Coroner's Inquests

What is an Inquest?

An inquest is a fact-finding inquiry which is intended to answer four questions: who was the deceased; when, where and how they died. In 'medical inquest' cases the first three questions are usually easily answered, and the focus is on the final question of 'how'. Inquests do not assign blame or determine liability for a death.

The Coroner is tasked with investigating certain types of deaths in specific scenarios, including where the cause of death is unknown or arose from unnatural/violent circumstances.

Medical Examiners and referral to the Coroner

Medical Examiners review the circumstances of deaths that would not usually be referred to the Coroner. They can also refer deaths to the Coroner where, after initial inquiries are made, concerns are present (often from the family) which justify the Coroner's involvement.

Changes to the death certification process mean that doctors can now provide a medical cause of death no matter when the patient was last seen by that clinician, if they can provide a cause 'to the best of the doctor's knowledge and belief' (the standard of proof required to complete a medical certificate of the cause of death).

Doctors are still legally obliged to refer certain categories of deaths to the Coroner's Office. The Coroner will then decide whether they need to investigate the death and, ultimately, hold an inquest.

Preparing a Statement

If an investigation is commenced, the Coroner's Office will write to witnesses who they require statements from. If you are asked to provide a statement, the first question to consider is whether you are the correct person to be providing a statement. It can be helpful, on occasion, to direct the Coroner to an alternative individual who is better placed to provide evidence.

Some requests for statements will be very easy to deal with, particularly if there has been limited involvement with a patient and the report effectively becomes a factual account of relevant past medical history. Other statements can be very detailed, reflecting the nature of the care provided and its relevance to the death.

It is important that a formal statement is provided, taking into account that it will likely be disclosed to the family of the deceased.

- Offering condolences at the start of the statement can set a helpful tone.
- The statement should be addressed to the Coroner and an introduction provided regarding the author's qualifications, level of experience and any areas of special interest they may have, so the Coroner has a good

understanding of who the author is. It may also be helpful to clarify the reason they are providing the report.

- Most of the statement will relate to the patient's relevant past medical history and the recent care provided. Some Coroners will set out a timeframe of care that they wish to be included (such as the previous year) but the overall test should be the relevance of the information being provided.
- It is helpful to provide a clear chronological account, ending with the most recent contacts.
- Clinical terms should be explained in lay language. A medication list is also helpful to include, along with their indications.
- Each clinician involved should be identified.
- Statements should be signed and dated when they are ready for submission, and should also include a 'statement of truth', for example '*I believe the above facts are true to the best of my knowledge and belief'.* This will potentially enable the Coroner to read the statement into the evidence, rather than requiring attendance at court as a witness; especially if the statement addresses all of the issues that will arise at the inquest.

Some deaths will have been investigated internally already and therefore any relevant information regarding action taken to prevent future deaths in similar circumstances should ordinarily be included in a statement.

It is important that statements should be a factual account, rather than opinion evidence, unless commenting on issues such as an internal investigation into the death or the care provided.

MDDUS can review statements on behalf of our members and provide advice on the draft. It is also important to obtain input from the hospital/organisation's legal team (if relevant), to ensure that they have the opportunity to provide similar commentary.

Hearings

If you are asked to attend an inquest, it is important to let MDDUS know as soon as possible and also establish if you are considered to be an 'interested person'.

The term 'interested person' applies to the family regulators (such as the CQC), life insurers and other individuals or organisations whose 'conduct might be called into question' during the inquest process. It is in the latter category that medical professionals are usually considered to be interested persons. This does not mean that they will necessarily be criticised, and the inquest process cannot assign blame, but it does reflect significant involvement in the inquest process.

Interested persons can obtain disclosure of documentation and statements that the Coroner has obtained. They can also be legally represented at the inquest (where necessary) and ask questions of other witnesses.

Employees of organisations are often able to be assisted at an inquest by their employer (even though the lawyers involved would, strictly-speaking, be representing the organisation itself). It is only in the unlikely event that conflict

arises between the witness and the employer that MDDUS would need to consider providing separate representation.

Pre-inquest reviews

Particularly complex inquests may be preceded by pre-inquest reviews, which are formal administrative hearings during which the Coroner will hear from the interested persons and potential interested persons involved in the inquest process.

At the pre-inquest review the Coroner will confirm who the interested persons will be, which issues will be central to the inquest, whether further documentation or evidence is required and when the inquest will be heard. It is often only lawyers that will have to attend pre-inquest reviews, so if you are informed that one is to occur, it is important to let MDDUS know.

