NHS
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Coroners' Inquests – A Guide for Trainees

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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 trainees on how to prepare for an inquest and what support is available. A Coroner is typically a Lawyer but may be a Doctor (or both), and is an independent judicial officer who must investigate sudden death of which the cause is unknown, violent or unnatural. A 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. The Medical Examiner (ME) advising your Trust will have reviewed the medical notes and issues and approved referral to the Coroner, and may have discussed this with Coroner's Officer/Coroner.

Section 2: Who does this guide apply to

The aim of these guidelines is to provide advice and support to all trainees involved in a Coroner’s inquest.

Section 3: Definitions of abbreviations used throughout the guide

- **HEE – Health Education England**
- **MCCD – Medical Certificate of Cause of Death**
- **MDO – Medical Defence Organisation**
- **ME Medical Examiner**
- **PFD – Prevention of Future Deaths**
- **PIM – Pre-Inquest Meeting**

Section 4: Roles and Responsibilities of the users

Coroners’ Inquests will feature in many trainees’ careers. Trainees should seek advice from their supervisors, mentors and their Medical Defence Organisation (MDO), who have expertise and can advise and if necessary provide legal support for the Inquest, 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. It should be discussed with the ME and if you are in doubt then seek advice from the Coroner’s Office, from the bereavement office or Trust/provider legal services, and your MDO. It is better to have a short conversation with the ME and, if necessary, the Coroner’s Office resulting in a view expressed that “the Coroner has no interest in this death” rather than the complexities of having to deal with a case which should have been reported. The ME advising the Trust will have a specific role in reviewing the accuracy of medical certificate of cause of death (MCCD) and referrals to the Coroner and can also, where appropriate, discuss the case with the Coroner’s Officer or Coroner.

Deaths that are unnatural, sudden or unexpected are likely to need to be reported to the Coroner. Regulations require that deaths in certain circumstances must be reported to the Coroner, and these include:-

- **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, with the ME who can advise on referral/discussion with the Coroner.**

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 bereavement process.
- Provide factual and explanatory information to assist the family's understanding.
- 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 Trail?

An Inquest produces a conclusion (previously referred to as a verdict although it is not a trial). An inquest is a fact-finding inquiry conducted 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, how and in what circumstances 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 set out who is responsible for a death. It is not the Coroner's role to determine whether any civil or criminal liability attaches to any named person or to apportion blame. 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. Under section 28 of Coroners and Justice Act it is open to the Coroner to provide a Prevention of Future Deaths (PFD) report, and as such the Trust must investigate and report any resultant changes in practice /procedure, which would address this in future situations, to the Coroner.

Section 8: Writing a Statement

An inquest statement is one example of a professional statement you may be asked to provide throughout your career. It is important to remember that statements may be seen by a number of people connected with the inquest.

It is therefore essential and important to write these well and accurately, as you may be questioned on any statement at the Inquest. When a request is made for a statement/report, it is important that it is provided in a timely manner and you should meet any deadline asked or seek permission for an extension if that is not possible for an unexpected reason. You should always make sure that you have seen the medical records and may take additional advice from your Trust, Educational Supervisor, and/or MDO. It should be remembered that a detailed chronology of events setting out your involvement in the patient's care may assist in accurately drafting a statement for another purpose at a later date.

Helpful Tips on Writing a Statement:

- Keep it professional. Statements should be typed and on headed paper. A suggested template is included below, although your Trust/organisation may have a preferred structure.
- No one can tell you what to include or take out of your statement. This is your document and you should include all of the information that informed you and/or whether and how you were involved that you consider relevant and you would wish the Coroner to be aware.
- Make clear the capacity in which you are making the statement. This will usually be as a professional witness; i.e. witness to fact (as opposed to an expert witness).
- Access to the medical records is essential and other documents may be helpful (incident report forms, theatre lists, ward diary, duty rotas, protocols etc.). Advice from your MDO may be helpful as it is usually best to refer to the medical record rather to append a document. The Coroner and inquest will have access to the deceased's medical record.
- Be honest, clear and factual. Giving the impression that you are concealing facts or misleading the court can lead to serious consequences. The GMC expects you to take reasonable steps to check the information you are providing is correct and that you must not deliberately leave out relevant information. It also requires you to make clear the limits of your competence and knowledge when giving evidence.
- Be clear what you cannot remember; for example, state that you do not remember or recall events where that is the case.
- Avoid hearsay and secondhand reporting
- As a witness of fact, it is important to keep to the facts and not to express an interpretation or opinion unless asked to do so at the inquest. Even then, it may be appropriate to state that you are in training and cannot do so. Moreover, do not speculate. Interpretation is the purpose of the inquest.
- Be concise and clear and avoid jargon. Abbreviations may be used but must include a written definition/explanation in full on the first occasion they are used with the abbreviation between parentheses thereafter. Explain medical terminology including medication and why it is being used. Write as for an intelligent lay person. This will be appreciated by the Coroner and the family.
- Try to deal with any errors or omissions – this is an opportunity to explain why something was or was not done.

