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Shared Insights

Coroner's question time

Speakers

Nicola Evans, Partner at Browne Jacobson
Miss Louise Pinder, Senior Coroner for Rutland and North Leicestershire
Mr Zak Golombeck, Area Coroner for Manchester City
Ms Patricia Londono, Assistant Coroner for South London and Barrister at Serjeants' Inn Chambers
Ms Laura Nash, Assistant Coroner for Lancashire and Barrister at Serjeants' Inn Chambers

Browne Jacobson

Introduction

This session of Coroner's Question Time, chaired by Nicola Evans, covered three main topics: tips on preparing for inquests, the legal test and threshold for a finding of neglect, and the circumstances in which a coroner might refer an individual to their regulator.

The discussion opened with practical guidance on what individuals and organisations can do to prepare for an inquest. Preparation should begin as early as possible and as soon as it becomes apparent that there will be an inquest. The panel then addressed the issue of neglect, emphasising that this is in practice a rare finding with a high threshold. The test for neglect was explored and examples given of inquests where a neglect finding has been made.

Finally, the panel considered the circumstances in which a coroner might refer a clinician or other individual to their regulator. It was emphasised that such referrals are rare, with the primary triggers being falsification of records or serious misconduct in court.

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How we can help

Advisory and Inquest Team

Browne Jacobson has an experienced team of inquest solicitors and barristers, which includes sitting Assistant Coroners. We provide expert inquest law advice and representation to organisations involved in complex and high-profile inquests and can do so for inquests lasting days or weeks. We guide our clients through the inquest process, providing strategic advice and ensuring that witnesses are supported and well prepared. Please do get in touch with Nicola Evans to talk about how our team can help if you are involved in an inquest and need expert legal advice.

Mock inquest course

Our mock inquest training course is essential for clinicians and health and care professionals seeking to understand the inquest process. The course is delivered virtually over a series of lunchtime modules and covers the entire inquest process – from reporting deaths and certification through to writing reports for the coroner and giving oral evidence in court. We hear insights from a range of speakers including 6 Coroners and an experienced Medical Examiner.

The course includes several pre-filmed mock inquests filmed in Coroner's courts before real Coroners, to provide a realistic experience of an inquest hearing.

Delegates will also learn about the wider ramifications of an inquest, such as media coverage, compensation claims, disciplinary and professional implications.

Our next mock inquest course will be running from 3rd – 24th June. All modules are recorded and can be watched on catch-up to fit around other professional commitments. For further details and to register your place, please click here.

Inquest Resources

Browne Jacobson have produced a range of free resources for health and care organisations involved in the inquest process and links to these are set out at the end of this note.

Preparing for inquests

Witness statements and internal investigations

The panel's overarching message on preparation was clear: it should begin as early as possible, once it is known that an inquest will take place. Mr Golombeck explained that the inquest is an inquisitorial, fact-finding process and it is important not to approach it defensively. It should be seen as an opportunity to state the facts as they happened and to identify lessons that can be learned – for the organisation and potentially for the wider health or social care system.

For an individual, preparation will start with writing a statement, which should be done as early as possible after the death while events are fresh in the mind. Where a death will clearly result in an inquest, witnesses should write down their recollection of events promptly, with the assistance of the medical or care records and any other contemporaneous notes.

Nicola advised that organisations should consider producing guidance for staff on the production of early Factual Recollection of Events - with a reminder that these are disclosable documents which are not protected by legal privilege so care needs to be taken when writing them to ensure they are accurate and that witnesses understand that these may be disclosed to the Coroner and the family in due course. Nicola shared an example of guidelines produced by a local Trust which are available online: FROE Learning From Inquest and Incident Guidance Final

Miss Nash highlighted that accuracy is important and that she sees statements where the deceased's name, date of birth or date of death has been written incorrectly. Whilst such typos wouldn't nullify the statement as a whole, it can be very upsetting for family members if such details are wrong and can suggest that a witness is not taking the inquest process seriously. It is important for witnesses to have protected time to prepare their statements, to ensure that they review the relevant records, policies and guidance before doing so and that statements are factually accurate, cover all relevant detail and are checked carefully.

Browne Jacobson have produced a guide for witnesses on writing statements for the Coroner, which is available free of charge here.

