# Inquests

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# Who is the Coroner?

- Responsible for investigating deaths and determining the cause of death
- Independent Judicial Officer appointed and appointed / paid by the local authority
- Qualifications: lawyer (>5 years standing) under 70 yrs old
  - Some are dual qualified (law and medicine)

# What does the Coroner do?

Upon reporting of a death the Coroner can do one of three things:

- certify the death as due to natural causes without a post-mortem
- certify as due to natural causes after a post-mortem
- initiate an investigation into the death (under CJA 2009)

When must the Coroner investigate a death?

- Death is violent or unnatural (including death due to self harm)
  - "Unnatural" relates to the circumstances of the death
- The cause is unknown
- Death in custody or state detention

# What is the purpose of an inquest?

- **Fact finding exercise**
  - **It is not a trial / purpose is not to apportion blame but...**
  - **It may feel like it during the inquest...!**

- **Four key questions**
  - **Who the deceased was?**
  - **How, when and where the deceased died?**
  - **NB: Article 2 provisions – "how *and in what circumstances*"**

# What is the purpose of an inquest?

- **Conclusions and liability [s10(2) Coroners and Justice Act 2009]**
  - ***"No <u>conclusion</u> shall be framed in such a way as to appear to determine any question of:***
    1. ***Criminal liability on the part of a named person, or***
    2. ***Civil liability''***
  - **Evidence can deal with issues relevant to fault / negligence so long as relevant to exploring 'how' someone died**

# What should the inquest achieve?

- Independent scrutiny of events surrounding a violent / unnatural death
- Establish the facts
- Allow properly interested persons an opportunity to question witnesses
- Draw attention to circumstances which might lead to further deaths

# Before the inquest

- NB *Internal investigation
- Review your witness statement
- Be familiar with the entries made in the medical records
- Consider the types of questions which may be asked and responses
- Make sure you know how to get to the Coroner's Court and have relevant contact numbers.

# The inquest

- Generally, witnesses may sit through the whole hearing
- Coroner will call witnesses in chronological order
- Evidence on oath or affirmation
- Questions:
  - By coroner
  - The family or their lawyer
  - Other ‘’interested parties’’
  - Your lawyer

# What can the coroner conclude?

- Short form conclusions
  - Natural Causes
  - Accidental death
  - Suicide
  - Unlawful killing
  - Open
  - *Alcohol/Drug Deaths*
  - *Road Traffic Collision*
- Long form conclusion (narrative conclusion)

# PREVENTION OF FUTURE DEATHS (PFD)

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# When is a PFD report issued?

- **Mandatory where the evidence gives rise to a concern that circumstances exist which create a risk that other deaths will occur in the future**

- **In the Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk**
  - **Para. 7 of Schedule 5 of the Act wide scope; coroner's concern may arise from *"ANYTHING revealed by the investigation"***
  - **Para. 15 of Guidance Note 5: *'Sometimes it may be necessary to hear some evidence which may be relevant for purpose of making a report but not strictly relevant to outcome of the inquest'.***

- **Para. 10 of the Guidance note No 5:**

  ***"Giving rise to a concern is a relatively low threshold" (London Bombings of July 2005/Lady Justice Hallett)***

# What's the fall out from a PFD report?

- Recipient must respond within 56 days
  - Must include an action plan and timetable for implementation or reasons why no action proposed
- Adverse publicity
- Impact on commercial contracts
- Spot light on systemic practices (time-consuming; expensive)
- Re-appearance before the same Coroner with the same problem later?!
- Supports litigation

# A guide to drafting your witness statement...the good, the bad and the ugly!

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# Accuracy

- Never write from memory – review medical and other records
- Cross-refer to drug charts, test results, observation charts etc
- Once committed to paper incorrect or misleading details will take a lot of explaining in witness box. Review and review again and:
  - Ask a senior colleague to proof read and double check and, if represented, to your lawyer

# Content

- Chronology of Events
- Include **times** and **dates**. Explain if the entry was made retrospectively
- Use unambiguous language:
  - Explain any medical terminology, acronyms, conditions and procedures in layman's terms
  - Use anatomical diagrams if necessary

# Content

- Be sensitive
  - Refer to the person by name not "*the patient*" or "*the deceased*"
  - Correct DOB, DOD, title, address…
  - Public document sent to the family
  - May also be read out in court in front of the family and press
  - Be mindful of misinterpretation, eg "problem client/resident"

# Fact NOT Opinion

- Unbiased and neutral facts:
  - NOT speculation/hearsay
  - NOT opinion

# Be careful what you write….

- A few excerpts from real statements in hospital-related inquests

- The patient has been depressed ever since she began seeing me in 1983
- The patient is tearful and crying constantly. She also appears to be depressed
- The patient has no past history of suicide


# Thank you☺

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