Northern Ireland Assembly

Committee for Justice

OFFICIAL REPORT (Hansard)

Justice Bill: Health and Social Care Board

21 January 2015

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Alastair Ross (Chairperson)
Mr Raymond McCartney (Deputy Chairperson)
Mr Sammy Douglas
Mr Tom Elliott
Mr Paul Frew
Mr Seán Lynch
Mr Alban Maginness
Mr Patsy McGlone

Witnesses:

Ms Anne Kane	Health and Social Care Board
Mr Alphy Maginness	Health and Social Care Board
Mrs Fionnuala McAndrew	Health and Social Care Board

The Chairperson (Mr Ross): I welcome Fionnuala McAndrew, director of social care and children, Alphy Maginness, director of legal services, and Anne Kane, governance manager of the Health and Social Care Board (HSCB). You will be aware that the meeting is being reported by Hansard and will be on the Committee website in due course. When you are ready, if you would like to brief us on your views, we will then open it up to members for questioning.

Mrs Fionnuala McAndrew (Health and Social Care Board): Thank you, Chair. I will make a short presentation to draw the Committee's attention to some of the issues that we have raised in our response. The Health and Social Care Board welcomes the opportunity to speak to the Committee on this important matter.

At the outset, I would like to commend the Committee for Justice and the Department of Justice for taking forward a number of initiatives that have directly benefited vulnerable children and adults in contact with the criminal justice system, many of whom are known to health and social services. The board has worked closely with the Department of Justice to deliver those and other improvements, which illustrates the value of collaborative working between criminal justice and health and social care systems, from the highest level to front-line services.

I would like to make the following points about the proposals being considered by the Committee today. We support some of the proposals unanimously. Many of them have the potential to be of significant benefit to vulnerable witnesses and victims of crime. I make specific reference to the proposals for sharing victim and witness information under Part 4 to provide a more effective mechanism through which victims can automatically be provided with timely information about the services available to them. The proposal contained in Part 5 in relation to the exchange of information

is a small but important additional safeguard for vulnerable groups — children and adults — and should assist in ensuring that appropriate persons are unable to get work with such groups of individuals.

However, as you know from our submission, there is a proposal that the Health and Social Care Board has expressed some concerns about. I think that we set that out well in our response, but I would like to draw the Committee's attention to a couple of issues that we have articulated in that response.

First, there is a robust argument that the current legislation provides a wide degree of discretion and a low threshold for action by the Attorney General where a decision by the coroner has been made not to hold an inquest, an inquest has been held but was deficient, or fresh evidence has become available. In our view, the Attorney General is already able to request all relevant documentation obtained by the coroner during his or her investigations into the deaths, and could review that documentation. In summary, we contend that the present system is sufficiently robust to ensure that the interests of justice are properly served and there is therefore no need for the proposed amendment.

The Attorney General's correspondence to the Committee dated 5 March makes specific reference to securing access to documents such as serious adverse incident (SAI) reports. That amendment would allow the Attorney General to require any person who has provided health or social care to a deceased person to produce any document or give any other information that, in the opinion of the Attorney General, may be relevant to the question of whether a direction to hold an inquest should be given by the Attorney General. It is our contention that the relevant documentation will already have been provided to the coroner and will have been used by him or her to inform the decision to hold or not hold an inquest. Again, we respectfully suggest that that amendment is unnecessary.

As I mentioned, the correspondence refers to some difficulty in accessing serious adverse incident reports in the past that he considered would assist him in determining whether a direction to hold an inquest should be made. That appears to us to reflect a common misunderstanding of the purpose of serious adverse incident analysis and reporting. The serious adverse incident process is primarily a service improvement process that seeks to identify and learn lessons for practice and organisations. It should not be seen as a vehicle for apportioning blame or determining culpability. That is a matter for other processes to determine as appropriate. The success of serious adverse incident reporting and investigation depends on the preparedness of staff to engage in the process in an open and transparent manner. This openness in reporting is positively encouraged in return for an assurance about the nature of any such report and how it will be used.

