record and for circulating it to the other members. If the HPSS organisation has been excluded from the ICG due to the nature of the investigation, the ICG must agree a secretariat. It is important that these meetings take place so as to ensure that all agencies remain up to date with one another's actions and so communications with other parties remain consistent.

**Securing and preserving evidence**

29. It is easy in the immediate aftermath of a patient or client safety incident to overlook the need to secure and preserve evidence. This may be particularly true of busy clinical areas that are in constant use by patients, clients and staff and when people are following routine operational practice within their organisation e.g. sterilising a piece of equipment after a procedure or operation.

30. However the safeguarding of physical, scientific and documentary evidence may be critical to understanding what has happened and thereby protecting public safety and the conduct of a satisfactory investigation by any agency. Destruction of evidence may also delay putting safety measures in place. It may also lead to a more protracted and complex investigation than would otherwise have been necessary. For example, the absence of the product, instructions for use, packaging and batch number or other means of identification of a piece of equipment may lead to a delay in effectively investigating an adverse incident or issuing an alert to the HPSS.

31. Where a criminal offence is suspected then it is especially important that evidence is retained since failure to do so may mean that legal proceedings are undermined.

32. Even in those incidents where concerns arise long after the event it is important to make every effort to secure and preserve all available evidence.

33. A record must also be kept and receipts obtained wherever possible of any HPSS documents, records or any other items passed to other agencies.

### Sharing information

34. There will be a need for organisations in the ICG to share information for the purposes of co-ordinating multiple investigations and for reasons of public safety. Subject to legal requirements and safety concerns, there are a number of factors to bear in mind when making judgements about information sharing. These include:

    - the nature and degree of risk associated with the incident itself and the circumstances and individuals involved;
    - the purpose for which any shared information is to be used and by whom;
    - whether consent to disclosure is necessary, and if so whether it can be obtained;
    - the justification for any necessary breach of patient or client confidentiality;
    - current law and guidance e.g. the statutory requirement to provide information to the HSENI and the obligations put upon different professionals by their individual codes of conduct;
    - confidentiality agreements with those with whom information is shared.

35. Information sharing is an important matter for the ICG to consider. Where necessary, legal or other specialist advice should be sought where necessary.

### Supporting patients, clients, relatives, HPSS staff and those injured

36. In the event of a patient or client safety incident it is important that the HPSS, police, coroner and/or HSENI work together to keep patients, clients, relatives, HPSS staff and injured parties informed. The organisations should therefore, as far as possible, agree and follow a liaison strategy for each incident. Such a strategy should be agreed at the first meeting of the ICG and reviewed as necessary at subsequent meetings

### Handling communications

37. A communications strategy needs to be agreed for dealing with patients, clients, relatives, other organisations and the media. Where possible, the organisations need to take a common approach to

communications although in the event of legal proceedings this may not be practicable. Specialist help and advice should be sought as necessary.

## Review

38. This memorandum will be subject to regular review.

## ACKNOWLEDGEMENTS

The Northern Ireland Working Group (see Appendix 6 for membership) is very grateful for support received from the National Development Group who have consulted on a similar Memorandum of Understanding between the National Health Service, Association of Chief Police Officers and Health & Safety Executive in England and Wales, upon which this Memorandum of Understanding is based.

The working group is very grateful to those individuals and organisations that helped with the development of this memorandum and the associated guidelines.

## APPENDIX 1

## REPORTING DEATHS TO THE CORONER

There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 1959 that any death ***must*** 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 of death.

The duty to report arises if the medical practitioner has *reason to believe* that the deceased died *directly or indirectly:*

- as a result of violence, misadventure or by unfair means;
- as a result of negligence, misconduct or malpractice;
- from any cause other than natural illness or disease;
- from natural illness or disease for which the deceased had not been seen and treated by a registered medical practitioner within 28 days of death;
- death as the result of the administration of an anaesthetic; and
- in any circumstances that require investigation.