If an internal investigation is initiated, this is a valuable opportunity to record events, setting out what was done, why certain steps were or were not taken, and providing a full and thorough account of the individual's involvement with the deceased and/or family. Critically, if a witness recognises at that early stage that there were shortcomings in the care provided, they should say so. If decisions were made in the context of a pressured environment – for example, a particularly busy ward, unit or team – this should be recorded and, if necessary, supported by organisational data.

The Coroner may wish to hear evidence about the investigation findings and organisational learning, and it is important that witnesses are involved in the investigation and able to speak about their experience of any changes made to practice as a result. Browne Jacobson have produced a guide to preparing and delivering organisational learning evidence to the Coroner, which is available free of charge here.

Preparing to give oral evidence

For witnesses giving evidence in court for the first time, familiarising themselves with the court building and environment in advance is strongly recommended. Mr Golombeck advised that witnesses can contact the local court and ask whether they are able to attend an inquest to observe and familiarise themselves with the setting.

In the period leading up to the inquest, witnesses should review their statement, the clinical or care notes and any other relevant documents in the Inquest Disclosure bundle. This will make witnesses more comfortable when giving evidence and when being questioned about particular aspects of the care provided.

When evidence is to be given remotely, witnesses should ensure their technology works and that they will have access to all necessary documents and records. The coroner must approve remote attendance, and Miss Londono noted that opinions on giving evidence remotely varies among coroners.

Chapter 6 of the Coroner's Bench Book sets out further guidance on remote hearings here

For more complex inquests, remote attendance is unlikely to be permitted but if a witness's evidence is less crucial to the central issues in the case, attending remotely is more likely to be allowed. Browne Jacobson have produced a checklist for clinical witnesses taking part in a remote inquest hearing, which is available free of charge here.

If a witness requires reasonable adjustments, the coroner's officer should be informed as early as possible. Witnesses who only raise this on the morning of an inquest create unnecessary anxiety for themselves and deprive the court of the opportunity to make appropriate arrangements.

It is important to remember that a coroner's court is a formal court. Witnesses should appear professional throughout the entirety of their attendance – not just when giving evidence, but also when they are sitting in court observing. Witnesses or observers who attend to other professional commitments during proceedings (e.g. responding to emails) can be deeply disrespectful to the family and to the court process. If other commitments genuinely cannot be avoided, the legal representative or court clerk should be informed so that the coroner can be made aware.

Miss Pinder highlighted that witnesses need to understand the issues from the perspective of both the coroner and the family. In more complex inquests, a pre-inquest review hearing (PIRH) will often be held, to identify and set out the scope of the inquest. Witnesses should then focus their preparation on those issues. If a witness or organisation is unclear on what the issues are, they should proactively seek this information from the coroner's office. Any concerns raised by the family that fall outside the scope of the inquest (e.g. because they are not relevant to the cause of death) will need to be addressed separately, and Miss Londono encouraged organisations to liaise directly with families to resolve such issues through the usual processes. The fact that there is going to be an inquest should not prevent organisations from contacting the family, seeking to address their concerns, involving them in any internal investigation and complying with Duty of Candour.

It can be helpful for witnesses to speak with colleagues who have previously given evidence at a coroner's court, as such conversations can be reassuring. It should be noted however that coroners conduct their courts differently, so the experience may not be identical; nonetheless, speaking to someone who has been through the process can help to reduce anxiety.

Neglect

The legal test and threshold

The panel addressed the topic of neglect. Witnesses and organisations are often fearful of a finding of neglect, however, in practice it is a rare finding in a coroner's court. Miss Pinder explained that neglect is not a conclusion in its own right but forms part of a broader conclusion. It is a much narrower concept than negligence in the civil courts.

Neglect requires a **gross failure** – something that goes well beyond a simple mistake. It must amount to a total and complete failure to provide adequate liquid, nourishment or **basic medical attention**.

The deceased must have been in a dependent position: someone who could not look after themselves, advocate for themselves, or make their own decisions – whether due to physical or mental incapacity, age or incarceration. Examples of neglect include the failure to apply routine procedures or carry out standard monitoring. The critical distinction is between an individual who considers all the relevant factors and reaches a wrong decision (which is generally not neglect) and one who does not engage with the relevant considerations at all.

There must also be a causal link between the gross failure and the death i.e. in order to return a finding of neglect the Coroner must be satisfied that there is evidence that (on the balance of probabilities) the gross failure did more than minimally contribute to the death.