- Look at the overall impact of your statement. Does it allow the reader to visualise how events occurred?
- A statement is disclosable in law. Do not write anything in a way that you would regret hearing if discussed in another venue later.
- Ensure that your statement/report is correct in all details. It must be correct and accurate and should not be written under pressure or without sight/reference to the medical records. Do not rush it or do it at the end of a busy shift. Seek advice from your MDO or the ME if you have concerns.
- Read your statement through, make any changes you feel are necessary, and only sign and date it when you are completely happy with what it sets out and how it says it. This is legally your statement.
- You may express your condolences to the family of the deceased if you wish, but this is not mandatory. However, do include a statement of truth, at the end of your statement, and then sign, date and send it to the Coroner with a covering letter. This should be with the knowledge and agreement of the Trust, usually the Medical Director or Director of Nursing, ME and MDO adviser.
- It is essential to keep a copy of your signed and dated report as the inquest may occur when you are working in a different Trust/GP Practice.
- Remember the Coroner will ask for a statement if they want your help; it does not imply you have done something wrong. If you are informed by the Coroner or the Trust that you are an Interested Person (IP) at the inquest, this may indicate that your involvement, through act or omission, may have caused or contributed to the death of the deceased. This is uncommon, and where this occurs, you may wish to contact your MDO if you have not done so already. The Trust's legal advisers will also guide you as legal support (representation) at the inquest is likely to be required.

Section 9: Giving Evidence

- As a witness of fact you are not on trial, you are there to assist the Coroner/court
- The Coroner decides which witnesses should attend, and in what order they are called. Normallythey will hear the family's evidence first, followed by the pathologist, then the treat-ing clinicians/staff in chronological order.
- A witness of fact must attend; you will normally receive a formal summons (subpoena). If you do not attend you may be fined.
- It is important to arrive in good time, usually hospital staff will travel together from the hospital
- Dress appropriately (as if attending for a job interview -The dress code is formal, for example menshould wear a tie although you do not now do this when working in hospital. It shows respect to the court (Coroner) and to the family).
- The Coroner is addressed as Sir or Ma'am.
- Remember to turn off mobiles/bleeps.
- Witnesses usually are asked to read their statements under oath, you will be asked which oath you wish to use. If you are not asked to read your report at the outset, you can be assured that the detail you previously provided has been read and will be taken into account.
- There is usually a seat in the witness box.
- The Coroner may ask a witness questions during and after hearing their statement to clarify details. If you wish to refer to your statement, a copy of which you should bring with you, or

to the medical records, you should ask the Coroner if you may refer to them before doing so.
- The Coroner may ask questions during and after hearing your statement. After the Coroner, the family or their legal representative can ask questions. The Coroner will ensure that no inappropriate questions or challenges are made. Although inquests are non-adversarial this does not mean that you will not be asked robust or challenging questions. It is important to maintain a calm, unhurried, professional demeanour. In some circumstances the Coroner will make a witness aware that they do not need to answer a question that could incriminate them. Rarely, you may find yourself facing hostile and critical questions from either an interested person's representative or, rarely, the Coroner that was entirely unanticipated. In that circumstance, you may wish to ask the Coroner for a short adjournment and, with the Coroner's agreement, seek advice immediately from your MDO or lawyer if they are there to support you.

Section 10: Being a Good Witness

- The proceedings in the Coroner's Court are recorded, and it is important that the witness' replies are audible.
- Concentrate on answering the question as it has been asked. It is essential not to answer the question you wanted to be asked. Give the shortest clear answer and then stop and wait to be asked further questions. Do not consider adding afterthoughts or anything that has not been covered in your statement.
- Avoid medical jargon that the family may not understand
- Prepare adequately - familiarise yourself again with your statement, the medical records and any other relevant documents (eg Trust policies). Before attending an inquest, 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 witness box take your time, concentrate, speak clearly and slowly. Be honest, reasonable, courteous,helpful, professional and caring!
- Do not try to predict the question, evade the question, guess/fabricate, react/retaliate; nor beclever, arrogant or argumentative.
- Never argue with the family or their legal representative. You may be correct but you may create an unfavourable impression with the Coroner.
- If you do not understand the question say so and request that it be put in a different form.
- Take your time, tell the story as it was, explain your answer and answer the question, not any agenda.
- In the event that you are asked a question in a confrontational manner, simply remain professional and courteous. If you consider a lawyer is goading you, simply keep looking at the Coroner when being asked the question and when giving the answer, as that is the important person at the inquest in deciding outcome. Do not become defensive, answer as fully and simply as possible.
- Acknowledge the family at the inquest as they are important person there. The inquest will be stressful and upsetting for them.
- If your evidence is complex or difficult to explain, consider the use of props (equipment) ordiagrams. This can be discussed at a pre-inquest meeting (PIM). If there is a PIM, it is likely that you will be supported by a lawyer either appointed by the Trust or your MDO and must take advice from them.

