Coroners Service
for Northern Ireland

Ms Bernie Conlon
Secretary
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Your Ref: BC – 0227-16

5 August 2016

Dear Ms Conlon,

Re: Hyponatraemia - related deaths Inquiry HE3-16-1114

Please find attached responses to questions 9 and 12 posed to the Department of Health which were referred to the Department of Justice for response.

If you require any further information, please do not hesitate to contact me.

Yours sincerely,

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- 8 AUG 2016
INQ-4590-16

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IHRD - Questions for Department of Health – DoJ Abstract

No	Context	Question	Response
9	*"I know there was some discussion about coroner's service, after Northern Ireland became a single coroner's district, should produce an annual report, and that would be a document that would allow for rule 23 referrals and responses to be published. But also, I think I should advise you that there is some suggestion of rule 23 in our legislation being amended, and that is under consideration at the present time."* **Transcript 26th June 2013 p.57 L.14-21 Coroners Evidence**	i. What liaison has there been between Department of Health and Department of Justice about improving the Health Service through the issue of Rule 23 reports following Inquests and the sharing of SAI reports for Inquests? ii. Is any further liaison under active consideration? iii. Are there any plans to bring the NI legislation in line with England and Wales or for amendments in any way?	1. When a Coroner issues a Rule 23 Report, the Department of Health are required to respond detailing any action that has been undertaken, or which it proposes to take together with a timetable for the proposed action. The report and response will be sent to interested persons and any other person or organisation the Coroner believes should see them to support improvements and contribute to the prevention of future deaths. In particular, the Coroner seeks assurance from the Minister of Health and the relevant Trust in who's area the death occurred, that any lessons learnt have been put into operation or are being actively considered. SAI reports are routinely shared pre inquest hearing and are referred to during the inquest hearing. 2. Work is underway to ensure that there is proper feedback and follow up to Rule 23 Reports taking account of best practice in other jurisdictions. 3. There have been no amendments made to the legislation providing for such reports and there are no imminent plans to amend the legislation.
12	**Inquiry List of Issues Departmental** *(iv). "Are there now more reports to the Coronial service than before?"*	i. Please provide information on number of reports to the Coronial service from all Trusts over past 10 years.	Please see attached table

Deaths reported per Trust 2006 - 2016										
	2007	2008	2009	2010	2011	2012	2013	2014	2015	30.6.16
Belfast	564	598	576	475	453	514	521	525	538	217
Northern	196	246	226	181	160	225	238	256	236	109
Western	208	203	208	190	146	197	215	198	205	91
South Eastern	283	271	252	232	203	213	248	202	188	82
Southern	152	195	206	156	144	153	180	216	204	115