NHS Resolution

Inquests: A guide for health providers

Supporting staff to prepare for an inquest

Advise / Resolve / Learn

Introduction:

Attending a Coroner’s court to give evidence can be worrying if this is something you have never done before, or if you have previously had a challenging experience. NHS Resolution has produced three films to help prepare staff called to give evidence at an inquest. The films can be viewed as standalone products or used as part of a wider training package including this written guidance.
It’s not possible to provide detailed guidance for all situations or for each profession, but this material has been produced to provide the widest range of support to a broad range of healthcare staff (tailor it for your organisation as needed).

These films have been produced as a support guide to help you prepare, as well as indicating where further advice can be obtained. Our aim is also to dispel possible misconceptions about the role of the Coroner and to explain how best a witness can help the Coroner and the patient’s family. The films provide an explanation of the role of the Coroner’s court and demonstrate giving evidence from different perspectives. The films were made in collaboration with clinicians, the Coroner’s office, solicitors and barristers. They have been tested with large clinical and non-medical audiences across England to inform and improve support available to healthcare witnesses.

Film 1: Conversation with a Coroner

Attending the Coroner’s Court for an inquest can be unfamiliar and feel challenging. The purpose of this first film is to reduce worry. Her Majesty’s Senior Coroner for London Inner South, Mr Andrew Harris, describes the role of the Coroner and shares his insights on the importance of candour and transparency.

The content covers:

- Role of the coroner
- Purpose of an inquest
- When to refer a death to the Coroner
- The difference between natural and unnatural deaths
- How you can best assist the court and the family
- What makes a good witness
- Coroners’ conclusions and learnings

Film 2: How to prepare for an inquest

The purpose of this second film is to describe the process of giving evidence in a Coroner’s court, so that witnesses will know what to expect when attending to give evidence, from when they are asked to when the inquest is completed. Gemma Brannigan, an Assistant Coroner covers:

- Purpose of an inquest
- Reason you have been called to give evidence
- How you can prepare yourself for giving evidence
- Professional and legal obligations
- What witnesses should take to court
- How to behave in court

Film 3: Giving evidence at an inquest - a well prepared witness

The purpose of this film is to demonstrate how it feels for a clinician to present evidence in the court, covering typical questions legal representatives may ask. When viewing the film, focus on how the questions flow between the advocate and the witness. The clinical scenario used to frame the questioning is for illustrative purposes - the principles for giving evidence are the same regardless of the precise facts or the speciality of the witness. While this film does not refer to the deceased by name, in reality the deceased's name would be used by the Coroner, witnesses and any advocates.

Training tips

If you are a trainer and are planning to use this video as part of a general inquest education forum, you may wish to ask your audience in advance (or after showing the video) to identify ten key factors that contribute to being well prepared – 12 areas are listed below.

Key principles highlighted in the content are:

- The importance of giving a full straightforward factual account, not speculating or guessing
- Reading your statement before court and taking this with you
- Asking for clarification if you do not understand the question
- Redirecting or declining questions that you are unable to answer (e.g. questions that are outside of your professional expertise)
- Familiarising yourself with medical records before court and any investigations or serious incident reports (including any action plans)
- Adding 'post it' notes to key areas in the medical records so that you can find them when you are giving evidence
- Liaising and seeking support from your legal team and line management
- Addressing your answers to the Coroner
- Speaking slowly, sharing the story of what happened logically from beginning to end in plain English
- Giving the full, honest answer, however difficult this may feel
- Be aware of when and how interested persons1 can ask questions

[1] An interested person is, defined in section 47(2) of the Coroners and Justice Act (CJA) 2009. This includes a long list of classes of people who are deemed to be stakeholders in what happens at an inquest e.g. the deceased's spouse, civil partner, child, Personal Representative or indeed a person who may have caused or

- Understand the order in which questions are asked: Coroner, family and, finally, the health organisation's appointed lawyer.

There is a longer inquest film in development for trusts to assist with more formal planned educational and learning development around an inquest. In the meantime, the frequently asked questions outlined below may help provide additional context and answers to questions witnesses may have.

