Shared Insights

Coroner's Question Time

Nicola Evans, Partner, Browne Jacobson

Mr Zak Golombeck - Area Coroner for Manchester City

Miss Louise Pinder - Assistant Coroner for Derby and Derbyshire, Assistant Coroner for Rutland and North Leicestershire

Dr Bridget Dolan KC – Assistant Coroner for West Sussex

14 July 2023

Browne Jacobson

Introduction

This session was titled "Back to Basics". It focused on 3 key areas:

1. Interested Person Status
2. The Statutory Duties of the Coroner, including the 4 statutory questions, scope and Prevention of Future Death Reports
3. The role of a witness at an inquest

We were pleased to welcome our panel:

Mr Zak Golombeck - Area Coroner for Manchester City

Miss Louise Pinder - Assistant Coroner for Derby and Derbyshire and for Rutland and North Leicestershire

Dr Bridget Dolan KC – Assistant Coroner for West Sussex

Interested Person (IP) Status

The panel considered the legislation around IP status, including when a healthcare Trust should consider themselves an IP and whether disclosure by the Coroner in itself indicates that an organisation has been granted IP status.

- IP status is often one of the most misunderstood areas of an inquest.
- It is the building block of the inquest process.

Nicola Evans
Partner

+44 (0)330 045 2962
nicola.evans@brownejacobson.com

Being an Interested Person (IP) is a right – not an obligation

The panel were asked what a Trust should do when they are not made aware they are an IP or are not sure whether they have been offered IP status and therefore do not know whether to have legal representation at the inquest?

- The panel advised that the moment a Trust is made aware of an inquest you should write to the Coroner's office and ask if you are being offered IP status.
- If so, ask the reason why you have been offered IP status.
- IP status is not about culpability, so this doesn't automatically mean you need legal representation. It is therefore worth clarifying with the Coroner why you have been offered IP status and also asking whether the Coroner has identified the key issues and whether the family have any questions or concerns that are likely to be addressed at the inquest.

Section 47(2) of the Coroners and Justice Act 2009 defines an IP. Organisations will usually be offered IP status at an inquest under Section (f) or Section (m) of the Act: "*Interested person" in relation to a deceased person or an investigation or inquest under this Part into a person's death, means—*

(f)A person who may by any act or omission have caused or contributed to the death of the deceased, or whose employee or agent may have done so;

(m)Any other person who the Coroner thinks has a sufficient interest.

What should you do if you are challenged about requesting IP status?

- IP status is a right. It is the Coroner's duty to identify organisations and persons who have these rights and offer them IP status.

You may need to make submissions that your organisation or witness falls within the definition of an IP set out in Section 47 (2) of the Act and therefore that you should be offered IP status at the inquest.

Would an individual employee at the Trust be offered IP status, in addition to the Hospital Trust?

- The hospital Trust will generally ONLY be an IP under 47(2)(f) because their employee may have caused or contributed to the death, and therefore it follows that if an organisation is offered IP status under S47(2)(f) then there must be an employee who should also be offered IP status and that employee should be identified by the Coroner and offered IP status.
- However, in practice it might not be necessary for the individual to have separate IP status if the organisation's position aligns with the employee and they do not want to participate in the inquest separately or be independently represented. It may be possible for the Trust's legal representative to act for both the organisation and the individual witness unless the witness wants separate IP status or there is a conflict between the individual and the organisation.

What rights does IP status provide?

- The right to participate in the inquest process, to attend the inquest and ask questions of the witnesses.
- The right to disclosure of documents.
- The right to legal representation at the inquest hearing.

If you are offered IP status this does not mean you are obliged to attend and participate or have legal representation at the inquest but it does mean that you have the right to do so if you wish to.