I have already referred to the fact that this information is already made available to the coroner, if necessary, through the High Court. The proposal from the Attorney General seems, to us, to seek that a system established to promote reflection, service evaluation and learning be used for a different purpose. In our view, it is likely, therefore, that the amendment will result in the unintended consequence of increasing staff reluctance to engage in this process. In addition, it is our experience that families who are already distressed about the loss of a loved one need a lot of support at that time, in both coming to terms with their loss and understanding the SAI process, why it is being initiated and their involvement. It is our concern that additional advice to them of the Attorney General's intervention is likely to compound that distress. Finally, I draw the Committee's attention to the fact that both the Department of Health, Social Services and Public Safety and the board have issued correspondence to trusts in relation to the legal requirement to report deaths to the coroner under section 7 of the Coroners Act. There is explicit reference to this requirement in our documentation.

I ask the Committee to understand that the HSCB welcomes the majority of the amendments proposed, but asks the Committee to give further consideration to the proposals suggested by the Attorney General.

The Chairperson (Mr Ross): Thank you very much. I have a couple of questions before I open it up to other members. The South Eastern Health and Social Care Trust has said that it does not have an objection to the proposed amendment and that it would provide a clear statutory basis for the disclosure of papers and assist the trust to be clear about what documentation could be released to the Attorney General. We have a letter from Mr Alphy Maginness in which you were asking on what authority the Attorney General was requesting certain papers. Would the amendment not be helpful in clarifying that, given that that is exactly what you are asking for in that letter of 23 December?

Mrs McAndrew: I will make an initial response and then ask Mr Maginness to come in. I have had access to the trusts' responses and the Department of Health's response. The South Eastern Trust response comes from a position of it having been asked for papers in the past and there being a lack of clarity about what exactly is being requested and how that might be used. When we reflect on the whole health and social care system's response, we are concerned about duplication and the impact on clinicians and families. If the amendment were to proceed, there would be an absolute need for more clarity about what its implications might be. I will ask Alphy to make a response.

Mr Alphy Maginness (Health and Social Care Board): Chairman, my letter posed this question: what is the legal authority for access? That is a perfectly legitimate question to ask in the circumstances. The law is quite clear. In fact, a response to that letter, which I do not think that you have, confirmed the Attorney General's Office's view that it did not have legal authority to access the documents. Nevertheless, the safeguards are already in place, as Fionnuala has pointed out.

In that circumstance, the request was in relation to an issue that had been brought to the Attorney General's attention by a third party. I do not know the circumstances of how it was brought to it, but I do know that, in that particular case, the trust had made a determination that there was nothing untoward in respect of the death of the individual. The death had, in fact, been reported to the coroner. The coroner concurred with that view and, as recently as today — I saw correspondence literally just before I came in the door — one of the more senior medical officers of the trust met the coroner's medical adviser, and she agreed completely with the trust's view that there was nothing untoward in respect of that death and that the coroner would not be changing his original decision; namely, not to hold an inquest. That case actually is a very good example of where this could go. There would be these nugatory exercises to determine whether there was anything untoward. An original decision has already been made by senior trust staff on the one hand, and then a third party interferes and says to the Attorney General, "You should question this further."

The role of the coroner is very expressly set out in the Coroners Act. If the coroner makes the decision, quite rightly that decision is subject to review by the Attorney General; no one is suggesting otherwise. Those are proper circumstances for the Attorney General to intervene. However, if it is without justification, that leaves it open to — abuse is too strong a term perhaps, but unnecessary duplication of effort and unnecessary waste of resources in the already difficult financial circumstance that we have. It will increase unnecessarily the administrative burden on trusts and medical staff.

The Chairperson (Mr Ross): I understand that you believe that it is unnecessary and would have unintended consequences. We need to be mindful of that in any legislation that we pass. If the power were to be given to the Attorney General, as is proposed, in your view, would it be helpful if an application to the High Court had to be made to exercise such discretion and call for evidence? A number of stakeholders have suggested that. Have you any view on that?