Inquests – frequently asked questions

1. **What do I call the coroner?**

   Sir or Madam.

2. **Who will ask me questions?**

   The coroner, interested persons (e.g. family members) or their legal representative and your legal representative, if you have one.

3. **What do I say if I can't remember something?**

   You are not expected to remember every detail. Do not guess or speculate. If the answer is in your statement or records, you can look at the document in order to answer. If you cannot remember the answer to a question, and your statement or the records don't contain the answer, you must tell the coroner that you cannot remember. There is no penalty if you can't remember.

4. **What do I say if it might upset a colleague?**

   If you are asked a question when giving evidence and you know the answer, then however embarrassing for a colleague, your answer must be fully honest. Do not filter your evidence. But you should not speculate, do not second guess what might have been in your colleague's mind. You are there as a factual witness, to say the things you saw, did, said or heard.

5. **Should I offer an opinion?**

   You may be asked to express a professional opinion. Sometimes the coroner needs to know whether an event is likely to have contributed to the death occurring at the time that it did. If you have, or are asked to offer, an opinion, and it is within your expertise/specialty to do so, then you can do so. If you do not know enough about the situation to give a professional opinion, you should say that.

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contributed to the death of the deceased; Ultimately considerable discretion sits with the Coroner to decide who has a sufficient interest.

6. **What if my memory differs to the records or the evidence from someone else?**

   People often remember a situation differently, sometimes because it was a long time ago, or because it was a common event in a busy shift. In advance, do consider all of the written records and accounts from other people, to assess whether you might be remembering it incorrectly. Be ready to explain your recollection. You might be asked whether the records made at the time are more reliable than your memory or a statement written later. But if you are confident in your recollection, then say so.

7. **Is it ok if I speak to the family? Should I speak to the family before or after the inquest?**

   Each situation and relationship is different. You can speak to the family before or after an inquest, if they want to speak to you. You can offer condolences or say sorry (saying sorry is not an admission of legal liability). If staff from the trust can express sympathy, then usually this is appreciated by families. But there is no obligation to do so on the day of the inquest, which can be a very stressful time for families and they may not feel like speaking to one or all of the staff. Trusts should not wait until the day of the inquest to express sympathy of offer apologies.

8. **What is the coroner likely to be most concerned about?**

   The coroner is looking for evidence to establish who died, where and when they died, and how they came by their death, and will write down what you say. Your evidence is given ‘on oath’ or after an affirmation (promise to tell the truth). The coroner needs the evidence to be fully honest and accurate. Inconsistency between your evidence in court, your written statement or the records, is likely to be explored. This is why we recommend that you refresh your memory with the document, before going into the witness box to give your evidence. You can have the records and statement in front of you and you can refer to these.

9. **What if I accept that my record keeping at the time of the care was inaccurate or incomplete?**

   If your entry in the medical records is incomplete or inaccurate, be ready to explain why and apologise if appropriate.

10. **Do I need to refer to relevant policies or guidelines and what if I have not followed guidelines?**

    If guidance or a policy was not followed, you are likely to be asked why this was and you should be ready to explain why. If you identify this, inform your line manager.

11. **What if there was inaccurate communication between staff?**

Many inquests identify inaccurate communication between healthcare professionals (within or outside your organisation) and with the patient or family. The coroner is likely to explore these: be ready to explain any gaps in communication and lessons learnt (including any improvements made in how professionals communicate with each other to reduce errors occurring).

12. **I am junior, is the extent of my training relevant?**

Be ready to explain any relevant training you have had. If you feel you had not had training to deal with the situation, inform your line manager. If you are in a management position, be ready to explain what training was given, and whether this has changed or improved.

13. **Might there be personal or professional repercussions for me?**

Information given to a court must be fully honest and accurate. There are criminal offences for intentionally withholding relevant information, or giving dishonest or misleading evidence to a coroner. Healthcare staff must also follow their professional regulatory requirements. Ask for advice from your legal department.