***All medical practitioners are under a statutory duty to report such deaths.***

In essence this means a requirement to report:

- All deaths from unnatural causes. ***It is the underlying cause that determines the need to report rather than the terminal event eg bronchopneumonia due to immobilisation due to a fractured neck of femur.*** For example, homicidal deaths; deaths following assault, road traffic accidents or accidents at work; deaths associated with the misuse of drugs (whether accidental or deliberate); any apparently suicidal death; deaths from the effects of hypothermia or where a medical mishap is alleged ***should always be reported.***
- Any death from natural illness or disease if the deceased has not been seen and treated by a medical practitioner within 28 days of death.
- All deaths from industrial diseases e.g. asbestosis. (It is advisable to ascertain the deceased's employment history before writing a death certificate as a means of ruling out any possible industrial link – a medical history of chest disease or mesothelioma in someone who had been employed *at any time* as a shipyard worker would raise the possibility of asbestos exposure.)

- All deaths on the operating table or under an anaesthetic. *NB There is no statutory requirement to report a death occurring within 24 hours of admission to hospital or of an operation – though it may be prudent to do so.* (Deaths which follow an operation necessitated by trauma should be reported to the coroner, but deaths which follow an operation necessitated by a natural illness need not be reported unless death took place before recovery from the anaesthetic.)

- The death of a patient or client who had an accident in the health or social care environment (e.g. a fall in the ward).

- The death of a patient or client where there is an allegation of negligence or of a medical or nursing mishap.

- The death of a patient in the course of, or following, any clinical procedure even where the possibility of death occurring was a recognised risk of the procedure.

## APPENDIX 2

## RIDDOR

### Reporting of Injuries, Diseases and Dangerous Occurrences (Northern Ireland) Regulations 1997

In determining if a patient or client safety incident requires to be reported under RIDDOR the following should be considered;

The phrase 'arising out of or in connection with work' is a key component in defining where the requirement to report a patient or client death or injury under Regulation 3 (1) of RIDDOR applies.

Regulation 2(2) of RIDDOR directs that an accident due to any of the following must be regarded as 'arising out of or in connection with work':

- 'The manner of conducting an undertaking'

  This refers to the way in which any work activity is being carried out for the purposes of an undertaking, including how it is organised, supervised or performed by an employer or any of their employees, or by a self-employed person;

- 'The plant or substances used for the purposes of the undertaking'

  This includes, for example: lifts; air conditioning plant; any machinery, equipment or appliance; gas installations; and substances used in connection with the premises or with processes carried on there;

- 'The condition of the premises used by the undertaking or of any part of them'.

  This includes the state of the structure or fabric of a building or outside area forming part of the premises and the state and design of floors, paving, stairs, lighting etc.

**Cases where the death or injury of the patient has arisen from medical treatment or diagnosis**

If a patient is injured as a result of an accident arising directly from the conduct of the specified medical procedure being carried out by or under the supervision of a registered practitioner or dentist, it is not reportable under RIDDOR. Although HSENI may not be involved in incidents of this nature, other Bodies may have an involvement.

Further guidance is contained in "*A Guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997*"

## APPENDIX 3

## REPORTING REQUIREMENTS ON HPSS ORGANISATIONS UNDER THE MEMORANDUM

*Note: the following arrangements are in addition to the normal statutory reporting to HSENI*

Consider if the incident requires involvement of each of the following organisations;

**PSNI**:
Any incident which displays one or more of the following characteristics:

- evidence or suspicion that the actions leading to harm were intended
- evidence or suspicion that the adverse consequences were intended
- evidence or suspicion of gross negligence and /or recklessness, in a serious safety incident, usually as a result of failure to follow safe practice or agreed protocols.

**Coroner**:
Any death **must** 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 of death. Appendix 1 provides fuller details.

**HSENI:**
Any work related death of a patient or client;
The death of a patient or client which has resulted from an accident arising out of or in connection with work that is reportable under RIDDOR. This does not include *accidents to patients that arise directly from medical treatment or diagnosis.* Appendix 2 provides further detail.

**DHSSPS:**
**Pharmacy Branch**
DHSSPS Pharmacy Branch Inspection and Investigation Team have statutory responsibility under various legislative frameworks including the Medicines Act, Misuse of Drugs Act and Pharmacy Order. These are centred particularly on the areas of misuse, diversion, illegal production and supply and inappropriate storage and record keeping as pertains to medicinal products including controlled drugs.

**Quality and Performance Improvement Unit**
Any incidents regarded as serious enough to warrant regional action, are likely to be of public concern or are likely to require an independent review. Further detail is contained in Circulars HSS (PPM) 06/04 and HSS (PPM) 05/05

**Social Services Inspectorate/Child Care Policy Directorate**
Child deaths, including suicides, where abuse or neglect is a known or suspected factor, must be reported as set out in *Co-operating to Safeguard Children*. Also, significant incidents, including death or serious adverse events, in relation to children who are being looked after by a Trust or Authority.

