Shared Insights
Coroners' Question Time

Mr Zak Golombeck - Area Coroner for Manchester City

Miss Louise Pinder - Assistant Coroner for Derby and Derbyshire

Mrs Debbie Rookes - Assistant Coroner for Avon and Assistant Coroner for Dorset

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Fundamentals of disclosure

Mr Zak Golombeck - Area Coroner for Manchester City

The Coroner has to answer four statutory questions about the death - who, when, where, how as well as making other determinations. Evidence stands at the heart of the proceedings, these determinations cannot be made without it. The starting point is disclosure.

Fundamental points Trusts and organisations need to remember

1. There is a distinction between disclosure to the Coroner and disclosure to the public and other IPs and disclosure should properly be regarded as a two stage process.
2. In the first stage, the Coroner should request all reports or other material which he/she believes to be relevant for the purpose of assessing the scope and content of the inquiry. It is for the Coroner to determine what is relevant and if the documents are not forthcoming then the Coroner now has the power to issue a Schedule 5 notice to compel a Trust to provide a written statement or produce any documents which are relevant to the investigation. In the first stage, this is disclosure to the Coroner only.
3. In the second stage, once documents have been presented to the Coroner it is for the Coroner to consider whether there can and should be onward disclosure to interested persons (IPs). In doing so, the Coroner must bear in mind Rules 13 and 15 on disclosure.

Rule 13 of The Coroners (Inquests) Rules 2013 is the starting point: it states that *'where an interested person asks for disclosure of a document held by the coroner, the coroner must provide that document or a copy of that document, or make the document available for inspection by that person as soon as is reasonably practicable'.*

Rule 13 expressly states that this applies to the Post Mortem Report and any other report that has been provided to the Coroner during the course of the investigation.

Rule 13 is, however, subject to Rule 15 of The Coroners (Inquests) Rules 2013, which states that 'a Coroner may refuse to provide a document or a copy of a document requested under Rule 13 where:

a) there is a statutory or legal prohibition on disclosure;

b) the consent of any author or copyright owner cannot reasonably be obtained;

c) the request is unreasonable;

d) the document relates to contemplated or commenced criminal proceedings; or

e) the coroner considers the document irrelevant to the investigation.

Where a document is deemed irrelevant, this simply means irrelevant to the scope of interest.

This should provide some comfort that certain documents may be provided to the coroner and remain with the coroner only i.e. where the coroner decides the documents do not need to be disclosed/are irrelevant or contain third party, confidential or sensitive information such that the public interest in non-disclosure outweighs the benefits of onward disclosure. An example might include Safeguarding Adult Reviews and the Coroner should hear submissions from the SAB before disclosing these more widely. The two stage process is considered further in the Worcestershire Case.

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General points on disclosure & Post - Pandemic

Mr Golombeck, Mrs Rookes and Miss Pinder set out some general points on disclosure

- The Coroner receives evidence from institutions, organisations and individuals.
- It is important for the Coroner to keep disclosure under control.
- Organisations have an ongoing duty of disclosure, not just at the outset of the inquest process. They should notify the Coroner of disclosure that might be relevant.
- In the early stages, Coroners are reliant on organisations being in the best position to advise on who is best placed to give statements or overview reports.
- Some documents may be helpful for the Coroner but not relevant so not for onward transmission e.g. some witness statements. Trusts should make submissions about this in correspondence with the Coroner.
- The process is like a funnel – Coroners cast the net wide at the outset and may receive many documents, some of which will not be relevant to the four statutory questions. This allows determination of the scope of the inquest and the identification of witnesses.
- In straightforward cases, generally the Coroners speaking on the call would await all the documents before making onward disclosure to the interested parties, rather than disclosing documents piecemeal.
- However, if a request for a post-mortem report is made by an IP those can be shared earlier to help Trusts identify and narrow the likely issues and address these in their overview report. This type of collaborative working can help reduce pressure on clinicians. See the takeaway tips section for what to include in a request to the Coroner for a copy of the PM.
- Some Coroners request an original document and a version with the Trust's proposed redactions so they can consider both.
- Check the quality of disclosure. Overview reports should address all the issues and deal with cause of death.
- In some cases comprehensive signed and dated written statements which address all the issues can be relied on pursuant to 3 Rule 23 of The Coroners (inquests) Rules 2013 which avoids calling clinician witnesses.
- It is worth a dialogue with your local Coroner about how they want to approach disclosure.

Post-Pandemic

Miss Louise Pinder spoke about the post pandemic position in her jurisdiction Derby and Derbyshire

- Miss Pinder's jurisdiction is running as it was pre-pandemic. They have become more flexible about timeframes and there is an understanding that clinicians are under time pressures.
- There is more reliance on documentary inquests where appropriate. The starting point is whether reports can be relied on under Rule 23 rather than routinely calling clinicians in non-contentious cases. Statements should be comprehensive, deal with all the issues and be signed and dated. This makes the quality of reports even more important. If they do not deal with the concerns raised it is more likely clinicians will be called to give evidence.