14. **I am concerned that my actions were below my usual high standards**

The coroner will investigate and record what happened, and also what should have happened by reference to the standard expected of a reasonable clinician, or guidance and policy. You should also consider your professional regulatory requirements. Ask for advice from your legal department.

15. **Is what is said in court recorded?**

Yes, every hearing is audio recorded and, as it is a public court room, anyone can apply for a copy of the audio record.

16. **What happens at the end of an inquest?**

After the evidence, the coroner will ask the interested persons whether they have any submissions about the law and the possible conclusions. The coroner will consider all of the evidence, and 'sum up' (briefly describe) the significant parts which are relevant for their decision, before stating their 'findings'. The coroner will state their findings (decisions) on each issue which is required to be recorded by the law which includes who died, where and when they died, and how they came by their death (in addition to identification details and the medical cause of death). In some cases, the coroner may state that the person died on X date at Y location as a result of natural causes. Or they might include one of the following 'short form' conclusions e.g.

- Accident or misadventure
- Alcohol/drug related
- Industrial disease
- Lawful/unlawful killing
- Natural causes
- Open
- Road traffic collision
- Stillbirth
- Suicide

The short-form conclusions provide useful national data and statistics. A coroner can also include a narrative conclusion; this is longer sentences to describe events which are relevant to how the person died. This can include things that happened, or did not happen, which contributed to the death. This can include a finding of 'neglect', which has a specific legal meaning. Ask your legal department what the likely outcome is going to be.

17. If the family are not happy with the care we provided, will there be a claim for damages for clinical negligence following the inquest?

A family can make a claim of clinical negligence either before or after the inquest. The inquest is a separate process, and the coroner does not decide whether there has been negligence, although the findings of the coroner might help inform an approach to a claim.

18. What is a report to Prevent Future Deaths (PFD)?

A coroner must send a PFD report (also known as a Regulation 28 report) to the trust chief executive if they have heard evidence of a risk of death occurring in the future and believes there is something the trust can do about it. The PFD report and the trust's written response is usually public (published on a website) and is copied to the Chief Coroner, the family, and Care Quality Commission (CQC). PFD reports are intended to reduce the risk of deaths occurring in the future. If a trust has already identified a problem, and 'fixed' or improved it, a coroner would not usually send a PFD report to that trust, although a PFD report might be sent to a national body to raise awareness of the problem.

19. Press interest

At a public court hearing, anyone can attend, and journalists can generally print what they hear in court. Photographs are not allowed within the court building. A reporter from local media or television may approach you at the end of the inquest, although this is relatively unusual. Your trust might ask you to refer any media enquiries to your legal representative, or the trust communications team.

20. When do I report a death to the coroner?

The Notification of Deaths Regulations 2019 came into force on 1 October 2019. The new regulations place a duty on registered medical practitioners to notify the coroner of a death if one or more of the circumstances set out in Regulation 3(1) applies.

The Ministry of Justice has published guidance to help medical practitioners understand when they are obliged to report a death to the coroner: https://www.gov.uk/government/publications/notification-of-deaths-regulations-2019-guidance

21. Will there be a jury?

Most inquests are heard and decided by the coroner. A small number of cases each year (about 400) are heard and decided by a jury. Most often, this is because the person died whilst they were 'detained', and the cause of death is not suspected to be natural. There are also deaths which have been 'notified' to a government body such as Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

(RIDDOR), or the Health and Safety Executive after a death at work, or where the death may be due to the action of a police officer. The coroner also has a discretion (choice) in some cases, for example if it is in the wider public interest.

Links for further support and resources:

Guide for bereaved families
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859076/guide-to-coroner-services-bereaved-people-jan-2020.pdf

NHS Improvement, Learning from deaths: guidance and resources
https://improvement.nhs.uk/resources/learning-deaths-nhs/

NHS England, Learning from deaths: information for families
https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/

NHS England guidance on reporting a death
https://www.gov.uk/government/publications/notification-of-deaths-regulations-2019-guidance

AvMA (Action against Medical Accidents), a charity for patient safety and justice
https://www.avma.org.uk/

INQUEST, a charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians https://www.inquest.org.uk/about-us

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