

# Coroner's Inquests – A Guide for Learners

## Section 1: Introduction

Being called as a witness at an inquest is an infrequent event. It can however cause much anxiety and uncertainty. This guide is written to give advice to learners on how to prepare for an inquest and what support is available. A Coroner may be a Lawyer or a Doctor (or both), and is an independent judicial officer who must investigate sudden death of which the cause is unknown, violent or unnatural. Coroner's jurisdiction has existed for eight centuries but has been greatly reduced over time to narrow their field of inquiry currently to sudden or unexpected deaths.

## Section 2: Who does this guide apply to

The aim of these guidelines is to provide advice and support to all learners involved in a Coroner's Inquest

## Section 3: Definitions of abbreviations used throughout the guide

- HEE – Health Education England

## Section 4: Roles and Responsibilities of the users

Coroner's Inquests will feature in many learners' careers. Learners should seek advice from their supervisors and mentors if they are unsure of any part of the process.

## Section 5: Reporting Deaths

The circumstances in which reporting a death is mandatory or advisable are covered in Trust/provider induction. If you are in doubt then seek advice from the Coroner's Office, from the bereavement office or Trust/provider legal services. It is better to have a short conversation with the Coroner's Office ending with "the Coroner has no interest in this death" rather than the complexities of having to deal with a case which should have been reported.

Common circumstances when the death will be reported are:

- The death was unnatural
- Death was due to accident, violence, neglect, abortion or any kind of poisoning
- Death was in other suspicious circumstances
- Death occurred in prison, police custody or other state of detention (including a sectioned patient in a psychiatric institution)
- No doctor attended the deceased during their last illness
- The deceased was not seen by a doctor within 14 days of death, nor after death
- The cause of death appears unknown
- Death occurred during surgery or recovery from anaesthetic. It is normal to discuss cases that occur within 30 days of surgery or an invasive procedure, even when the circumstances do not cause concern
- Death occurred at work or was due to industrial disease or poisoning
- Death was sudden or unexpected. It is normal to discuss all deaths occurring in the Accident and Emergency Department, and any deaths within 24 hours of admission

## Section 6: What the Inquest means to the family

In most cases a Coroner's Inquest will be the only public and independent investigation into the circumstances of a particular death. For the family of the deceased it can:

- Help with the grieving process
- Provide factual information
- Provide a setting in which their questions can be answered
- Demonstrate changes in practice or procedures which may save future lives

## Section 7: Is the Inquest a Trial?

An Inquest produces a verdict but it is not a trial. It is a fact-finding inquiry by a Coroner, with or without a jury, into the circumstances surrounding a death. The purpose is to determine **who** the deceased was, **when** and **where** they died, and **how** they came by their death. The majority of inquests are heard by a Coroner sitting alone. Only about 4% of inquests require a jury. A jury is required in:

- Any death in custody
- Any death involving the workplace and Health and Safety executive
- Any death on a railway line
- Where it would be in the public interest

The inquest does not say who is responsible for a death. It is not the Coroner's role to probe for any potential clinical negligence. It is however quite possible that the findings of an inquest may be influential in subsequent legal action as part of the prosecution or defence.

## Section 8: Preparing a Report

An inquest statement is one example of a professional statement you may be asked to provide throughout your career. Statements may be seen by a wide group of people including:

- Police
- Coroner
- Care Quality Commission/Health Ombudsman
- Patients and their families
- Solicitors and barristers
- Secretary of State for Health

It is therefore worth doing them well and knowing what is expected. When a request is made for a report, it is important that it is provided quickly and preferably within two weeks. A single comprehensive statement suitable for all possible investigations is recommended.

See separate guidance *Writing a Statement*

## Section 9: Giving Evidence

- As a witness you are not on trial, you are there to assist the court
- The Coroner decides which witnesses should attend, and in what order they are called. Normally they will hear the family's evidence first, followed by the pathologist, then the treating clinicians/staff in chronological order
- A witness must attend; you will normally receive a formal summons (subpoena). If you do not attend you may be fined
- Arrive in good time, usually hospital staff will travel together from the hospital
- Dress appropriately (as if attending for a job interview)
- The Coroner is addressed as Sir or Ma'am
- Remember to turn off mobiles/bleeps
- Witnesses read their statements under oath, you will be asked which oath you wish to use
- There is usually a seat in the witness box
- The Coroner asks questions during and after hearing their statement to clarify details
- After the Coroner, the family or their legal representative can ask questions. The Coroner will ensure that no inappropriate questions or challenges are made. Cross examination of witnesses is not allowed. In some circumstances the Coroner will make a witness aware that they do not need to answer a question that could incriminate them.

## Section 10: Being a Good Witness

- The proceedings in the Coroner's Court are taped, and it is important that the witness' replies are audible
- Concentrate on answering the question as it has been asked
- Avoid medical jargon that the family may not understand
- Prepare adequately – re-familiarise yourself with your statement, the medical records and any other relevant documents (policies). It is important for witness to have all the clinical facts at their fingertips. Muddled thinking or speaking or shuffling of papers always gives a bad impression. The gap between the event and the inquest can be a long one – sometimes more than a year
- In the box take your time, concentrate, speak clearly and slowly. Be honest, reasonable, courteous, helpful, professional and caring!
- Don't try to predict the question, evade the question, guess/fabricate, react/retaliate; don't be clever, arrogant or argumentative.
- Never argue with the family or their legal representative. You may be correct but you will be viewed as an unreliable witness by the Coroner.
- If you do not understand the question say so
- Take your time, tell the story as it was, explain your answer and answer the question, not any agenda
- If asked a question in a confrontational manner, do not become defensive, answer as fully and simply as possible
- Acknowledge the family at the inquest. The inquest will be stressful and upsetting for them
- If your evidence is complex or difficult to explain, consider the use of props (equipment) or diagrams. This can be discussed at a pre-inquest meeting.