Mr Alphy Maginness: It is an option, of course, that is readily available. My understanding from looking at other jurisdictions, such as England and Wales in Great Britain and the South of Ireland, is that the situation there is very much as it pertains today in Northern Ireland. The Attorney General there does not have additional powers to access records, reports and information of any description. However, in those jurisdictions, the Attorney General does retain the power to effectively review a coroner's decision. We respectfully suggest that there is no reason to change a system that is apparently working extremely well and does have the safeguard, not just for those individuals directly affected by the events but for the public generally, that the Attorney General can come in if he believes that it is necessary to intervene in a coroner's decision. In our view, the coroner being the first port of call is entirely proper, and it is unnecessary to have another party effectively carrying out the same role.

Mr Lynch: Fionnuala, you spoke about the unintended consequences for staff involved in the process. Could you elaborate on that? Secondly, when the Attorney General was here, he said that there was no harm in having a second pair of eyes. Do you see him intervening where he should not?

Mrs McAndrew: I referred to the unintended consequences for clinical staff and families. I will start with clinical staff. The people who deal with these situations are front-line nurses and doctors. They are the people who break the bad news to families in the first place. Where we feel that the matter needs to be looked at, they are then required to explain our SAI process. Our experience is that that, in itself, can lead to all kinds of emotional responses from families. Clearly, it is already a very distressing time. They are concerned that something may have gone wrong, and we are looking to see if there are any lessons that can be learned from that case. That whole process needs to be

managed. Front-line nurses and doctors carry out that function in the knowledge that it is a learning exercise. We are not looking for blame. We are not looking to see who is at fault. We are encouraging an open debate about how we can provide better quality services. Our concern is that the more legal powers you introduce around this whole process, the more professional clinicians get concerned about the consequences for them and their colleagues.

Our experience of family involvement is that it is very distressing at times. We have to remember that we are talking about the loss of loved ones; sometimes it is a baby who has died. It is very challenging for families to understand why we would be looking to see if there was anything that could be improved upon. More than two pairs of eyes look at this whole process. I will explain. In the first instance, the procedure requires the trust to look back on the case, in order to understand what interventions happened, who was involved and what measures were taken. That is when they would look for any potential learning. After that, the information is scrutinised by the Health and Social Care Board in what is quite an intensive process that often involves an iteration of looking at reports and asking for more detail until we are satisfied that everything has been looked at appropriately. As Alphy said, an unexpected death, under section 7 of the Coroners Act, is referred to the coroner, who will look at it in his own right, as well. I am not sure at this stage of the benefit in introducing yet another person into this process, because the process is robust as it stands. I hope that answers your question.

Mr Frew: Will the coroner always be assured that he or she has all the information at hand? What safeguards are in the system to ensure that happens?

Mr Alphy Maginness: There is a legal obligation to provide the coroner with all relevant information pertaining to the death, including reports and records, in keeping with the serious adverse incident procedures introduced in recent years, and which have been added to. I personally was involved in an inquest last week, and in the pre-hearing consultation with the trust, I was assured, and I know, that the coroner had been given a copy of the serious adverse incident report, as had the family. The solicitor on the other side confirmed to me that he had also received the report.

The other safeguards include section 10 of the Coroners Act, which makes it an offence not to report a death within the terms of section 7. In other words, if a death ought to be reported, it is an offence not to report. Criminal action could be taken against an individual who fails to submit a report. Furthermore, under section 17C, which deals with offences relating to evidence — I will not read the whole lot — it is an offence:

> *"... for a person to do anything that is intended to have the effect of—*
>
> *(a)distorting or otherwise altering any evidence, document or other thing that is given or produced for the purposes of any investigation or inquest under this Act, or*
>
> *(b)preventing any evidence, document or other thing from being given or produced for the purposes of such an investigation or inquest,*
>
> *or to do anything that the person knows or believes is likely to have that effect.*
>
> *(2)It is an offence for a person—*
>
> *(a)intentionally to suppress or conceal a document that is, and that the person knows or believes to be, a relevant document, or*
>
> *(b)intentionally to alter or destroy such a document.*
>
> *(3)For the purposes of subsection (2) a document is a "relevant document" if it is likely that a coroner making any investigation or holding an inquest would (if aware of its existence) wish to be provided with it."*

The penalty is not just a fine but potentially up to six months in prison. So, it is imperative, and not just for medical staff in trusts, to ensure that, firstly, the death, if it falls within the confines of section 7, is reported, and that, secondly, all relevant documentation is made available to the coroner.

