COPY : Chief Medical Officer

Coroners Service for Northern Ireland

Mr John Compton
Chief Executive
Health and Social Care Board HQ
12-22 Linenhall Street
Belfast BT2 8BS

JOHN L LECKEY LL.M.
SENIOR CORONER
FOR NORTHERN IRELAND

Dear Mr. Compton,

Date 2nd April 2014

Serious Adverse Incident Reports (SIAs)

I am writing to advise you that to date the Coroners' Service for Northern Ireland has received six SAI reports from Belfast Health & Social Care Trust Litigation Department and one from a solicitor representing a bereaved family all relating to deaths occurring as far back as February 2011. We have been able to ascertain that some of the deaths had already been reported but at the time the death had been reported we had been unaware that the need for a SAI report was under consideration. I am enclosing details of each of the SAI reports received.

I would point out that the sending of a SAI report does not by itself constitute a formal reporting of the death pursuant to the provisions of section 7 of the Coroners Act (NI) 1959. It will be necessary for a doctor from the hospital concerned to confirm in writing that the death is being reported pursuant to the provisions of that section, give reasons why, clarify if contact has been made with the deceased's family to explain that the death has been reported to the coroner and the reasons for that action being taken and provide contact particulars for the family.

We note from media reports that there are other SIA reports available relating to deaths in other Trusts but we have not been provided with copies of these and we have no knowledge of the name of each deceased or of the contents of the SIA reports. If it is felt that these deaths should be the subject of a report to the Coroners' Service then each should be the subject of a formal report in the manner set out above and a copy of each SAI report should be provided.

Please remind all relevant staff within Health & Social Care in Northern Ireland of the circumstances in which they have a duty to report deaths to the coroner, the need for complete candour and the importance of engaging with the family.

In conclusion, I would remind you that the Coroners' Service relies on medical practitioners and others being aware of the circumstances in which their duty

to report deaths to the Coroners' Service arises and the need for complete candour. A coroner's role is a reactive one restricted to investigating a death that has been reported, unlike the proactive role of a Medical Examiner who has responsibilities involving death certification in general.

A copy of this letter is being sent to the Minister and the Chief Medical Officer.

Yours sincerely,

John L Leckey
Senior Coroner for Northern Ireland

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