Coroners Service
for Northern Ireland

ROSALIND JOHNSTON LLB
SOLICITOR TO THE CORONERS FOR NORTHERN IRELAND

Ms Anne Dillon
Solicitor to the Inquiry
The Inquiry into Hyponatraemia
Related Deaths
Arthur House
41 Arthur Street
BELFAST
BT1 3JL

10th December 2013

Dear Ms Dillon,

RE: Raychel Ferguson (Lucy Crawford Aftermath)

I refer to my letter of the 6th August 2013.

Since that time the Senior Coroner has reflected on the general issues regarding disclosure raised with him by the Chairman when he was giving his evidence at the Inquiry. We have consulted with our Senior Counsel, Nicolas Hanna QC, and considered that it was appropriate to request Mr Hanna to write an opinion to be submitted to the Inquiry.

I enclose a copy of that opinion and confirm that the Senior Coroner endorses Mr Hanna's opinion in its entirety.

You may already be aware of a publication by the NIHRC on Investigating Deaths in Hospital in Northern Ireland dated September 2004 but if not the Senior Coroner has asked me to draw it to your attention.

Yours sincerely

Rosalind Johnston

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CORONERS' POWERS TO COMPEL DISCLOSURE IN NORTHERN IRELAND

TO ADVISE THE SENIOR CORONER FOR NORTHERN IRELAND

OPINION

1. I am asked to advise the Senior Coroner for Northern Ireland what powers, if any, are available to a coroner to compel the disclosure of documents/information of relevance, or potential relevance, (1) to the determination by the coroner of whether or not an inquest is necessary in a particular case, and (2) to an inquest itself, if one is to be held.

2. The powers of coroners in Northern Ireland are statutory in origin. Before considering their powers of compulsion, it is worth noting those statutory provisions which impose obligations on certain categories of individual to provide information to coroners.

3. Section 7 of the Coroners Act (Northern Ireland) 1959 ('the Act') imposes a duty ('the section 7 duty') on certain categories of person to notify a coroner of facts and circumstances relating to deaths which have occurred in certain defined circumstances.

4. The categories of person upon whom the section 7 duty is imposed are: medical practitioners; registrars of deaths; funeral undertakers; occupiers of houses or mobile dwellings in which a deceased person was residing; and persons in charge of any institution or premises in which a deceased person was residing.

5. The section 7 duty is not universal in its application and there may be potentially significant categories of person upon whom it is not imposed. A notable example is that of midwives. They are not medical practitioners. Nevertheless certain maternity units in Northern Ireland operate without any medical practitioner. Accordingly, if a notifiable death[1] occurs in a 'midwife only' maternity unit, there may be no one present at the time when the death occurs who is under any *duty* to inform a coroner of that death. Although it might be possible to regard the unit as an 'institution or premises', it would be highly unusual for the deceased person to be 'residing' therein. In practice this may not often be a problem because, in the event of a death occurring in such a unit, it is likely that a medical practitioner and/or a funeral

[1] see paragraph 6

undertaker will have been called, and will have been apprised of the relevant facts and circumstances. There may, nevertheless, be circumstances where such an individual is not made aware of the relevant facts and circumstances.

6. Although section 7 is grammatically deficient, it is reasonably clear that the section 7 duty arises if any person in any of those categories has reason to believe that a deceased person died, either directly or indirectly: (1) as a result of violence; (2) as a result of misadventure; (3) as a result of unfair means; (4) as a result of negligence, misconduct or malpractice on the part of others; (5) from any cause other than natural illness or disease for which the deceased person had been seen and treated by a registered medical practitioner within 28 days prior to his death; or (6) in such circumstances as may require investigation (including death as a result of the administration of an anaesthetic). I shall refer to these as 'section 7 notifiable circumstances' and 'section 7 notifiable deaths'.

7. Section 8 of the Act imposes a different statutory duty ('the section 8 duty') upon superintendents of the Police Service of Northern Ireland ('PSNI'). This duty arises in the following circumstances: (1) whenever a dead body is found; (2) whenever an unexpected death occurs; (3) whenever an unexplained death occurs; or (4) whenever a death attended by suspicious circumstances occurs. If the body is found, or if a death in one of categories (2), (3) or (4) has occurred, within the district of a particular police superintendent, section 8 imposes a duty upon the superintendent to give immediate notice thereof in writing to the coroner within whose district the body is found or the death has occurred. In addition he is required to give the coroner such information, also in writing, as he is able to obtain concerning the finding of the body or concerning the death[2]. I shall refer to all four of these as 'section 8 notifiable circumstances' and 'section 8 notifiable deaths'.

8. The duty imposed by section 8 is limited to superintendents of police. It is nevertheless clear that there are likely to be many occasions upon which parallel section 7 duties and section 8 duties will arise in respect of the same death.

9. Beyond the duties imposed by sections 7 and 8, there is no duty on anyone else to give information to a coroner concerning the facts or circumstances of a death. There is, however, no reason why anyone (whether or not subject to any duty under

[2] This is a continuing duty: *McCaughey v Chief Constable of the Police Service of Northern Ireland* [2007] 2 AC 226.

sections 7 or 8) should not *voluntarily* provide information and/or documents to a coroner concerning any death and I understand that this often happens.