The panel noted an example where there was a gross failure in the care provided, but the expert evidence established that the deceased would not have survived even if proper care been given. In that case, the Coroner cannot return a neglect finding even if there has been a gross failure to provide basic medical care because the causal link to the death is not established. Causation is therefore key.

The implications of a neglect finding can be significant, not least in terms of press coverage. However, the panel emphasised that the threshold is very high. It is not met simply by an error or by making a decision that, in hindsight, was the wrong one.

The failure must stand out as something beyond the norm of what one would ordinarily see, whether that be basic errors or shortcomings in care.

Multiple failures amounting to neglect

Mr Golombeck highlighted that it is not necessary for there to be a single, individual failure for the neglect threshold to be met. Failures which in isolation would not cross the threshold of gross failure can, if linked and considered together, cumulatively amount to a gross failure. He cited an example involving very poor multi-agency working between a local authority, a mental health trust and other state agents, where the failings taken together amounted to neglect.

For wider reading on the legal test and threshold for Neglect see Chapter 15 of the Coroner's Bench Book

Indications of neglect prior to the inquest

Miss Pinder noted that she has, on occasion, indicated at a pre-inquest review hearing that she is considering neglect as part of her conclusion. Where a coroner signals the direction of travel at an early stage, it gives the interested persons the opportunity to focus their minds on that issue, which can be helpful to everyone involved.

Miss Nash noted that prior to one inquest hearing in which she acted as a barrister for an NHS Trust it had become clear that neglect was a live issue. The Trust took the decision in advance of the inquest to produce a Position Statement, effectively conceding that certain elements of Neglect were present on the evidence. The position statement went before the jury, which allowed the jury to return a conclusion of neglect. This saved a considerable amount of time and allowed the issues to be explored with witnesses in a focused way. The Panel agreed that Position Statements can be helpful in narrowing the issues in advance of an inquest and ensuring that the court focusses on those issues which are disputed.

Referrals to regulators

Circumstances in which a referral might be made

Mr Golombeck addressed the circumstances in which a coroner might refer an individual to their regulatory body. Generally, there is a very high threshold for such a referral and it is in practice very rare. He tends to consider referral primarily in the context of the falsification of records or serious misconduct in court – conduct that is "*particularly arrogant or obnoxious*".

Mr Golombeck highlighted that a referral might also be made if records are amended retrospectively after a patient's death – in effect, post-mortem alterations to records where it is apparent that the individual had knowledge of the death and was seeking to conceal shortcomings in the care through the notes. Electronic records with audit trails have made it considerably easier to identify when records have been amended in this way.

He also noted that he has on one occasion referred a solicitor to the Solicitors Regulation Authority as a result of their conduct in a specific case — a reminder that it is not only health or social care staff who may be subject to referral.

The SRA and Chief Coroner have produced guidance for solicitors practicing in the Coroners Court which you can read here.

Miss Pinder described a specific example where she referred a doctor to the GMC, involving falsification of records and obnoxious behaviour by a witness. In another case, she had not been fully satisfied with the evidence given by certain nurses, and a member of the public subsequently raised concerns about repeated behaviour in other proceedings. A referral was made to the NMC in light of that additional information. However, Miss Pinder emphasised that it is rare for Coroners to refer witnesses to the regulator.

Avenues for referral

It was noted by the panel that there are in fact at least three potential avenues for referral: referral by the coroner, referral by the family and self-referral. Mr Golombeck highlighted that, if a referral is required, it is always better for the referral to come from either the individual themselves or their organisation, rather than from the coroner.

To read our article on the duty to self-refer, click here.

Discussion and questions

Accessing cause of death information before the inquest

A question was raised about what options are available to a Trust when the coroner has requested statements or an investigation report, but the Trust has not yet been granted interested person (IP) status – can the Trust request the medical cause of death and disclosure bundle from the coroner?

Mr Golombeck said that where a coroner is requesting a statement from a clinician about their involvement with a particular patient, the medical cause of death is often not directly relevant to that statement. A clinician does not necessarily need to know the cause of death in order to give an accurate account.

Nicola highlighted that her practice is to contact the Coroner at an early stage to request a copy of the Postmortem or the proposed medical cause of death as these can greatly assist the witnesses and the internal investigation to focus on the key issues relevant to the cause of death. It is useful to set out in the request an explanation of why that information will assist the witnesses and the organisation to provide the best quality evidence to assist the Coroner.