## Section 11: Court Day Checklist

- Childcare (if required)
- Cover your clinical duties, inform your clinical supervisor
- Travel arrangements, most Trusts/providers will take all involved staff to court together
- If you are travelling alone courts rarely have car parks for witnesses. Allow plenty of time to find somewhere to park and have change for the meter.
- If travelling with a colleague have a contingency plan for getting home in case you are giving evidence at very different times
- Have you got a copy of your statement?
- Dress code; view it as a job interview. Men jacket/tie or suit, women suit or shirt/skirt.

## Section 12: After Giving Evidence

- You are normally free to leave after you have completed giving evidence. You are free to stay to the conclusion to hear the conclusion and verdict, you may find this helpful
- If the Coroner makes recommendations in relation to his findings, you may wish to reflect on how this will influence your practice.
- After court you may feel tired and emotionally drained. Most Trusts/providers will not expect you to return to work after giving evidence
- You may wish to offer a debrief after court. This can normally be organised through your employer
- The media can (and usually are) present at inquests. Media reports are selective and reports can be biased. Be prepared to see journalists inside and outside the court. Media interest should be covered by your Trust's/provider's Communications Team. It is best to avoid being drawn to give any comment to journalists.
- Media reports can be frustrating and stressful. You may wish to try to avoid them. You may feel you are being unfairly blamed. If this occurs please seek support from your friends, from the Trust/provider and from HEE.

## Section 13: Verdicts

At the conclusion of the evidence the Coroner will sum up the facts. If there is a jury he/she will direct them on the law. No one else is entitled to address the coroner on the facts (including any legal representatives present) It is only permissible to address the Coroner on matters of law.

Verdicts of "unlawfully killed" or "suicide" must be proven "beyond all reasonable doubt". All other verdicts are dealt with to the civil standard of proof, "the balance of probabilities" (i.e. 51%). Verdicts include:

Short form verdicts:-

- Died from natural causes
- Died from industrial disease
- Died from want of attention at birth
- Died from dependence on drugs/non-dependent abuse of drugs
- Killed himself – whilst the balance of his mind was disturbed
- Died as a result of an attempted/self-induced abortion
- Died as a result of accident/misadventure
- Killed lawfully
- Killed unlawfully – murder, manslaughter, infanticide
- Stillborn

Clarifications: Accident implies something over which there is no human control (e.g. a fall) whereas misadventure suggests a lawful human act (e.g. an operation) which takes an unexpected turn and leads to death. If the deceased had a life threatening condition which was either exacerbated by medical treatment or allowed to progress, then the death may be considered to be by accident or misadventure. If, however the death was caused by the underlying disease that proved fatal then natural causes would be the verdict

Neglect in the Coroner's court does not imply negligence. The Coroner can add a rider of "neglect" to the verdict where he/she feels that there was a missed opportunity or gross failure to provide medical attention. There must be a clear connection between this neglect and the cause of death on "the balance of probabilities". Neglect often occurs from a breakdown in communications rather than a deliberate act

Unlawful killing is extremely rare, but the consequences are severe. The coroner cannot accuse a named person of criminal liability, but will state that the deceased was unlawfully killed, without making reference to the culprit. The Coroner will refer the case to the Crown Prosecution service.

Narrative verdicts:-

The use of narrative verdicts is increasingly common. The Coroner will often do this to make the sequence of events clearer for the family, and can also use the narrative where shortcomings of care have occurred.

Occasionally there will be serious findings in a verdict which contain future implications for the public health. The Coroner can write a report (Prevention of Future Death Report – previously known as a Rule 43 report) to a Trust or another body indicating a need for corrective actions, and requiring a report on actions taken within 56 days.

There is no right of appeal against the verdict of a Coroner's court. It is inevitable that some parties may be aggrieved by the verdict and seek to have this overturned. This is done by way of a judicial review. This is not a re-hearing of the facts; the review hears the specific application that the matter was dealt with in a manner that was unlawful, unjust or unreasonable. A successful review may result in a re-hearing but would not substitute a verdict.

## **Section 14: Representation at the Inquest**

This will depend on the circumstances of each case. The fact that a family has representation does not necessarily imply that your Trust/provider will do likewise. The Trust/provider is usually aware as to whether the family are represented or not. It is sometimes assumed that any contact with inquests or litigation needs the involvement of your defence society. Most inquests do not end with controversial or negative findings. By simply being a witness it is not usually normal to inform your defence society, the Coroner would be surprised if a legal representative appeared in the court for an individual witness.

## **Section 15: Support**

Being involved in an inquest creates understandable anxiety. It can be an unpleasant experience, for both witnesses and family. It is reassuring to know that most witnesses feel that their anxiety was overstated when looked at after the event.

In the Trust/provider, the governance/complaints/legal services departments will be co-ordinating statements and the date of the inquest. They are familiar with the process and can give a lot of

advice. It will be normal practise to have pre-inquest meetings to go over statements and give advice on giving evidence and the process. They also frequently offer post inquest debriefing.

Consultants, who will be giving evidence, can also give support and advice. They may have given evidence before and will understand concerns. If anxiety is turning into overt stress then support is available from Occupational Health. Your Educational Supervisor, Training Programme Director, Head of School and other supervisors and mentors are also available to give you advice and support.