Statutory duties of the Coroner: Prevention of Future Deaths Report

Prevention of Future Deaths (PFD)

- Coroners have a statutory duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths.
- The Chief Coroner's Guidance on PFD Reports is available here.
- The Coroner has a legal duty to send a report to Prevent Future Deaths (PFD report) if anything is revealed by the Coroner's investigation which gives rise to a concern that there is a risk of deaths occurring in the future. This duty is set out in Schedule 5 Paragraph 7(1) of the Coroners and Justice Act 2009, which states that *"where a Coroner has been conducting an investigation into a person's death and:*

  a) *anything revealed by the investigation gives rise to* ***a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future****, and*

  b) *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 of death created by such circumstances,*

  the Coroner ***must*** *report the matter to a person who the Coroner believes may have power to take such action"* i.e. to make a PFD Report.
- Regulation 28 of the Coroners (Investigations) Regulations 2013 sets out the steps a Coroner must take if their duty to issue a PFD report under Schedule 5 Paragraph 7(1) is triggered. The report will be sent to the person or authority that has the power to take the appropriate steps to reduce the risk.
- On receipt of a PFD Report, a response must be submitted to the Coroner within 56 days. The PFD report and the response are public documents. They are often copied to the CQC and other regulators.
- You can read all published PFD Reports here and use the search function to look for PFD Reports which are relevant to your are of practice.

What should an organisation do if you receive a PFD Report but have not had the opportunity to attend the inquest and provide evidence and/or a response to the issues raised during the inquest?

- It is important to remember that the Coroner has a **duty**, not a power, to make a PFD Report if he or she believes that circumstances creating a risk of future deaths exist. This does not have to be at the end of the inquest process, it can be at any stage.
- Many (but not all) Coroners will give an IP the opportunity to make representations in relation to this risk but in some cases this is not possible. There is no obligation on the Coroner to seek what has become known as "PFD evidence" from anyone or to allow submissions on it. The PFD process is ancillary to the inquest process.
- If you receive a PFD Report and you believe that the Coroner did not have all of the information/evidence before issuing it then your response should set out the organisation's position and explain why it believes that the risk has already been addressed/mitigated.

Statutory duties of the Coroner: Prevention of Future Deaths Report continued

What about Regulation 28(3) which says *"A [PFD] report may not be made until the Coroner has considered all the documents, evidence and information that in the opinion of the Coroner are relevant to the investigation."*

Would this not prompt the Coroner to hear evidence from the organisation about PFD issues before issuing a PFD Report?

- Regulation 28(3) is about the Coroner's statutory duty relating to who, when, where and how a patient came by their death. The Coroner must consider all the documents, evidence and information that are relevant to these 4 statutory questions.
- The Coroner does not have a duty to get additional evidence outside of this scope. Specifically, it is not the duty of the Coroner to obtain and consider all of the documents which are relevant to PFD risk before making a PFD report.
- The PFD process is ancillary to the inquest process.
- The purpose of the inquest is to ascertain who has died and when, where and how they died. The Coroner must consider the documents, evidence and information which are relevant to those questions. As stated above, there is no obligation on the Coroner to seek what has become known as "PFD evidence" from anyone or to allow submissions on it.

The Panel addressed the different ways a Trust can respond to a PFD report …

- The Panel agreed that PFD Reports should not be seen as punitive or a punishment.
- Keep your PFD response simple – set out what have you done and/or what are you planning to do.
- Make sure it is a document the family can understand. The family are at the heart of the process and they often want to make sure that what happened to their loved on will not happen to someone else.
- Remember that your response will be published here and may also be sent to your regulator e.g. CQC

The panel stated that in their view a PFD report is not a red card or black mark. It is the Coroner confirming an issue has arisen and is an opportunity for the Trust to embrace, to learn, and to look at whether systems and processes can be improved.

Statutory duties of the Coroner

What are the Coroner's statutory duties?