Mrs McAndrew: May I add to that, Chair? All the documentation that we have within the health and social care family relating to the serious adverse incident report, such as reporting formats and

checklists, make reference to reporting to the coroner. The designated officer at the board level will make sure that that is complied with. There are checks and balances within the process, as well, to make sure that it happens.

Mr Frew: Who categorises an incident as a serious adverse incident?

Ms Anne Kane (Health and Social Care Board): In the health and social care trusts and all arm's-length bodies in the Department, we have adverse incidents and then there is a set of criteria in the SAI procedure that determines whether something is a serious adverse incident.

Mr Frew: I take it that, by the nature of the incident, such categorisations could be contested.

Ms Kane: The board encourages our health and social care trusts to report something that might look like a serious adverse incident and that may then not meet the criteria when investigated by the trust. They will then come back to the board and liaise with the designated review officer, when a decision will be made on whether to de-escalate.

Mrs McAndrew: The statistical information that we provide to our board shows an increase in SAI reporting over the years in which the process has been under way.

Ms Kane: Absolutely.

Mrs McAndrew: That is because we are encouraging reporting, transparency and openness. It is my understanding that our procedure was submitted alongside our response to the consultation, but, certainly, if that is not available to the Committee, we would be happy to share it.

Mr Alphy Maginness: May I make one further point? A recent case was alluded to earlier about which the Attorney General had written to the Committee. The trust had deemed that case at a senior level not to be a serious adverse incident. That remains the trust's position, despite further investigation and the coroner's own independent investigation. It was not a serious adverse incident. The demarcation between what is and what is not a serious adverse incident is very clear, and the criteria are well set out in the document.

Mr Frew: In your opinion, when it is right and proper for the Attorney General to get involved?

Mr Alphy Maginness: As the law currently states, where he has reason to believe that an inquest should be held following the decision of the coroner. The exact terms are set out in section 14 — it has previously been referred to — which provides that:

> *"Where the Attorney General has reason to believe that a deceased person has died in circumstances which in his opinion make the holding of an inquest advisable he may direct any coroner".*

He could direct a coroner after the coroner has made a decision that there should not be an inquest, or he could intervene if the coroner has held an inquest, but he finds the inquest unsatisfactory.

Mr Frew: Excuse me for my ignorance, but how would the Attorney General know what incidents he should get involved in? Is there a form of reporting, or is it just a case of a member of the public writing in? How would the Attorney General ever get involved in the first instance?

Mr Alphy Maginness: When the coroner makes a decision and he is unhappy with it. I am not sure of the interface between the coroner and the Attorney General. I do not know whether the coroner reports to the Attorney General on every decision.

Mrs McAndrew: I do not know either.

Mr Alphy Maginness: I do not know the circumstances. The present position is that the Attorney General may intervene where the coroner has decided not to hold an inquest. I am aware of recent situations where the Attorney General has intervened and directed that an inquest should be held.

Mr Frew: Would serious public concern be a trigger for the Attorney General?

Mr Alphy Maginness: After the coroner has made a decision, it could be; or it might be that the family were unhappy with the coroner's decision or their solicitor wanted to take it further. Presumably there is no impediment to the solicitor making a referral to the Attorney General's office.

Mr Frew: As the law stands, the Attorney General would then have to go to the High Court?

Mr Alphy Maginness: No. The Attorney General can make the decision, as provided for in section 14, "Inquest on order of Attorney General". The key point is, though, that it has been through the coroner's books, if you like.

Mr Frew: Then when the Attorney General asks for information, you are duty-bound to give it to him or her.

Mr Alphy Maginness: The Attorney General will get the information that has been provided to the coroner, and there is a duty to provide the raft of information I referred to to the coroner in the first place. Unless someone has intentionally withheld documentation — if they have, that is a criminal offence — the coroner should have all the relevant material. I fully accept that there could be additional material after the inquest, which might force the hand of the Attorney General.

Mr Frew: If the coroner gets his lot, how does he know whether there is any more? If the Attorney General gets only the coroner's lot, how can he assure himself that there is nothing more?