**Northern Ireland Adverse Incident Centre (NIAIC) Health Estates Agency**:
Any incidents relating to medical devices, non-medical equipment, plant and building items must be reported to the NIAIC. Guidance for reporting adverse incidents is contained in the NIAIC Medical Device/Equipment Alerts MDEA (NI) 2005/01.

**HSS Boards**:
HSS Trusts must report serious incidents to the relevant Board in line with local policy.

**Regulation and Quality Improvement Authority**:
All deaths and serious incidents occurring in Residential Care Homes, Nursing Homes and Children's Homes (including Statutory Homes) in accordance with:-
Regulation 30 of the Residential Care Homes Regulations (NI) 2005
Regulation 30 of the Nursing Homes Regulations (NI) 2005
Regulation 29 of the Children's Homes Regulations (NI) 2005

**Mental Health Commission**:
All untoward events relating to people suffering from a mental disorder, including death, attempted suicide, alleged assault or sexual assault. Further details are contained in letter S56/2004 issued to Chief Executives or Boards and Trusts in August 2005.

**District Councils**:
Work related death of a resident or client where the main activity at the premises is the provision of permanent or temporary residential accommodation, for example a statutory residential home.

**Professional Regulatory Bodies:**

**General Chiropractic Council**
If there are concerns due to the behaviour of a chiropractor.

**General Dental Council**
If there are concerns due to the behaviour of a dentist, dental hygienist or dental therapist.

**General Medical Council**
If there are concerns due to the behaviour of a doctor.

**General Optical Council**
If there are concerns due to the behaviour or health of dispensing opticians and optometrists.

**General Osteopathic Council**
If there are concerns due to the behaviour of an osteopath.

**Health Professions Council**
If there are concerns due to the behaviour of health professionals regulated by the HPC. The HPC regulates 13 professions in the UK: Art therapists, Biomedical scientists, Chiropodists/Podiatrists, Clinical scientists, Dietitians, Occupational therapists, Operating department practitioners, Orthoptists, Paramedics, Physiotherapists, Prosthetists / Orthotists, Radiographers, Speech & language therapists.

**Northern Ireland Social Care Council**
If there are concerns due to the behaviour of social workers and social care staff.

**Nursing and Midwifery Council**
If there are concerns due to the behaviour of a nurse, midwife or health visitor.

**Pharmaceutical Society of Northern Ireland**
If there are concerns due to the behaviour of a pharmacist.

## APPENDIX 4

## CONTACTING RELEVANT ORGANISATIONS

**PSNI**
Crime Operations
Headquarters, Brooklyn
65 Knock Road
Belfast BT5 6LE
Tel: 028 9065 02 22 ext 21347
Out of Hours Tel: 028 9090 1334 ask for Call Out Senior Investigating Officer

**Coroner**
Coroners Office
The Courthouse
80 Victoria Street
Belfast BT1 3GL
Tel: 028 9072 8202
Fax: 028 9072 4559

**HSENI**
Health and Safety Executive for Northern Ireland
83 Ladas Drive
Belfast BT6 9FR
Tel: 028 9024 3249
Fax: 028 9023 5383

**DHSSPS – Pharmacy Branch**
Inspection and Investigation Team
Castle Buildings, Stormont
Belfast BT4 3SQ
Tel: 028 9052 2094
E-Mail: martin.mcilveen@dhsspsni.gov.uk.

**DHSSPS - Quality and Performance Improvement Unit**
Castle Buildings, Stormont
Belfast BT4 3SQ
Fax: 028 90528126
E-Mail: adverse.incidents@dhsspsni.gov.uk.

**DHSSPS - Child Care Policy Directorate**
Castle Buildings, Stormont
Belfast BT4 3SQ
Tel: 028 9052 0416
Fax: 028 9052 2500

**Northern Ireland Adverse Incident Centre (NIAIC)**
Health Estates
Estate Policy Directorate
Stoney Road
Dundonald
Belfast BT16 1US
Tel: 028 9052 3704
Fax: 028 9052 3900
Web: www.dhsspsni.gov.uk/niaic

**Regulation and Quality Improvement Authority**
20 Adelaide Street
Belfast BT2 8GD
Tel: 028 9072 6018
Fax: 028 9051 7235
E-mail: info@hpssria.org.uk

**Mental Health Commission for Northern Ireland**
Elizabeth House
118 Holywood Road
Belfast BT4 1NY
Tel: 028 9065 1157.
Fax: 028 9047 1180.