If that request is refused but it is felt that understanding the cause of death would assist the witnesses and internal investigation, Nicola would consider going back to the Coroner to request IP status and would also refer to Chapter 12 of the Coroners Bench Book when making such a request and specifically to:

- Paragraph 15, which reminds that Coroners Rule 13 of the Coroners (Inquests) Rules 2013 (the Rules) requires that where any Interested Person requests disclosure of a document held by the coroner, disclosure must be given ‘as soon as is reasonably practicable’ either by providing a copy of the document or by making it available for inspection. The disclosure obligation arises from the commencement of an investigation, it is not limited to cases where an inquest is to be held.
- Paragraph 17: There is no specific formality required in making a request for disclosure. An informal oral or emailed request for information or documents made by an IP should be considered as if it were a rule 13 request.
- Paragraph 20.: IPs need to be given sufficient information at an early enough stage for them to participate fully in the investigation process.

Miss Londono observed that her approach would depend on the proximity of the clinician's treatment to the death.

Where there was a close relationship between the treatment provided and the death, she would be inclined to provide the cause of death. She noted that she would certainly not be irritated by a request for information, even if she did not agree to it.

Calling a witness without IP status

A delegate asked if a coroner might call a witness when either they or their employing organisation does not have IP status. Mr Golombeck explained that this is possible, as sometimes a witness is required to provide factual evidence even when there is no indication that their actions or omissions contributed to the death, meaning they do not automatically qualify for IP status. This situation can occur, for example, when a GP is called to give background information. However, such cases are uncommon in a hospital or community health setting where a person has died while under the care of the team. IP status was covered in a previous Shared Insights session, the note of which can be found here. For further reading, see Chapter 2 of the Coroner's Bench Book here.

Organisational learning and investigations under the Patient Safety Incident Response Framework (PSIRF)

A question was raised about whether a coroner would call the author of an internal investigation (such as a Patient Safety Incident Investigation) as a witness at the inquest, even though they were not directly involved in the care of the deceased. Both Miss Pinder and Ms Londono confirmed that they do routinely call such witnesses to present organisational learning evidence, particularly where the family has concerns about the care provided.

Another delegate queried whether coroners rely too heavily on learning responses produced by Trusts under PSIRF. NHS England recently addressed this concern, advising that evidence gathered for a PSIRF learning response and for an inquest must remain distinct. According to NHS England, whilst coroners can use learning response outputs as supplementary information if available, they should not be relied upon as the primary or sole evidence for an inquest.

Further detail can be found in our recent article, "Newsletter guidance for healthcare providers on PSIRF and inquests".

A delegate commented that organisations appear to be taking fewer witness statements as part of the changes in how they review and investigate deaths with PSIRF and queried whether coroners are accepting other types of report submissions. As above, evidence gathering for an inquest and a learning response under PSIRF should be distinct, and so a coroner will (or should) accept other reports or witness statements that have been prepared solely for the purpose of an inquest.

Asking for an opinion from another organisation

There was a query regarding whether coroners may ask an organisation about actions they might have taken concerning the care of a deceased individual, where that organisation was not directly involved in the care. This is unlikely to happen, unless an individual from a separate organisation is called as an expert witness to comment on the care provided. However, in cases where individuals from multiple organisations are giving evidence in court, a coroner may pose a question to a witness from another organisation regarding what their approach would have been under similar circumstances.

Neglect in the context of coercive and controlling behaviour

A delegate asked if a neglect finding could be returned in cases of domestic abuse or coercive and controlling behaviour by the deceased's partner. Whilst the coroners on the panel have not done so in any inquests they have dealt with, another coroner has returned an unlawful killing conclusion in such circumstances, as reported by the media. In another recent inquest, a coroner found that the deceased's death was contributed to by coercive and controlling behaviour.

Extensive narratives in an 'assurance report' vs a simpler updated action plan

Whether Coroners prefer a detailed organisational learning/assurance report will depend on the facts of the case. In straightforward cases, a simpler action plan will be sufficient. In cases where there were more extensive organisational failings, more detailed evidence of organisational learning may be required, usually delivered by someone senior in the organisation. For more detailed guidance on the preparation of organisational learning evidence, you may find Browne Jacobson's Guide to Preparing and Delivering Organisational Learning evidence to the Coroner helpful.

