HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

HEALTHCARE SAFETY INVESTIGATION BRANCH
HSIB, A1
Cody Technology Park
Farnborough
Hampshire
GU14 0LX

3rd June 2020

Sent by email to:
Andrew Fyles
andrewfyles@anesthetists.org

Dear Andrew,

Thank you for your letter of 30 April 2020 concerning the investigation of the deaths of clinical staff from COVID-19 by the Healthcare Safety Investigations Branch (HSIB) and my apologies for the time taken to respond. I have been working with the Department of Health and Social Care to work out how best to use the investigation resources available.

The Health and Safety Executive (HSE) is the national independent regulator for health and safety in the workplace and its role includes investigating work-related risks. Any responsible person as defined by RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013), including NHS and social care providers as employers, are required to report an occupational exposure to a biological agent to HSE in accordance with the RIDDOR. The HSE has published guidance relating to cases of, or deaths from, COVID-19 at https://www.hse.gov.uk/news/riddor-reporting-coronavirus.htm.

The Department of Health and Social Care has also confirmed that the current non-statutory system of medical examiners will scrutinise the deaths of health and social care workers from COVID-19 and there will be a process of notifying the employer of the deceased staff member if there is reason to suspect that a staff fatality was due to the coronavirus infection acquired in the course of employment. It is for the employer to make any onward referral to the HSE in accordance with RIDDOR. Given these arrangements and the statutory independent role for HSE, these investigations will take priority.

You may also be aware that there are some instances in which a COVID-19 death may be reported to the coroner, such as where the virus may have been contracted in the workplace setting. This may include frontline NHS staff. The Chief Coroner has published guidance on COVID-19 deaths and possible exposure in the workplace (Chief Coroner's Guidance No. 37).

HSIB investigations focus on systemic themes and we will scrutinise information from the HSE, Medical Examiner and Coroners' work against our usual investigation criteria. If thematic risks affecting patient safety begin to emerge, we will consider launching specific investigations into those risks.

In the meantime, you may be specifically interested to know that although we have paused publication of some reports, we have been continuing themed investigation work on Covid-19 related maternal deaths, placement of NG tubes and diagnosis of pulmonary embolism in inpatients.

If there are other areas that you wish to refer us as possible investigation reference activities, these are always gratefully received.

Your sincerely

Keith Conradi
Chief Investigator