Witness Name: Michael Meehan
Statement No: **WITN7589001**
Exhibits: **WITN7589002 - WITN7589011**
Dated:24 November 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF MICHAEL MEEHAN Coroners Service for Northern Ireland

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 22 September 2022.

I, Michael Meehan, will say as follows: -

Section 1: Legislative Framework

Question 1

1.1 The Coroners Service for Northern Ireland (CSNI) was established as a centralised body in April 2006 to carry out investigations into sudden, unexplained or suspicious deaths occurring within Northern Ireland. Coroners deal with matters relating to deaths, in accordance with two main pieces of legislation, namely, the Coroners Act (NI) 1959 and the Coroners (Practice and Procedure) Rules (NI) 1963.

1.2 The CSNI was restructured from seven Coroners Districts to a centralised service in 2006 and an electronic database was installed to accommodate centralisation.

Questions 2-4

1.3 Coroners deal with matters relating to deaths, in accordance with two main pieces of legislation, namely, the Coroners Act (NI) 1959 **[WITN7589002]** and the Coroners (Practice and Procedure) Rules (NI) 1963 **[WITN7589003]**. The principal circumstances in which deaths are reported to the Coroner are set out in Sections 7 and 8 of the 1959 Act. These are framed to ensure, as far as possible, that all questionable deaths are brought to the Coroner's notice.

Coroners Act NI 1959.pdf

1.4 The Coroners (Practice and Procedure) Rules (NI) 1963 govern inquests and post-mortem examinations.

Coroners Rules 1963.pdf

Section 2: CSNI

Paragraph 5 and 6

2.1 The CSNI was established as a centralised body in April 2006 to carry out investigations into sudden, unexplained or suspicious deaths occurring within Northern Ireland.

2.2 Prior to 2006, there were seven Coroner's districts with each district having a Coroner and deputy Coroner. This is referenced by Mr Leckey, the then Coroner for Greater Belfast, in his publication "Coroners' Law and Practice in Northern Ireland [1998]". The Coroner for Belfast was the only full-time appointment and was provided with clerical staff. No clerical support was provided for part-time Coroners, who were mostly solicitors in private practice, where they relied on the services of their practice staff for assistance with coronial work.

2.3 The CSNI was restructured from seven Coroners districts to a centralised service in 2006 and an electronic database installed to accommodate centralisation. At that time all "live" cases were transferred onto the database. Additionally, limited details of some closed cases were data captured. This means that we are unable to provide an assurance that all cases that were both reported and closed prior to centralisation in 2006 were data captured.

2.4 Centralisation brought a streamlined process for Coroners' investigations including the centralisation of records in a case management system, and a reduction in the registration delays of deaths in Northern Ireland. Due to the fact that pre-centralisation only the full-time Coroner was provided with clerical support and part-time Coroners relied on

practice staff, given the passage of time we are unable to determine how records were maintained pre-centralisation.

2.5 The CSNI holds records of deaths reported to the Coroner under s7 and s8 of the Coroners Act (Northern Ireland) 1959 from the establishment of the centralised service in 2006. The challenge is that many of the deaths where the Inquiry has sought information, pre-date the centralisation of CSNI and the creation of a dedicated database. We are unable to assist with any cases that were not reported to the Coroner and which consequently had no coronial involvement or input.

Section 3: Request for Records and Further Information [22 June 2022 and 12 August 2022]

Letter of 22 June 2022

3.1 The Inquiry has requested the production of all files and documentation held by the CSNI. Having set out the background of CSNI prior to the creation of the centralised service and database, we interrogated the database against the list of 36 cases provided by the Inquiry. In the CSNI letter of 27 July 2022 **[WITN7589004]** we confirmed and provided information on three cases in respect of (i) GRO-A, (ii) GRO-A GRO-A and (iii) GRO-A

Letter to Infected Blood Inquiry 27 Jul

3.2 For these cases, we will provide you with additional screen shots extracted from the narrative section of the CSNI database **[WITN7589005; WITN7589006; WITN7589007]** as well as an electronic copy of the case file for GRO-A **[WITN7589008]**.

3.3 The Inquiry may wish to consider contacting the General Register Office for Northern Ireland (GRO) General Register Office for Northern Ireland - GOV.UK (www.gov.uk) to establish death certificates for each of the deceased on the list. A death certificate confirms whether there was coronial input to a case, as follows:

- Certified: means medical practitioner's Medical Certificate of Cause of Death (MCCD) – closed no further action;
- Coroners Statement is a Form 14: Where a doctor has reported the death to the Coroner but is able to provide a cause of death, which is then authorised by the Coroner, without the need for post-mortem examination;

- Coroners Certificate is a Form 17: Where a Coroner's post-mortem has occurred but no inquest is deemed necessary;
- Inquest cases provide the information such as the date/location/Coroner at inquest.

3.4 When someone dies, the death must be reported to the General Register Office for NI. Before it can be registered, the Registrar must be provided with notification of the death and either a MCCD from a doctor, or authorisation from a Coroner.