The Inquest

Inquests are formal court hearings that are held in public and recorded. On occasion, members of the press will attend, as can any other member of the public.

Inquests are often held 'remotely' meaning that witnesses can provide their evidence via video conferencing, if the Coroner agrees. It is important to remember that it is still a court hearing, and you should therefore ensure the Coroner is made aware who is present in the remote location. The GMC provides guidance to doctors who act as a witness in legal proceedings. You may find this additional resource on giving evidence helpful.

In certain situations, such as if the deceased was under state control at the time of their death (usually meaning prison, police custody or detained under the provisions of the Mental Health Act (1983) then a jury inquest is required. The jury, rather than the Coroner, is required to reach the necessary conclusions, but the Coroner will lead the questioning of witnesses. This type of inquest tends to last longer (days to weeks) but is otherwise similar in nature.

A Coroner/Jury cannot determine criminal or civil liability through the inquest process, nor can they assign blame to any individual/organisation. This makes the process different from other types of court hearings where witnesses can be cross-examined by lawyers and liability determined.

The Coroner will begin by formally resuming the hearing and setting out the purpose of the inquest. The 'interested persons' will be identified, along with their legal representatives. There will be confirmation of which witnesses are attending to give evidence and which statements will be read, which will have been previously determined by the Coroner.

Giving evidence at an Inquest

Evidence will then be heard from the witnesses 'on oath', meaning that they have to swear on a holy book or take an 'affirmation'. The Coroner will ask questions of the witness first.

It is often helpful to offer condolences to the family before answering the first question, if the Coroner allows and it feels appropriate to do so. The Coroner should be addressed as 'Sir'/Ma'am'.

If you do not know the answer to the question, for example if it is outside of your competence, it is important to set this out clearly to the Coroner. Once the Coroner has concluded their questions, the other interested persons will have the opportunity to ask relevant questions of the witness. The witness' representatives will be the last to ask questions, although it is rarely necessary for multiple questions to be raised at this stage.

Once the witness has given their evidence, they can leave the inquest, with the permission of the Coroner. In any case, it is also possible to remain as inquests are public.

Once all of the evidence has been heard, the Coroner will ask the interested persons (via their representatives, if present) to provide legal submissions on three main issues; the medical cause of death, the conclusion (previously called the verdict) and prevention of future death issues. The Coroner will then summarise the evidence and reach determinations on the four main questions of who the deceased was, when, where and how they died.

The Conclusion

The Coroner (or Jury, if relevant) has to judge whether conclusions can be reached on the 'balance of probabilities' meaning that it is more likely than not that a fact can be found. Some conclusions will be familiar to medical professionals, such as 'accidental death', 'suicide' and even 'natural causes'. However, narrative conclusions are often reached in medical inquests, given the complexity and nature of the circumstances. This means that a short paragraph will be used to explain how the death occurred.

The most significant conclusion for medical professionals is one that includes reference to 'neglect'. This is different from 'negligence', which is not for the Coroner's court to determine. Neglect in this context means 'a gross failure to provide basic care and attention'. This is a relatively rare but significant outcome and has potential relevance to the professionals involved in the inquest.

The Outcome

The main issues of concern that can arise out of an inquest are whether criticism has been made (usually indirectly, since a Coroner would not ordinarily assign criticism) and if the Coroner is required to write a prevention of future death report.

Prevention of Future Death Reports

If a Coroner is concerned that risks of future deaths have not been addressed, they are under a duty to write to an individual or organisation, asking what steps will be taken in response. The addressee has 56 days to respond to the report and to set out what steps are being taken or the reasons why no steps will be taken. Both the report and response will be public documents and therefore it is

important to discuss receipt of such a report with your organisation, along with MDDUS so that we can advise on how best to respond.

Criticism

If a doctor is criticised in a public hearing, GMC guidance sets out that self-referral to the regulator should be undertaken. It is often difficult to interpret whether criticism is inferred. As such, it is vital to discuss this issue with MDDUS, even if we have not been involved directly in the inquest process. We can provide advice as to whether self-referral to the GMC is required and, if so, look to support our members through this process.

In summary

Although the inquest process can sound intimidating and concerning, most Coroners now consider that the process should be an opportunity for learning and therefore they should not have adverse implications for medical professionals involved. Nonetheless, it is important to contact MDDUS early on so that we can advise and support you through the process.