Section 11: Court Day Checklist

- Childcare (if required).

- Ensure in advance that your clinical duties will be covered by a colleague. This may need discussion with the consultant, Medical Director and/or your Educational/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 for public transport elays or to find somewhere to park and have change for the meter if required.
- If travelling with a colleague have a contingency plan for getting home in case you are giving evidence at very different times.
- It is important to ensure that you have a copy of your statement to which you can refer if the Coroner agrees to that.
- 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 hear the conclusion, you may find this helpful.
If the Coroner makes recommendations in relation to their findings, you may wish to reflect on how this will influence your practice. At some point after the inquest, you should discuss this with your Educational/Clinical Supervisor and record in your e-prtfolio as learning point(s).

- After court you may feel tired and emotionally drained. Most Trusts/providers will not expect you toreturn to work immediately 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 canbe biased. Be prepared to encounter journalists inside and outside the court. Media interest should be covered by your Trust's/provider's Communications Team. It is advisable to avoid being drawn to give any comment to journalists and simply refer them to the Trust's Communications team.
- There may be media cameras outside the Coroner's court. Where that is the case, maintain a professional demeanour, neither smiling nor other facial expression, and do not hide from the camera. Simply allow a dignified picture and remember, it may never be used.
- Media reports can be frustrating and stressful. You may wish to try to avoid them. You may consider you are being unfairly blamed. If this occurs please seek support from your friends, from the Trust/provider, MDO and from HEE.

Section 13: Conclusions

At the conclusion of the evidence the Coroner will sum up the facts. If there is a jury he/she will directthem 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.

All conclusions are dealt with to the civil standard of proof, or on “the balance of probabilities” (i.e. more likely than not). Conclusions include:

Short form conclusions:-

- **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 conclusion.

Neglect: in the Coroner's court does not imply negligence. The Coroner can add a rider of "neglect" to theconclusion where they feel 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 balanceof probabilities". Neglect often occurs from a breakdown in communications rather than a deliberate act.

Unlawful killing: is extremely rare, but the consequences are very serious. It is very unlikely that you and the Trust would not be aware of this potential conclusion, as you would be termed an IP should either neglect or unlawful killing be thought possible conclusions at the outset. In the latter (extremely rare) situation the Coroner, or your legal representative, will inform you when you do not need to answer a question due to the risk of self-incrimination. The Coroner cannot apportion blame to 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 (CPS).

Narrative conclusions:- The use of narrative conclusion(s) is increasingly common. The Coroner will often choose this form of conclusion 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 conclusion which contain future implications for the public health. The Coroner can write a Prevention of Future Death report (PFD), 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. PFD reports and responses are recorded by the Coroner and published in the annual Chief Coroner's Report. There is current debate that more interrogation needs to occur as to actions taken by the Trusts in response to a PFD if they are to achieve their objective of 'learning lessons'.

There is no right of appeal of the conclusion of a Coroner's court. It is inevitable that some parties maybe aggrieved by the conclusion and seek to have this overturned. This is effected 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, procedurally unfair and/or irrational. A successful review may result in a re- hearing but would not substitute a conclusion.

Section 14: Representation at Inquest

This will depend on the circumstances of each case. The fact that a family has legal support/representation does not necessarily imply that your Trust/provider will do likewise. The Trust/provider is usually aware as to whether the family are legally supported or not. It is sometimes assumed that any contact with inquests or litigation needs the involvement of your

MDO. Most inquests do not end with controversial or negative findings. By simply being a witness of fact you are not obliged to inform your MDO; however they do have extensive experience in advising on inquests.

There is no problem in contacting your MDO if you wish to have additional legal support or are uncertain what to expect and desire further guidance. MDOs can liaise with the Trust if there is any aspect that remains unclear for you. Legal support/representation at the inquest is not usually required, but may be available if the Trust is to be legally supported/represented. In the event that you consider the Trust may be conflicted between its staff or that your situation is not recognised, it is open to you to ask the MDO for further advice and assistance. Where appropriate, your MDO can provide you with legal support/representation if it is necessary, for example if you are an IP in relation to your role in caring for the patient.

Section 15: Support

Being involved in an inquest creates understandable anxiety. It may be an unpleasant experience, forboth witnesses and family. It is reassuring to know that most witnesses feel that their anxiety was overstated when looked at retrospectively.

In the Trust/provider, the governance/complaints/legal services departments will be coordinating statements and be aware of the date of the inquest. They are familiar with the process and can give appropriate advice. It will be normal practice to have a Trust pre-inquest preparatory meeting to go over statements and give advice on giving evidence and the inquisitorial 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 your concerns. If anxiety is turning into overt stress then support is available from Occupational Health departments, your Educational Supervisor, Training Programme Director, Head of School and other supervisors and mentors are also available to give you advice and support.