The Honorable Mr Justice Colton
Royal Courts of Justice
Chichester Street
BELFAST
BT1 3IF

Your Ref:

Our Ref: JOH-0457-16

Date: 22nd June 2016

Dear Adrian,

During the course of the public hearings, the then Senior Coroner, John Leckey, gave very helpful evidence to me on a number of issues relevant to the reporting of deaths in hospitals. Broadly speaking, the areas covered included Rule 23 Reports, multiple reports to the Coroner of one death and the role of the Coroner's medical adviser.

Arising from those areas, I would be grateful for your assistance with the following issues:

1. Rule 23 reports

    - Have there been any amendments made to the legislation providing for such reports or are there any plans to amend the legislation in any way, including any changes which reflect more closely that which pertains in England and Wales?

    - I have requested an update from the Department of Health about their use and dissemination of Rule 23 reports as a tool to improve practice in the Health Service. Does the Coroner's Service get any feedback regarding the use of these reports? Are you aware of any initiatives between the Departments of Justice and Health concerning Rule 23 reports post inquest.

2. Reporting of deaths

    Are there any recorded instances in the last 5 years of more than one Trust reporting a death to the Coroner's Service? For example where a patient has been treated in one Trust area but is then transferred to the Belfast Trust area , would the initial "treating Trust" ever report in addition to the Trust where the patient actually dies?

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3. Medical adviser

   Does the Coroners' medical adviser have the facility to obtain specialist advice in order to enable her to advise a Coroner whether an inquest is required? If so, since when has this facility been available?

I am grateful for your assistance.

With best wishes

John O'Hara

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