**Health and Social Services Boards**

**Eastern Health & Social Services Board**
Champion House
12-22 Linenhall Street
Belfast BT2 8BS
Tel: 028 9032 1313
Fax: 028 9055 3680

**Northern Health & Social Services Board**
182 Galgorm Road
Ballymena BT42 1QB
Tel: 028 2565 3333
Fax: 028 2566 2311

**Southern Health & Social Services Board**
Tower Hill
Armagh BT61 9DR
Tel: 028 3741 0041
Fax: 028 3741 4550

**Western Health & Social Services Board**
15 Gransha Park
Clooney Road
Londonderry BT47 6FN
Tel: 028 7186 0086
Fax: 028 7186 0311

## Professional Regulatory Bodies

**General Chiropractic Council**
44 Wicklow Street
London WC1X 9HL
Tel: 020 7713 5155
Fax: 020 7713 5844
E-mail: regulation@gcc-uk.org

**General Dental Council**
37 Wimpole Street
London W1G 8DQ
Tel: 020 7887 3800
Fax: 020 7224 3294
E-mail: complaints@gdc-uk.org

**General Medical Council**
Regent's Place
350 Euston Road
London NW1 3JN
Tel: 0845 357 0022
E-mail: practise@gmc-uk.org

**The General Optical Council**
41 Harley Street
London W1G 8DJ
Tel: 020 7580 3898
Fax: 020 7436 3525
E-mail: goc@optical.org

**General Osteopathic Council**
176 Tower Bridge Road
London SE1 3LU
Tel: 0207 357 6655
Fax: 0207 357 0011
E-mail: info@osteopathy.org.uk

**Health Professions Council**
Park House
184 Kennington Park Road
London SE11 4BU
Tel: 020 7840 9814
Fax: 020 7582 4874

**Northern Ireland Social Care Council**
7th Floor, Millennium House
19-25 Great Victoria Street
Belfast BT2 7AQ
Tel: 028 9041 7600
Fax: 028 9041 7601
Textphone: 02890 239340
E-mail: info@niscc.n-i.nhs.uk

**Nursing and Midwifery Council**
23 Portland Place
London W1B 1PZ
Tel: 020 7333 6564
E-mail: fitness.to.practise@nmc-uk.org

**Pharmaceutical Society of Northern Ireland**
73 University Street
Belfast BT7 1HL
Fax: 028 90439919
E-mail: chief.executive@psni.org.uk

**APPENDIX 5**
**Other, related documents**
More information can be found in the following publications or via the following web sites.

*Seven steps to patient safety – a guide for NHS staff* SSG/2003/01 The National Patient Safety Agency

*Decision making tool to reduce unnecessary suspensions and support a safety culture* – The National Patient Safety Agency
www.npsa.NHS.uk/idt

*Maintaining high professional standards in a modern HPSS: A framework for the handling of concerns about doctors and dentists in the HPSS*
*The Protection and Use of Patient and Client Information*. DHSSPS 1999

*Confidentiality: Protecting and Providing Information*. General Medical Council 2004

*Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults*. DHSSPS & PSNI 2003

*Co-operating to Safeguard Children*. DHSSPS 2003
http://www.dhsspsni.gov.uk/publications/2003/safeguard/safeguard.asp

*Choosing to Protect - A Guide to Using The Protection of Children, Northern Ireland [POC (NI)] Service.* DHSSPS 2005
http://www.dhsspsni.gov.uk/foi/Prof_advice.asp

*Choosing to Protect - A Guide to Using The Protection of Vulnerable Adults, Northern Ireland [POVA (NI)] Service.* DHSSPS 2005
http://www.dhsspsni.gov.uk/foi/Prof_advice.asp

*Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – NI September 2004*

*Investigation of Work-Related Deaths- Northern Ireland Agreement for Liaison.* (Draft guidance on criminal investigations into deaths at work)

*A Guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland)* 1997 ISBN 0 337 11259 2

## WEBSITES

National Patient Safety Agency
www.npsa.nhs.uk

DHSSPSNI
www.dhsspsni.gov.uk

HSENI
www.hseni.gov.uk

## APPENDIX 6

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