

Mr Alastair Ross MLA Chairman Committee for Justice Room 242 Parliament Buildings Stormont Estate Ballymiscaw Belfast BT4 3XX

Our Ref: 18/01/14/032 &

18/05/13/012

23 December 2014

Dear Chairman

Justice Bill 2014 – Proposed amendment to the Coroners Act (Northern Ireland) 1959.

You will be aware that by letter dated 5 March 2014, during the passage of the Legal Aid and Coroners Bill, I asked the Committee to give consideration to a potential amendment to the Coroners Act (Northern Ireland) 1959 ('1959 Act') which I considered would of material benefit to the public. My letter of 16 September 2014 to Ms Darrah contains the proposed text of the amendment. The Committee is currently considering this amendment in the context of the Justice Bill and I am grateful to the Committee for its continued interest in this matter.

Under section 14(1) of the 1959 Act I can direct a coroner to hold an inquest where I consider it is 'advisable' to do so. I do not possess a statutory power to obtain papers or information that may be relevant to the exercise of this power. In recent years I have had some difficulty in securing access to documents from Health and Social Care Trusts ('HSC Trust'), such as Serious Adverse Incident ('SAI') report forms which I have considered relevant to the proper exercise of my

discretion. In two recent, and high profile, incidents I was able to secure documents relating to delay in treatment in the Royal Victoria Hospital Emergency Department and concerning the deaths of a number of babies and adults in Causeway and Antrim Hospitals. In a number of these cases medical practitioners had not reported the deaths to a coroner. These two cases caused me very real concern and strengthened my view that a power to obtain relevant material is crucial to the public interest in ensuring a high standard of healthcare and investigation of incidents that result in the death of a patient.

In June 2014 I was made aware that a death had occurred during February 2014 in the Urology Department of the Belfast City Hospital. This death had occurred as a result of a cystectomy and, although the coroner was informed and an Incident Reporting (TR') form had been completed, the death had not warranted a Serious Adverse Incident inquiry, despite this death being the first death within 30 days following cystectomy in the Urology Department in over ten years.

On 7 July 2014, for the purpose of deciding whether to exercise my discretion under section 14(1) of the 1959 Act to direct a coroner to hold an inquest, I corresponded with the relevant HSC Trust and requested details on this death to include the IR form, materials relating to internal HSC Trust investigations and specific details of any involvement of the Coroners Service and details of the information that was provided to the coroner. It would, you will agree, be a matter of concern if the coroner was given an incomplete picture about such a serious matter.

After some delay my colleague received a letter, a copy of which is enclosed, from the Chief Legal Adviser to the Trust questioning the legal basis for obtaining this information. The Committee may well think, as I do, that this response further emphasises the need for an amendment dealing with this issue.

ym since

John F Larkin QC

Attorney General for Northern Ireland

By E Mail Only

Mr Joseph McCrisken BL Principal Legal Office Office of the Attorney General for NI

Date:

Our Ref:

Your ref:

23 December 2014

CNG B101/17

18/01/14/032

Dear Sir

REPORTED DEATH FROM CYSTECTOMY SURGERY

I refer to the above matter and to an email from Julian Johnston, Belfast Health and Social Care Trust dated 27th November 2014.

The Trust has instructed me to write to you. I understand you are seeking access to certain Trust documents relating to the Serious Adverse Investigation. I should be grateful if you would provide me with your legal authority for accessing same.

I await hearing from you.

Yours faithfully

ALPHY MAGINNESS Chief Legal Adviser

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jjohnson