Discussion -

Interested Persons & Patient Safety Incident Response

Interested Persons

- The Coroner decides who the IPs are in accordance with Section 47 of the Coroners and Justice Act 2009.
- Family is automatically an IP.
- IPs can be added at a later stage if disclosure reveals more parties are involved.
- Historical practices have changed significantly over the years. There is no national Coroners service and each jurisdiction has its own way of doing things, although having a Chief Coroner is helping e.g. Useful guidance on disclosure and other issues.
- Chief Coroner is encouraging early disclosure of Post Mortem reports to IPs.
- 'Should we apply for IP status?' There can be reticence to put the organisation in the firing line.
- The identity of IPs is something a Coroner will consider at an early stage. Unless you have particular concerns if the Coroner does not grant your organisation IP status, assume it is not necessary.

Patient Safety Incident Response - PSIRF

The NHS is preparing for the introduction of a new Patient Safety Incident Response Framework (PSIRF). At the recent NHS Confed, NHS England/Improvement explained that:

- This is a new regime and will be a significant change.
- Once implemented, this will mean that there will no longer be an SI level investigation for all incidents. This will impact on inquests because Coroners currently expect an SI level investigation and Trusts rely on these as evidence of organisational learning to mitigate the risk of a Prevention of Future Deaths Report.
- It will be important for Trusts to engage with their local Coroners to explain the changes so that Coroners understand that there will no longer be an SI Level Investigation in each case.
- NHSE/I intend to release their report in June and are hoping to run a webinar for Trusts shortly after release.

You can find more information **here**

There is some concern that the move to PSIRFs rather than SI reports will result in both the Trust and the Coroner losing a helpful document which has mapped out the issues and the factual matrix and addresses PFD issues. Trusts will need to consider whether another document is required to serve that purpose and there is concern that this will require additional governance resource.

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How we can help & Takeaway Tips

Is the new Medical Examiner process making things easier?

- Still bedding in. Too early to say yet, but:
- Probably more deaths being reported.
- Formulation of causes of death has improved which helps with decision making.
- Helping in terms of process.

How we can help

Our specialist health sector inquest and advisory team provides expert advice on all patient-facing matters which affect public and private health and care organisations. We are trusted by clients to provide user-friendly, straightforward advice and excellent representation in court and to support witnesses and organisations throughout the inquest process, having particular regard to reputational impact and prevention of future death strategy. We attach a Team Contact Sheet - please do not hesitate to contact Nicola, Ed or any member of the team if we can help in any way.

We are now taking bookings for our Mock Inquest Training Course – please contact Nicola for more information or to talk about block booking discounts.

Finally, you may also find our Inquest Guide for Clinical Witnesses a useful (free) resource. The Guide explains what an inquest is and sets out clear guidance for witnesses on what to expect at the inquest hearing, a court day checklist and tips for giving oral evidence. It also contains useful links to other resources that witnesses may find useful including our Mock Inquest Training Video, Checklist When Preparing to Give Evidence Remotely and the Maternity Hub and Mock Inquest Films. We hope you find these free resources useful – please do disseminate to anyone you think would find them of use.

Takeaway Tips

1. Good communication between your organisation and the Coroner is key.
2. Make sure the most relevant person (someone who saw the Deceased and will be comfortable giving evidence) is providing your overview report and that it addresses cause of death.
3. Ensure statements are signed and dated, cover all the issues and separate fact from opinion.
4. If you are unsure whether a particular document should be disclosed notify the Coroner of its existence and ask.
5. With early internal investigations, e.g. minutes etc. think about the language being used - the reality is some of those things may well get disclosed at a later stage.
6. If you are unable to comply with timeframes, explain why, and when you expect to be able to do so as early as possible, but be aware Coroners can use Schedule 5 powers to extract reports from Trusts.
7. If the Coroner has not disclosed the Post Mortem report you should formally request this setting out that disclosure will assist you with preparing reports and flagging the general principles of fairness and openness. You should also refer to Rule 13, which is clear that *'where an interested person asks for disclosure of a document held by the coroner, the coroner **must** provide that document or a copy of that document, or make the document available for inspection by that person **as soon as is reasonably practicable'***. The Rules expressly state that this applies to the Post Mortem Reports.
8. Position statements on causation can help narrow the issues and the number of witnesses required where there is a Trust investigation which highlights care and service delivery problems but does not address causation. These can also be useful to set out the Trust's response to an external investigation e.g. HSIB . Remember if you are making admissions in the Position Statement then you will need to get approval from your indemnifier (NHS Resolution) before doing so.

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