Coroner's Inquests

Overview

The coroner is an independent judicial officer who investigates deaths in England and Wales which may be due to violent or unnatural causes, where the cause is unknown, or when an inquiry is needed for some other reason, for example if the death occurred in prison.

Where necessary the coroner can hold a public hearing in court, known as an inquest. This seeks to establish who the deceased was, and when, where and how they came by their death.

Inquests are fact-finding hearings and the coroner determines the evidence to be heard and which witnesses to call. The coroner can designate any witness as an interested person (IP), a specific legal status which gives rights such as to be legally represented at the hearing, to ask questions of other witnesses and to obtain disclosure of documents. Essentially, an IP will play a more active role in the inquest proceedings, as opposed to a factual witness. The coroner may grant the status of an IP to an individual or organisation because of a concern that an act or omission by that individual or organisation may have contributed to the death.

The coroner cannot blame individuals, or determine civil or criminal liability for a death, but they can be critical of individuals involved and standards of care. Being criticised by a coroner would necessitate self-referral to the General Medical Council (GMC) or General Dental Council (GDC) as appropriate.

Basic considerations

Before an inquest

- You may be asked to provide a written report about your involvement in a patient's care, or the care provided by an organisation or department where you worked. The statement should be focused on facts relevant to the death, and should be detailed, accurate, objective, and written in full English rather than in note or bullet point form. Medical terms should be avoided where possible, or explained. Any actions should be linked to an identified individual, and the report should not leave unanswered questions. A good report may be read out in court and may avoid the need for you to attend in person.
- When called to attend an inquest ensure you note this clearly in your diary as a priority. If there is a problem with proposed dates liaise with the coroner's officer early on. Failure to attend an inquest without a reasonable excuse is an offence, and a breach of GMC or GDC guidance.

- Establish with the coroner whether you are an IP, whether the coroner and/or the family have any concerns or potential criticisms of your involvement in the care of the deceased, and whether the family is legally represented.
- Enquire as to whether the inquest is an Article 2 inquest. These are enhanced inquests where consideration is given to whether there has been a breach of obligations under Article 2 ('right to life') of the European Convention on Human Rights.
- Contact MDDUS for advice and support at every stage.

Preparing for an inquest

- Familiarise yourself with and take along a copy of your statement and highlight any aspects that may be more important so they can be easily located. If you are not sure whether the patient records will be in court, also take a copy of these. You can refer to these when necessary.
- Make sure you know where you are going and allow plenty of time to get there. There are court officials who can guide you to the relevant room and will help with any practical questions. Inquests are heard in a variety of settings, from modern rooms to old courthouses, but all are formal courts.
- If you have legal representation, take their advice. You can take a friend or supportive colleague if you need support; it is usual to feel nervous so this can be helpful.
- Dress professionally, perhaps as you would were you attending a job interview.
- If you are called to give evidence you are first asked to take the oath or affirm. You will usually be sitting in a witness box.
- The coroner addresses questions to you, including when you have legal representation. These questions must relate to the key focus of the inquest: who the deceased was, where, when and how they came by their death. You can also be questioned by any IP (including the family) or their representative. Listen carefully to the question, and try to remain calm and professional, sticking to the facts.
- You must answer questions honestly. This includes responses of "I don't know" or "I can't remember" if this is the truth. You should stick to matters within your own experience and field of expertise, relevant to your knowledge of and involvement in the care of the patient. Once you have answered a question, stop talking and don't feel obliged to fill a silence.
- If you are an IP and have your own representative, they too can ask questions of you to ensure that all your relevant evidence is heard. They can also ask questions of other witnesses.
- Once you have finished giving evidence the coroner will excuse you. You may choose to stay for the rest of the inquest, or leave.
- At the end of the inquest the coroner (or jury if there is one) comes to a conclusion which includes the legal 'determination'. This states who died, and where, when and how they died. The coroner or jury also make 'findings of fact', which are based upon the evidence and necessary to register the death. The cause of death may be recorded as: accident or misadventure; alcohol/drug related; industrial disease; lawful killing; unlawful killing; natural causes; open; road traffic collision; stillbirth; suicide. The coroner (or jury) may also return a 'narrative' conclusion setting out the facts around the death and the reasons for the decision.

- Pay close attention to any assessment made by the coroner, at any point during the inquest, in relation to the standard of care you provided. This is so you can be aware of whether the coroner has been critical of you. If there is any uncertainty and you have not been legally represented, contact MDDUS. It may be necessary to seek further information from the coroner to determine this at a later date.
- The coroner is under a statutory duty to consider any action that could be taken to prevent future deaths as a result of findings made at an inquest. If they do identify any such actions they will issue a report to that effect which requires a response. This is known as a Prevention of Future Deaths ("PFD") report. If you have managerial responsibility for responding to such a report, contact MDDUS.

Common pitfalls

- A confusing timeline of care is difficult to follow. Events should generally be presented in chronological order. Ensure that each event is clearly dated (and timed if appropriate), identify who consulted and whether or not this was face-to-face. It is helpful to highlight the latest date on which the deceased consulted the author of the report and the last date of contact with any clinicians.
- Producing a good statement at the outset is crucial and can avoid being called to attend an inquest. Do not rush, and make sure the statement is detailed and accurate. Ensure that you review the medical records when preparing your statement. Concentrate on matters relevant to the death, including in all cases significant past medical history, drug history, history of drug/alcohol use and mental health history. Seek advice from MDDUS.
- Do not delay in seeking advice on any inquest you are asked to attend, especially where there may be criticism of your care. Preparation is key and can avoid adverse consequences.

Key points

- Inquests are fact-finding hearings and are usually straightforward, but there are risks and therefore any inquest should be carefully considered.
- When a healthcare practitioner is at risk of criticism they are given the status of IP and should seek advice as soon as possible.
- Always seek advice if you are involved in an Article 2 inquest.
- If a doctor or dentist is criticised by the coroner at the conclusion of an inquest there is an obligation to self-refer to the GMC or GDC.