10. Where a coroner is informed (by whatever means – whether under a duty of voluntarily) that there is within his district the body of a deceased person and that there is reason to believe that the deceased person died in section 7, or section 8 notifiable circumstances (collectively 'notifiable circumstances') he is required by section 11 of the Act to make such investigation as may be required to enable him to determine whether or not an inquest is necessary. If, as a result of his investigation, he concludes that the death occurred in notifiable circumstances he may hold an inquest. His jurisdiction to hold an inquest is at his discretion and the power do so is conferred by section 13 of the Act.

11. In order to carry out his section 11 duty to investigate and determine whether or not an inquest is necessary, and in order to conduct an inquest which he has decided to hold under section 13, it is clear that the coroner will require access to information of various kinds concerning the death, often including documentary information and information in the form of testimony from witnesses/potential witnesses. The latter may be documentary, taking the form of witness statements prepared for the purposes of the investigation and/or inquest, or it may be oral, whether provided during the investigation, or in the witness box at the inquest itself.

12. Where a death has occurred in notifiable circumstances in a hospital, and has been notified to a coroner, it is virtually inevitable that he will require information of the kind outlined in the preceding paragraph.

13. No doubt in many cases the managers of the hospital will co-operate with the coroner and will voluntarily provide information, including documentary information, relating to the facts and circumstances of the death. The question is whether, if they do not do so, they can be compelled to do so.

14. Unless the deceased person was *residing* in the hospital (which in most cases is probably unlikely) the statutory obligation imposed by section 7 is not imposed upon the managers of the hospital (since they would not be the person in charge of any institution or premises in which the deceased person was residing). It is merely imposed on each of the medical practitioners who, pursuant to the section 7 obligation, notify the death to the coroner. Strictly speaking, if the deceased was being treated by more than one medical practitioner, and each of them was aware of

different facts and circumstances relating to the death, they would each be under a separate section 7 duty to notify the coroner of the facts and circumstances of which each of them, individually, were aware. The obligation of each such medical practitioner is to notify the coroner of 'the facts and circumstances' relating to the death. Clearly an individual practitioner cannot notify the coroner of facts and circumstances of which he is not aware. Accordingly the obligation upon him will be limited to those of which he is aware. I consider it rather unlikely that the duty to notify 'facts and circumstances' would be interpreted as imposing an obligation on the practitioner to provide *documents*, such as medical notes and records. Apart from anything else, it is unlikely that such documents would belong to the practitioner himself, and much more likely that they would belong to, and/or be under the custody or control of the managers the hospital (ie the relevant Trust). I am not aware of any case law in which this issue has been considered.

14. The duty imposed by section 8 is only imposed upon a superintendent of police. It cannot therefore be relied upon as imposing any duty upon the managers of a hospital to provide potentially relevant documents, such as medical notes and records. Nevertheless, if a death in hospital has occurred in section 8 notifiable circumstances (but not section 7 notifiable circumstances) the superintendent of police will have been under an obligation to endeavour to *obtain* information concerning the death, and this implies some degree of obligation upon him to investigate in order to try to obtain that information.

15. It has nevertheless been held, both in England and Wales and in Northern Ireland, that a coroner has no power to order the production of documents[3]. He can only compel such production, in Northern Ireland, by means of a *subpoena duces tecum* issued out of the Crown Office of the High Court. This is a special kind of witness summons which requires the person to whom it is addressed to bring documents specified in the *subpoena* to the inquest. The ordinary power, granted by section 17 of the Act, to summon witnesses to attend inquests does not extend to compelling such witnesses to bring documents with them.

16. This arrangement is far from satisfactory, because it means that, unless the managers of a hospital comply voluntarily, they cannot be *compelled* to produce potentially relevant documents until they actually attend the inquest itself in compliance with a *subpoena duces tecum*. Since such documents may need to be

[3] *R -v- Southwark Coroner, ex parte Hicks* [1987] 1 WLR 1624 At 1629; *re McKerr's Application* [1993] NI 249

examined and considered by expert witnesses, the only practical solution would appear to be that of formally commencing the inquest and requiring the relevant witness to attend and bring the documents, and then adjourning the remainder of the hearing of the inquest for some weeks or months until the documents have been considered by the experts.

17. In many cases of deaths in hospital the relevant Trust may have obtained reports from experts. Provided those reports have been obtained for the dominant purpose of seeking, or obtaining legal advice, or for the purpose of pending or contemplated litigation, they will be subject in the ordinary way to legal professional privilege. While privilege can be waived voluntarily, production of such reports cannot be compelled by a coroner. If an expert witness attends an inquest, and gives evidence, and as part of this evidence relies upon a report which he has written he can, of course, be asked whether he has on any previous occasion expressed a different view to that contained in his report and/or evidence.

18. It is also important to remember that rule 9 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 provides that "no witness at an inquest shall be obliged to answer any question tending to incriminate himself or his spouse". This is the well-established and widely recognised privilege against self-incrimination.

Nicolas Hanna

NICOLAS HANNA QC
Bar Library
Belfast
8 December 2013