

The Inquiry into Hyponatraemia-related Deaths

Chairman: Mr John O'Hara QC

Chairman's Meeting with Coroners

At a meeting on Thursday 17th May 2018, Mr Justice O'Hara addressed the Presiding Coroner, Mrs Justice Keegan and the Coroners, Ms Suzanne Anderson, Mr Patrick McGurgan and Mr Joseph McCrisken.

After summarising the background to his recent report, he highlighted a number of matters. In summary, they included:

1. The possibility that not all deaths which should be reported to the Coroners' Service are being referred.
2. A relatively low level of knowledge among doctors about their obligations to appropriately report certain hospital deaths to the Coroners' Service.

In conducting inquests, Mr Justice O'Hara urged the Coroners' to ensure they consider the following:

1. How the statements that are presented to them are taken and by whom.
2. Obtaining a full list of witnesses who were involved in the treatment of the deceased patient in order that the Coroner is aware of the identity of everyone involved in the care and treatment of the deceased person. Accordingly, the Coroner can determine from whom statements are required.
3. Expert reports - all parties should be asked if they have sought to commission or have commissioned expert reports; whether they intend to share those reports and if not, why not.
4. Breadth of legal representation - should all medical personnel have the same legal representative? Potential conflicts should be raised with the lawyers.

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