Mr Alphy Maginness: Both can request any additional information. If it is a medical issue, coroners routinely request statements from the relevant medical and nursing staff and from management. They get statements from the family and the police, and they also have access to patient records. If it is a complex medical issue, a coroner can also institute an independent report from that specialty. It is all within the remit of the coroner.

Mr McCartney: May I take up that point? The Attorney General is entitled to all reports, subject to the coroner, and also reports that you retain and do not send to the coroner.

Mr Alphy Maginness: Documents are not withheld from the coroner. That is the point.

Mr McCartney: I ask that question because, in the John O'Hara inquiry, was a report not withheld — not illegally — but it is now accepted that perhaps it would have been enlightening to the coroner if it had been passed on? That is the Warde report.

Mr Alphy Maginness: In the suggested wording of the Attorney General's proposed amendment, it states that no parties should be asked to provide documentation that they would not be asked to provide in a High Court hearing and:

> *"A person may not be required to produce any document or give any other information under this section if that person could not be compelled to produce that document or give that information in civil proceedings in the High Court."*

I think that you are referring to the hyponatraemia inquiry. If an independent report is obtained by any party to the inquest, they are not required to disclose that report unless they intend to rely on it in High Court proceedings.

Mr McCartney: In this instance, if this amendment had been in place, and there was the scenario of a second pair of eyes, would the Attorney General have seen the Warde report?

Mr Alphy Maginness: I do not think that that would have made any difference, because —

Mr McCartney: I am not saying that it would make a difference; I am just asking whether he would have seen it?

Mr Alphy Maginness: No. In my view, he would not have seen it, because of that —

Mr McCartney: So the Health Department is in possession of some documents, which may inform the coroner. From my reading of this — I was not at the inquiry so I do not want to pretend that I know all

of it — it seems to be accepted that, if the Warde report had been at the Coroners' Court, he may have come to a different decision. It also states that the Department subsequently accepted liability in that case.

Mr Alphy Maginness: The Warde report was not provided in the inquest in that case. It was not provided in a medical negligence action in that case, because, under current law, there was no requirement to provide the report, but, even under the law in the Attorney General's proposed amendment, there is no requirement or legal obligation to furnish that report. The proposed amendment states:

> *"A person may not be required to produce any document or give any other information ... if that person could not be compelled to produce that document ... in civil proceedings in the High Court."*

We are going slightly off tangent, but, very briefly, if there is a medical negligence action before the High Court, you are not necessarily required to produce any expert report — that is, a report to determine your liability or otherwise — unless you intend to rely on it.

Mr McCartney: I understand the technicalities, and you maybe need a lawyer to go through them, but Fionnuala, in her opening remarks, talked about staff reluctance and not compounding the distress of the family of the deceased. As a layperson, I ask myself a question about a second pair of eyes: if the Attorney General had seen the Warde report in these circumstances, would he have had the power to ask that that be shown to the coroner?

Mr Alphy Maginness: I do not believe so.

Mr McCartney: So a report somewhere in the system, which would assist a family to find out how their loved one died, can be held back.

Mr Alphy Maginness: It is to do with the nature of the report. I think that we are confusing two issues. A report such as that considers a variety of factors, one of which, for example, is whether or not there was negligence. In that case, the Warde report was not critical. That is my view, but everyone is entitled to a different view. The point is that, if you intend to rely on it, you have to disclose it. That is the legal nicety around it in the High Court, but that is not a relevant factor in the proposed amendment, because the law will be unchanged in respect of that. It would not make any difference whether it is the Warde report or a report on an obstetric or orthopaedic case that was obtained for a different purpose.

Mrs McAndrew: The reassurance that we can give the Committee is, as I said, that documentation about a patient's care is submitted to the coroner.

Mr McCartney: I will read this out, because I think that it is important for us for clarity. Michael Stitt QC for the directorate of legal services (DLS) said:

> *"The point has been made that this would have been of benefit to the coroner. This may be the case but it does not mean that the Trust acted either illegally or in any way improperly".*

Nobody is doubting that, but it may have been good practice in this instance to provide the coroner with it, because you can say that something is not illegal or improper, but it still allows you room to say, "Let's do it". Michael Stitt continues:

> *"The Trust notes the evidence from the coroner that he would have expected to have had sight of the Warde Report".*

So the coroner himself said that he should have had sight of it. I accept that the trust says that, with respect, it disagrees with the interpretation of the practice and prevailing legal principles. That is when the second pair of eyes comes in. I will not make a judgement on who is right or wrong because it is the law, but, when a second pair of eyes talks about safety, good practice and not compounding the distress of the family of the deceased, I believe that the Warde report should have been submitted. That reassures us that, when people may not have acted illegally or improperly, you could go the extra mile and put all the documents on the table, so that there is no distress for families in the aftermath.