- Coroner's must determine the medical cause of death and the particulars set out in the Births and Deaths Registration Act 1953.
- The purpose of the inquest is to ascertain who the deceased was, how , when and where the deceased came by his or her death. This is set out in Section 5 (1) of the Coroners and Justice Act 2009.
- No matter whether the Coroner is sitting a 3-week Article 2 inquest, a half day inquest or a documentary inquest, the role of the Coroner is to determine **who has died, when did they die, where did they die and how the individual came by their death**.
- The first 3 points (who, when and where) are almost always the most straightforward to answer. It is the question of "how" which often requires further analysis and becomes the focus of the inquest hearing.

An inquest is not the same as a trial, it is inquisitorial and not adversarial. What do you think this means for organisations in terms of their approach, preparation and conduct of an inquest?

- The purpose of an inquest is fact finding to ascertain who the deceased was, how, when and where they died and to help the Coroner come to the truth of what happened to an individual.
- Trusts should not prepare witnesses that they are attending to "put a spin on things", they are attending to tell the Coroner what happened. It is not their role to put forward the Trust's position. There are no parties to an inquest – everyone is there to assist the Coroner.
- The panel felt that the atmosphere in Court can sometimes change when lawyers are involved. It is part of the Coroner's role to keep reminding IPs and their legal representatives that an inquest is a fact finding inquiry and not adversarial. The Solicitors Regulation Authority have recently published a range of resources designed to help solicitors who practice in inquests in the Coroner's Courts, which you can read here. The Bar Standards Board have issued similar guidance for barristers here.

The role of a witness

How can Trusts help witnesses to understand what their role is. For example, when witnesses are asked to provide an overview report going beyond their own factual involvement?

- The quality of written statements and reports is really important as this will form the basis of the witness' evidence in court. You may find this Guide to Writing Statements for an Inquest a useful resource for witnesses and includes a statement template as a starting point.
- The panel agreed that overview witnesses can be really helpful. A Coroner does not want to empty a department because all the clinicians or professionals are giving evidence as witnesses attending an inquest.
- It is important that overview witnesses understand all the key issues. If there are issues they cannot address, the Trust should notify the Coroner about that as soon as possible so that a different witness can be identified.
- If you need clarity on the issues and scope of the inquest then write to the Coroner and ask for this.
- You can make a submission that a statement or report should be read into evidence under Rule 23 if the evidence is unlikely to be disputed. This would mean that the witness is not required to attend court.

An example of the wording you might use for these submissions is set out below:

If the evidence is not disputed, may I formally request that the evidence of [X] is read under Rule 23 (1) (d) of the Coroners (Inquests) Rules 2013. As you know, The Chief Coroner's Guidance No 29 is that this can be a useful and proportionate method to conclude an inquest in certain cases, if the family and other interested persons do not dispute the evidence.

If the family or any other Interested Persons indicate that they do dispute the evidence, could they be asked to outline the areas of the evidence which are disputed or the additional issues that they want to put to the witness. It may then be possible to address these by way of a supplemental written report if you consider this would be appropriate.

Can a factual witness be asked to provide an opinion in their written or oral evidence?

- Yes, a witness can be asked to provide an opinion, but it is important they do not stray outside their own area of expertise. Sometimes this is done with the best of intentions, wanting to assist the Coroner or the family but it often leads to more issues if a witness does this.
- In medical death inquests, it is very helpful to the Coroner if Trust witnesses are able to can correlate the clinical picture in life with the Post Mortem findings and provide a clinical opinion on the cause of death. This greatly assists the Coroner. If your witnesses disagree with the provisional cause of death given at Post Mortem you should let the Coroner know about this in advance of the inquest.