3.5 Additionally you have confirmed from death certificates that three further cases had coronial involvement. This means that the deaths were reported to the Coroner however occurred prior to centralisation [from 1985, 1990, and 2002]. These cases were not data captured onto the database, having been closed prior to centralisation:

- GRO-A date of death 1985 (Coroners certificate – Form 14);
- GRO-A date of death 1991 (Coroners statement – Form 17); and
- GRO-A date of death 2002 (Coroners statement – Form 17)

3.6 In the case of GRO-A you may wish to contact the GRO to determine if any further information is held. Enquiries made by CSNI on your behalf with the State Pathologist's Department for further information relating to the Form 17 cases produced copies of the postmortem reports which are attached as **WITN7589009** and **WITN7589010**.

Letter of 12 August 2022

Question 1

3.7 Since centralisation in 2006, all deaths reported to the Coroner have been recorded on a database. The CSNI has searched the database and identified 3 cases [the CSNI letter of 27 July 2022 refers].

3.8 The CSNI has searched the database for the terms "contaminated blood" and "infected blood". One record, which is not on the list of cases provided by the Inquiry, was extracted under the term "infected blood". The record refers to a case where an inserted drain became septic and where the database records "½ litre of infected blood", which does not appear to be relevant to the work of the Inquiry.

Question 2

3.9 Prior to 2006 there was no electronic database. The CSNI was re-structured from seven Coroners Districts to a centralised service in 2006 and an electronic database was

installed to accommodate centralisation. At that time all "live" cases were transferred onto the database. Additionally, limited details of some closed cases were data captured. Centralisation brought a streamlined process for Coroners' investigations including the centralisation of records in a case management system, and a reduction in the registration delays of deaths in Northern Ireland. We are unable to determine if or how records were maintained prior to centralisation [see paragraph 2.4].

Question 3

3.10 We have provided a route for the Inquiry to contact the GRO to establish if there was coronial input to specific cases. Additionally, the CSNI will make inquiries with the State Pathologist's Department for any further information relating to the cases that refer to a Form 17.

Question 4

3.11 The case was reported to CSNI by a staff nurse. Additional screen shot narrative information from the database has been included at **[WITN7589006]**.

3.12 More generally, the Coroner will consider all cases reported to him/her on a case by case basis. Initially the Coroner will gather information to investigate whether the death was due to natural causes and if a doctor can certify the medical cause of death. If it is established at this stage, that section 7 of the 1959 Act does not apply, a doctor may proceed with completing an MCCD.

3.13 The Coroner will authorise the police to gather this information which means that they will need to speak to relatives and others present when the death occurred or involved in the care of the deceased.

3.14 If the reason why a doctor cannot certify the death is simply because they have not seen and treated the patient in the last 28 days, then the doctor will discuss the cause of death with the Coroner. If the Coroner is satisfied that the death was from natural causes and no further investigation is necessary, then the Coroner may accept the medical cause of death that the doctor gives and issue a Coroners notification (Form 14) to enable the death to be registered.

3.15 If a doctor cannot certify the medical cause of death then the Coroner will investigate the death and may order a post-mortem examination to be carried out.

Additional Information Request reference 5-7

3.16 The Inquiry may wish to refer to the Department of Health publication on 'Guidelines for Notifying the Coroner of a Death' **[WITN7589011].** You will note that Hepatitis is listed as a diagnosis that is referable to the Coroner. [Page 15 refers: "Hepatitis* If due to occupation or drug abuse (usually Hepatitis B)" however, "*If MCCD indicates blood poisoning, septicaemia or hepatitis is due to natural causes, the case does not need referred to the Coroner."].

3.17 The Department of Health will confirm when the guidance was published; it is unlikely to have existed around the time of the early deaths. We are not aware of any memorandum or guidance in relation to infection following blood infected products.

3.18 The CSNI has no correspondence from Professor Elizabeth Mayne on the records management system that dates back to the time covered by the Inquiry which predates the centralisation of CSNI.

3.19 **The Inquiry should note that documents referenced are provided in an unredacted form containing personal and sensitive information which should be handled accordingly.**

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 24. 11. 2022

Table of exhibits:

Date	Notes/Description	Exhibit Number
1959	The Coroners Act (NI) 1959	WITN7589002
1963	The Coroners (Practice and Procedure) Rules (NI) 1963	WITN7589003
27/07/2022	CSNI Letter of 27 July 2022 attaching Annex A	WITN7589004
22/11/2022	Screen shots from case management system: GRO-A	WITN7589005
22/11/2022	Screen shots from case management system: GRO-A	WITN7589006
22/11/2022	Screen shots from case management system: GRO-A	WITN7589007
GRO-A 2018	Copy of case file for GRO-A	WITN7589008
GRO-A 1991	Copy of post-mortem report GRO-A GRO-A	WITN7589009
GRO-A 2002	Copy of post-mortem report GRO-A GRO-A	WITN7589010
No date	Department of Health, 'Guidelines for Notifying the Coroner of a Death' (V0.17)	WITN7589011