Mr Alphy Maginness: The proposed amendment will not achieve that. That is all that I am saying to you.

Mr McCartney: However, if he has access to all documents —

Mr Alphy Maginness: He will not have access to that if it is not required to be produced in the High Court.

Mr McCartney: Perhaps we need to look at that. It surprises me that a Department can be in possession of a document that, when it is subsequently brought to court, people felt would have been of benefit, particularly when the coroner said that it would have been of benefit. Even under this legislation, that could happen tomorrow. It is in your gift. If you do not feel that it is illegal or improper to withhold a document that may be of benefit to someone trying to establish the cause of death, I think that we should look at that in the form of an amendment to the Justice Bill.

Mr Alban Maginness: I just want to tease out, Mr Maginness, in section 14 —

Mr Alphy Maginness: This will be good.

Mr Frew: We are all thinking the same. *[Laughter.]*

Mr Alban Maginness: I read a Hansard report from 1959 in relation to this debate. Mr Topping — I think that he was the Minister of Home Affairs at the time — said that it was a power that would obviously be used most sparingly and only in the most exceptional cases. Has there been any change in that? Is that fixed in law? Is it a residual power used by the Attorney General sparingly and in the most exceptional cases?

Mr Alphy Maginness: I am aware of it being used on two occasions in recent years. It is some 55 or 56 years since that was stated. The fact is, whether it is exceptional or not, the power remains open to the Attorney General, and it is a matter for him when he wishes to exercise it.

I would not have thought that it would be used frequently, but it will be used when the Attorney General believes that it is appropriate to intervene and has a reason to believe that an inquest ought to be held. I think that the coroner is best placed to answer when he would wish to use it. Whilst that is a debate within the Senate, that in itself is insufficient to say that you could not use it more frequently. It is when he has "reason to believe": that is the key phrase.

Mr Alban Maginness: I will take that phrase that you have just used: it is his belief that there ought to be an inquest. That threshold is quite low in comparison with other thresholds that the Attorney General might have to meet.

Mr Alphy Maginness: It is. That is all the more reason why we believe that the amendment is unnecessary. He can still intervene. The key point is that the coroner makes the first call, and, if the Attorney General is unhappy with that call, he can intervene.

Mr Alban Maginness: In a sense, the Attorney General's role is to supervise the coroner's system, and, if he suspects or believes that there is some sort of deficiency in what the coroner is dong, he can intervene.

Mr Alphy Maginness: I think that that was the intention of the legislation. That is still available to him.

Mr Alban Maginness: I have one further point that relates to the serious adverse incident reports. How do you characterise those reports? Are they documents that are intended to improve performance, or are they intended to be part of an investigation into a death?

Mrs McAndrew: I will bring Anne in a moment, but our procedures are based on international best practice. The purpose of the serious adverse incident system in any jurisdiction or in any business — even in the aviation industry — is to look at whether things could have been done differently, to take that learning and to change the way you do things to avoid another incident of that nature happening again. Our whole process is based on those principles. It is important to understand that, because it is about the learning that clinical staff — nurses and doctors — want to take from the process to make

sure that they learn from a situation and amend their practice. It has led to policy changes, practice guidance changes as well as individual practice changes. It is not just clinicians, although it is important that they feel confident that they can go into the process without fearing that it is about blame. It is not a disciplinary process, which is a separate process. The process, among the many that we have, is about learning.

When that learning comes forward from within the health and social and care system across Northern Ireland, we have looked at whether the policy, the guidance on practice needs and our serious adverse incident procedure need to change. We have built that in. Anne, if I am not reflecting that —

Mr Alban Maginness: Are you suggesting that there might be a detrimental impact if those are disclosable in the context of the amendment?