Unexpected deaths in the community

In law, the Coroner has a duty to investigate a death where:

- The cause of death is unknown.
- The death occurred in custody or state detention, which will include deaths in prison or police custody and deaths while the deceased was detained under the Mental Health Act (MHA).
- The death was violent, including by self-harm.
- There is reasonable cause to suspect that the death was unnatural. This will include deaths that were more than minimally contributed to by medical treatment or a procedure, for example:
- The death was due to a recognised complication of medical treatment.
- The death was more than minimally contributed to by shortcomings in the medical treatment.

If there is reasonable cause to suspect that any of these criteria apply to an unexpected death in the community then the Coroner must investigate the death. So, for example, if the cause of death is unknown or unnatural, that will trigger the duty to investigate. If the family raise concerns about care that may also trigger the duty to investigate. If the cause of death is clear, it is a natural cause and there are no concerns about care then it is likely that a death in the community will be registered without an inquest.

Jury inquests

An inquest is usually heard by a coroner sitting alone. However, in certain circumstances, the law mandates that an inquest must be held with a jury. An inquest must be held with a jury if the Coroner suspects that:

- The deceased died in state detention and either the death was violent or unnatural, or the cause of death is not known.
- The death resulted from an act or omission of a police officer or a member of a service police force.
- The death was caused by a notifiable accident, poisoning or disease.

A patient is in state detention if they are compulsorily detained under the MHA. 'Violent' deaths include those by self-harm, suicide, a fall, road accidents or being deliberately killed by another. Therefore, where a patient detained in hospital under the MHA has died as a result of suicide, the inquest must be held with a jury.

A jury may also be summonsed if the coroner thinks that there is "sufficient reason" for doing so. When deciding whether to exercise this discretion, the coroner will take into account the following:

The wishes of the family – whether they want a jury to hear the inquest or not.

- Whether the facts of the case bear any resemblance to the types of situation where a jury is mandated.
- The circumstances of the death.
- Any uncertainties in the medical evidence.

For further reading on jury inquests, see Chapter 11 of the Coroner's Bench Book.

Key takeaways

- Preparation should begin as early as possible, as soon as a clinician or organisation becomes aware that there will be an inquest.
- Witnesses should prepare their statements promptly, reviewing medical records and other contemporaneous notes and local and national guidance.
- Basic accuracy in witness statements — in particular, getting the deceased's name, date of birth and date of death correct — is essential. Errors in these details, however inadvertent, cause significant distress to families and suggest a lack of care for the process.
- If shortcomings in care are identified at an early stage these should be reported and investigated through the organisation's usual governance processes and the outcome shared with the Coroner and the family, rather than leaving issues to emerge in the witness box.
- Familiarise yourself with the court building and process in advance. In the lead-up to the inquest, review your witness statements and other relevant documents and, for remote hearings, check technology and access to documents well ahead of time.
- A coroner's court is a formal court. Professional conduct and appropriate behaviour are expected of everyone in attendance throughout — not just when in the witness box. How witnesses and those supporting them behave at all times is noticed by the family and by the court.
- Neglect is rare and the threshold is high. It requires a gross failure — a total and complete failure to provide basic care — in circumstances where the deceased was in a dependent position, and a causal link between that failure and the death. Making the wrong clinical decision, having considered all the relevant factors, will not ordinarily amount to neglect.
- An accumulation of failures can, if linked together, meet the threshold for gross failure even if individual failures would not do so on their own.
- Referrals to regulators are rare. The primary triggers are falsification of records and serious misconduct in court.
- Self-referral is preferable to a referral by the coroner and we have written an article to provide guidance on self referral which is included in the resources below.

Inquest resources

Chief Coroner's Guidance for Coroners on the Bench - Courts and Tribunals Judiciary

Our website provides several free inquest resources, including several useful guides on the inquest process:

- Guide to coroners' inquest process for witnesses
- Guide for witnesses writing coroner's inquest statements
- Guide to inquests into death of mental health patients
- Inquests and Article 2 of the European Convention of Human Rights
- Guide to preparing and delivering organisational learning evidence
- Newsletter guidance for healthcare providers on PSIRF and inquests
- Guidance on self-referral to a regulator following an inquest

You can access these and other resources here.

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