Attorney General
for Northern Ireland

Mr Alastair Ross MLA
Chairman
Committee for Justice
Parliament Buildings
Stormont
BT4 3XX

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Dear Chairman

Justice Committee meeting 4 February 2015

Thank you for your invitation to speak to the Committee on 4 February. On the matter of the proposed amendment to establish a clear basis upon which I can obtain information to assist in the exercise of my function in relation to inquests (on which the Committee has heard from both the Health and Social Care Board and the DHSSPS in recent weeks) I thought it might be helpful, in advance of the meeting, if I commented on some of the key points raised. I will also respond in this letter to the issues highlighted in the responses to the preliminary discussion paper on extension of rights of audience to lawyers in this office. While I understand that you wish to explore aspects of the Bill and the other proposed amendments, what follows addresses only the two issues noted above. I will, of course, be very happy to assist you on any matter arising from the Bill on Wednesday.

Proposed amendment to the Coroners Act (NI) 1959

An inquest is designed in our legal system to be a transparent and accessible way of discovering how death has occurred. It has much in common, in that regard, with the serious adverse incident process. As a

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coroner cannot offer any opinion on questions of civil or criminal liability, it is important therefore not to equate the disclosure of information to the Attorney General necessarily as a step towards apportioning blame or determining culpability. If information points towards culpability, particularly criminal culpability, then no one should shrink from acting on that information but I see the proposed amendment primarily as a tool to increase transparent and public knowledge. Here I am conscious of what was said recently by Sir Liam Donaldson in his report on the quality of care in Northern Ireland when he referred to the 'overwhelming evidence that a climate of fear and retribution will cause deaths not prevent them' [p27]

The Donaldson report is of relevance in many ways. While noting that the phenomenon is not particular to Northern Ireland, his view is that,
'patients are dying and suffering injuries and disabilities from poorly designed and executed care on a scale that would be totally unacceptable in any other high risk industry' [p.33].

The proposed amendment seeks to ensure that one of the safeguards in place, the Attorney General's power to direct an inquest, can be improved. We are, rightly, more concerned now with statutory authority for disclosure of information than we might have been in 1959. A clear statutory basis for the processing of relevant information does not alter the scope of the power to direct but it does place the gathering of the relevant information on a firm statutory footing.

I note that the Donaldson report picks up on the role that families can play when a death occurs:

> 'the judgments of clinicians and coroners' officers alike have a substantial bearing on which cases proceed to inquest. The subset of cases that end up in front of a coroner's inquest are also determined as much by family's wishes as by the content of the cases.' [p29]

You will remember that I highlighted my concern about how we learn from deaths when the deceased did not have surviving friends or family. Self evidently those who die without interested friends or family may not have concerns, including well founded concerns, expressed on their behalf. The proposed amendment could help close this public safety gap.

Contrary to the misapprehension of the Board, the statutory power to direct an inquest is not limited to cases on which a coroner has already been informed of the death or has made a decision about whether or not to hold an inquest. My function is not limited to reviewing the decisions of a coroner or enabling a fresh inquest where new evidence comes to light. I am able to direct an inquest where there has been a decision not to notify the coroner. A coroner, in contrast, has no statutory power to 'call in' a death where the death is not referred to him. He will, of course, become involved if I make a direction and any material which is made available to me, is, in turn, made available by me to the coroner.

It can be seen, therefore, that it would not be sufficient to rely, as the Board suggests, on a request from me to the coroner to share the documents received by him in order to inform my decision on whether or not to direct. This suggestion does not (1) cover those cases which are not referred to the coroner and (2) does not, more generally, deal with the absence of any legal requirement on the coroner to share material with me.

I appreciate that the criminal law by section 10 (1) of the Coroners Act (NI) 1959 imposes a sanction for failure to comply with the section 7 obligation to report certain deaths to the coroner and that the duty to refer has been brought to the attention of practitioners. Nevertheless, the impetus still remains with those closely associated with the circumstances of the potential malpractice or negligence. I am pleased that the 'look back study' commissioned by the former Minister to review emergency department serious adverse incidents revealed that deaths were being referred to the coroner in line with the statutory duty. I do maintain however that there will be, hopefully isolated, cases which are neither recorded as serious adverse

incidents nor referred to the coroner. If a death in such circumstances is drawn to my attention, I need to be able to access information in order to carry out my statutory function in the public interest.

Perhaps paradoxically, the Board suggests that I may be able to direct an inquest without obtaining information. While it is true that the threshold of advisability is low, it would not be right to burden the coronial system with unnecessary inquests. If an independent Attorney General decides, and explains, why he has not directed an inquest, family members and other interested parties will have the reassurance that the decision took place on a properly informed basis – provided I am able to access relevant material. A decision of this nature is of benefit to family members, clinicians and the much-burdened coronial system.

In terms of the scope of relevant material, the Committee heard evidence from the Board that even with this proposed amendment it would not consider a Trust to be under an obligation to disclose to the Attorney General an expert report similar to that produced by Dr Warde at the time of the inquest into the death of Raychel Ferguson. I understand that the coroner considered that the report should have been disclosed to him. If, as I believe, the coroner was correct in that view then such a report would fall within the terms of the proposed amendment. Indeed, even if the Trust was not bound to disclose it, the report would still come within the terms of the amendment unless protected by legal professional privilege. In general terms, if a report is prepared for legal proceedings then it would, quite properly, fall outside the proposed amendment.

Rights of audience

Extending rights of audience to the small number of lawyers in my office would represent increased value for money, while preserving and, on occasion enhancing quality, without risk to the independent Bar. The lawyers who assist me are familiar with the legal issues in advance of a case coming to court. It makes no economic sense to have them instruct junior

counsel to spend additional time reading papers and attending court when the real expertise may already be being paid for through lawyers in this office. In short, public funds would be much better spent if the role of junior counsel is undertaken in appropriate cases by my employed legal staff who are fully familiar with the issues rather than by external counsel at greater public expense. In advance of the law society regulations being drafted, which would also confer rights generally on employed barristers – albeit indirectly, there would be no harm in rights of audience being extended to a small group of public sector lawyers pending the implementation of the broader change contemplated by the Justice (Northern Ireland) Act 2011.

The working environment in my office is distinct from that elsewhere in government and public sector legal services. In this office lawyers are working on a daily and intensive basis with the senior Law Officer of this jurisdiction who has personal responsibility for the quality of the work produced. In addition to the personal supervision which the scale and nature of this office permits, there is an underpinning of statutory independence which is simply not present in the Departmental Solicitor's Office, the Crown Solicitor's Office or the Directorate of Legal Services.

Yours sincerely

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