Mrs McAndrew: I am reflecting to the Committee that it is a difficult process for everybody concerned. Doctors, nurses and other clinicians come to care for people and to save life. It is difficult for them. It is equally difficult for the families. We do our best to encourage clinicians to get involved in the process. There is fear and some reluctance if they feel that the report will be used for a different purpose. There is concern that the report will suddenly be used for blame and to look at who is at fault. Clearly, the report is used for a number of purposes at the minute, but the actual investigation is predicated on the basis of looking at learning, not at blame and guilt. It is an important distinction. It is what separates it out from disciplinary and criminal procedures. Those procedures can run alongside, but it is not what this process is about.

Mr Elliott: What is the process that the Attorney General has proposed about then? It is really difficult. If you are saying that all the required information can be made available under current regulations in law, in your opinion, what is the Attorney General looking for in addition?

Mrs McAndrew: I am not sure that we fully appreciate the need for it. That is the point that we are making.

Mr Elliott: That is what I am trying to establish.

Mrs McAndrew: We feel that there are processes and systems whereby that information is available and can be made available to the Attorney General under certain circumstances. That is already in existence. So, if I am being honest with the Committee, we are not quite sure what the intention behind the amendment is.

Mr Elliott: The case that you are making is that there is no need for it and that everything is in place to make the required information available. Is that right?

Mrs McAndrew: That is what we believe.

Mr Elliott: From my perspective, let us turn that the other way round. What would be the difficulty or problem in introducing the proposed amendment? If everything is already there, would this make any difference or inhibit you and the trusts any further?

Mr Alphy Maginness: It is not just asking for information relating to a death. The coroner is the first port of call. You have to inform the coroner of a death within the terms of section 7. The proposed amendment opens that up significantly. It could be any document in relation to any death. Lots of people die in hospital. That is a natural phenomenon. The proposed amendment suggests that the Attorney General will have access to any document relating to any death at any time. I also note that it is not even time-limited. May I read the amendment? It states:

> *"The Attorney General may, by notice in writing to any person who has provided health care or social care to a deceased person, require that person to produce any document or give any other information which in the opinion of the Attorney General may be relevant to the question of whether a direction should be given by the Attorney General under section 14."*

Section 14 deals with inquests on an order of the Attorney General. Where are the limits? There are no limitations in that. There are no boundaries or time limits. There are no limits to documents. Does it include the medical officer's personnel records, for example? Does it include any other records that may have a peripheral relationship to a death but are not strictly relevant?

Mr Elliott: So what you are saying is that the current —

Mr Alphy Maginness: It opens it up to what might be termed a fishing expedition, effectively to undermine the views of senior medical staff, who are already in a position and have a very serious obligation to make a decision on whether a matter should be referred to the coroner. As the law exists, if they fail to refer a death to the coroner when it ought to have been referred, that is a criminal offence.

Mr Elliott: I want to be clear about that explanation. The Attorney General's amendment would open it up to more information. While you are making the case that it is not necessary because all the information is available, it is opening up the opportunity for the provision of more information.

Mr Alphy Maginness: It is not, however, relevant information.

Mrs McAndrew: I think that the dispute or discussion needs to be about the relevancy of the information. Alphy is making the point that the amendment is open to absolutely anything. In responses from the trusts, they are also asking for that point of clarification. What does this mean for the breadth of information that would be required? There is the potential for additional costs and additional work for the trusts. As we said, given that we think that the relevant information is available, by and large, there is the potential for duplication.

Mr Elliott: In your opinion, is there anything else that could be made available that is not covered under current statute or regulations and could be somewhere between what the Attorney General is looking for — basically, that everything should be available — and what is in the current regulations?

Mr Alphy Maginness: Under the Coroners Act 1959, the coroner is entitled to access any information that is relevant to a person's death, so that is fairly extensive. The key point is that, when a situation enters the arena of an inquest — sorry, not an inquest, because the coroner makes that decision — but when the coroner must intervene, the Act sets out very clearly the circumstances of unexplained deaths, whereby there is a statutory obligation to report a death to the coroner and allow the coroner to then undertake investigations. Here, the PSNI is available to the coroner to assist with investigations. As I understand it, in England and Wales, they have their own investigators, which is slightly different. The issue is the point at which the coroner's role kicks in. We are saying that the coroner is the statutory authority to properly investigate unexplained deaths. The duty is on trust staff to report those deaths. We are saying that there are sufficient safeguards in the current process and that the Attorney General does have a role — we are not denying that the Attorney General should have a role — if he is unhappy with the way in which the coroner has proceeded.