The role of a witness continued

The Panel's Top Tips for Witnesses

- Be familiar with the clinical notes
- Answer questions truthfully, do not try to be an advocate on behalf of the Trust
- Raise any concerns about any aspect of the care with your organisation's internal governance team prior to the inquest. Do not raise issues for the first time in the witness box.
- Be prepared to answer questions on causation. If there are any shortcomings in care or management, witnesses may be asked for their opinion on how this has altered the patient's journey and if this has contributed to the patient's death.
- Take your time. The best witness will slow down the pace and will stop and ask for clarify if the Coroner uses any inaccessible wording.
- Use simple, straightforward language and avoid abbreviations or using inaccessible language.
- Do not be arrogant or defensive. This sends the wrong message to the family and does not help the Coroner's investigation.
- If you do not know the answer you must say that. Do not try to answer questions if you do not understand the question, do not know the answer or it is outside your area of expertise.
- Be prepared. Preparation is key to giving good evidence at an inquest.
- Dress appropriately. Smart, sombre clothing.
- Make sure you are familiar with the documents. You can take a laptop or paper bundles into the witness box and refer to these when giving evidence. You can use sticky notes, highlighter pens and flags so you can locate key documents or medical notes easily when giving your evidence. Remember that if you refer to documents in evidence then the lawyers in court or the Coroner may ask to see a copy.
- If you have not been to the Coroner's Court before then you can visit and watch an inquest before you give evidence. Contact your legal team or local Coroner's Court to ask when there are inquests in court which you can observe.
- If the inquest is conducted virtually, remember you are still in Court. You may find our guide for giving evidence remotely helpful.
- Your organisation should consider communication with the family in the lead up to the inquest and comply with the Duty of Candour. Being open and honest with the family is always the right thing to do and NHS Resolution have produced this 8 minute animation to help those working in health and social care to understand their Duty of Candour. If there were shortcomings with the care the family should not hear about this for the first time at the inquest hearing. The right approach will vary from case to case - speak to your organisation at an early stage to ensure that there is a plan in place to communicate with the family and comply with the Duty of Candour.
- Also think about how you will interact with the family at the inquest hearing itself. You will be in court with the family – be prepared for that and think about how you will communicate with the family with compassion and empathy.

Resources

Resources

Browne Jacobson have produced a range of resources to help organisations and witnesses involved in the inquest process, which are all free of charge on our website:

- Inquest Guide for Clinical Witnesses
- Writing Statements for an Inquest
- Checklist when preparing for remote participation in an inquest hearing
- Mock inquest training video and other inquest resources

NHS Resolution have also produced some free resources which you can access here.

Finally, there are still spaces available on our next **Mock Inquest Training Course** which starts in September. If you have a number of people who would like to attend please contact Nicola.Evans@brownejacobson.com to discuss block booking rates.

Contact us

Lorna Hardman
Partner

+44 (0)115 976 6228
lorna.hardman
@brownejacobson.com

Simon Tait
Partner

+44 (0)115 976 6559
simon.tait
@brownejacobson.com

Damian Whitlam
Partner

+44 (0)3300452332
damian.whitlam
@brownejacobson.com

Nicola Evans
Partner

+44 (0)330 045 2962
nicola.evans
@brownejacobson.com

Sian Quirk
Associate

+44 (0)330 045 2575
sian.quirk
@brownejacobson.com

Heather Caddy
Partner

+44 (0)330 045 2516
Heather.caddy
@brownejacobson.com

brownejacobson.com
+44 (0)370 270 6000

Please note:
The information contained in this document is correct as of the original date of publication.
The information and opinions expressed in this document are no substitute for full legal advice, it is for guidance only.

[2023] ©

Browne Jacobson

Browne Jacobson is the brand name under which Browne Jacobson LLP and Browne Jacobson Ireland LLP provide legal and other services to clients. The use of the name “Browne Jacobson” and words or phrases such as “firm” is for convenience only and does not imply that such entities are in partnership together or accept responsibility for acts or omissions of each other. Legal responsibility for the provision of services to clients is defined in engagement terms entered into between clients and the relevant Browne Jacobson entity. Unless the explicit agreement of both Browne Jacobson LLP and Browne Jacobson Ireland LLP has been obtained, neither Browne Jacobson entity is responsible for the acts or omissions of, nor has any authority to obligate or otherwise bind, the other entity.