Mr McCartney: For clarification: when you read out the amendment and described it as a fishing expedition, which I can understand —

Mr Alphy Maginness: Sorry, I said that it has the potential to be.

Mr McCartney: It has the potential — sorry. You can understand why a doctor does not want somebody to come to his house and say, "I want to read your personal diary". I can understand that part of it. I will go back to my original question about the second pair of eyes, as envisaged by this amendment. The Warde report was commissioned by the trust. It suggested heavily that the hospital was at fault, yet that report was not given to the coroner. Under the scenario of a second pair of eyes, it could be.

Mr Alphy Maginness: I do not think that it would make any difference. I honestly do not.

Mr McCartney: I am not saying that it makes a difference. It strikes me and my opinion is that the Warde report, commissioned by the trust, should have been given to the coroner, because it would have assisted in some way to find out the cause of death. It states very clearly that the hospital was at fault. At that stage, the hospital had not admitted that it was at fault. If I were the second pair of eyes reading that document, I would have asked why it was not with the coroner.

Mr Alphy Maginness: I have explained what —

Mr McCartney: I understand that, but the legislation would allow that to happen. At present, it does not have to happen. In the future, there is nothing to prevent a trust having a similar report in its possession and not giving it to the coroner. A second pair of eyes gives us the potential. The Attorney General might say no, but the potential is there that that document would have been with the coroner at the appropriate time.

Mr Alphy Maginness: There is a slight difference: the Attorney General is talking about documents that relate to the care and treatment of a patient.

Mr McCartney: It is all relevant documents. A good lawyer would make the case that it is a relevant document.

Mr Alphy Maginness: I know, but I will go back to the point:

> *"The Attorney General may, by notice in writing to any person who has provided health care or social care to a deceased person, require that person to produce any document or give any other information which in the opinion of the Attorney General may be relevant".*

It is the person who has provided the health care, so it is up to the individuals and, indeed, the trusts to provide the information in relation to the health care. The distinction that I am making is that the Warde report was a commentary on the care that had been provided. Commentaries and expert reports will often comment on the nature of the treatment that was given, such as whether it was of a high standard and good practice and will look at the context in which the records were kept and decide whether there was good record-keeping. A commentary could focus on a variety of issues, but it is not necessarily about the actual care and treatment. It is a commentary on the care and treatment.

Mr McCartney: It asks, however, for the people who provided the care. If it had been in support of someone, you can make the case that it is relevant to the case because the person who provided the care asked that the report be commissioned.

Mr Alphy Maginness: The trust asked for it.

Mr McCartney: Those are the people who provided the care. Individual employees can become —

Mr Alphy Maginness: It is perfectly reasonable for a trust to do that. I explained earlier that the coroner can say to an expert, "I want a report from you, expert, on the orthopaedic treatment, the obstetrics unit or whatever". A trust will do the same thing. Any attorney can do that, or the family can do that. Any party to the inquest is perfectly entitled to obtain an expert report.

Mr McCartney: I am sorry for taking so much time, but, in conclusion, are you saying that, if there were a report like the Warde report tomorrow and the legislation were in place, the trust would have the power not to show that to the Attorney General?

Mr Alphy Maginness: Yes, even with the Attorney General's amendment, because he is talking about a person who could not be compelled to produce that document or give that information in civil proceedings in the High Court. If it is a medical negligence action, the plaintiff's side and the defence are both perfectly entitled to obtain medical expert reports on the treatment and the nature of that treatment. If they are going to use that report, they are under an obligation to disclose it. If they are not going to use that report, they are not under an obligation to disclose it.

Mrs McAndrew: The amendment does not change that. That is the point that we are making. It does not alter the extant provisions.

The Chairperson (Mr Ross): Thank you very much. I appreciate your time.