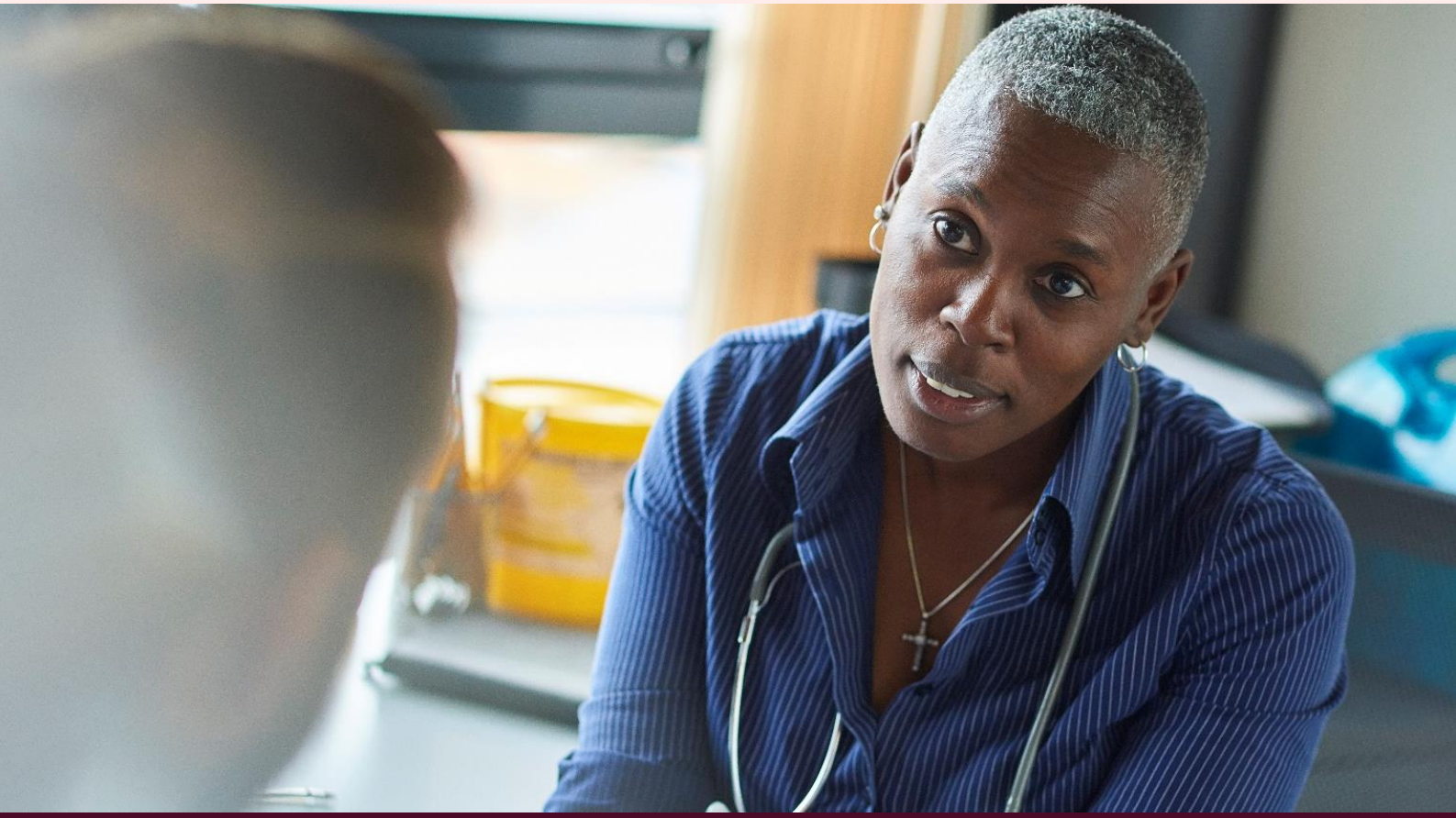
25 June 2024

Shared Insights

Coroner's Question Time

Panel of speakers

Nicola Evans, Partner, Browne Jacobson
Mrs Debbie Rookes, Assistant Coroner for the County of Dorset and Assistant Coroner for Avon
Miss Louise Pinder, Senior Coroner for Rutland and North Leicestershire and Assistant Coroner in Derby and Derbyshire.
Mr Zak Golombeck, Area Coroner for Manchester City



Browne Jacobson

Introduction

The session was chaired by Nicola Evans, Partner at Browne Jacobson. We were delighted to be joined by a panel of extremely experienced Coroners who shared their insights with over 150 senior leaders and professionals drawn from the health and care sector across England and Wales.

We covered a range of topics including a back to basics reminder of when and why a death is referred to the Coroner and the processes followed by the Coroner when a death is referred, including what happens at inquest.

Before taking questions, the Panel also considered the Coroner's duties under Regulation 28, what organisations can do to assist the Coroner when considering whether the duty arises and what evidence the Coroner is looking for from organisations regarding organisational learning.

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How we can help

Advisory and Inquest Team

Our specialist Advisory and Inquest team provides expert legal advice to organisations across the public and independent health and care sector. Please do not hesitate to contact us if we can assist with any inquest or advisory matters or support you with training.

Mock Inquest

Our market leading Mock Inquest training course provides essential knowledge and tools delivered by a range of legal experts. It includes lectures and mock inquest scenarios involving an experienced Medical Examiner and five experienced Coroners from different jurisdictions who share their insights throughout the course.

The course covers the inquest process from start to finish and provides practical advice and guidance on reporting deaths and certification, writing reports for the Coroner and giving oral evidence in court or remotely. It includes several mock in-person inquests and a mock remote inquest hearing to provide a realistic experience from opening to conclusion and aims to introduce delegates to best practice when dealing with inquest hearings.

It also considers the wider impact of an inquest for the organisations and clinicians involved, looking at media coverage, compensation claims, disciplinary and professional implications. See Mock Inquest Course details and register your place here.

We have also produced the following inquest guides which are free to access and share with colleagues:

- Guide to coroners' inquest process for clinical witnesses (brownejacobson.com)
- Guide for clinical witnesses writing coroner's inquest statements (brownejacobson.com)
- Guide to preparing and delivering a prevention of future deaths report (brownejacobson.com)

There are other free resources available on Browne Jacobson's Inquest page which you can access here.

Back to basics

Mr Zak Golombeck
Area Coroner for Manchester City

Referral and investigation process

Some people may think of Coroners just as Judges who sit in court, but a lot happens behind the scenes.

When someone dies, a doctor involved in their care has to complete a Medical Certificate of Cause of Death (MCCD), which is then forwarded to the register office to register the death

However, there are certain circumstances in which the death must be notified to the Coroner. These are set out in the Notification of Deaths Regulations 2019: the death MUST be notified to the Coroner where there is reasonable cause to suspect that the death was due to (that is, more than minimally, negligibly or trivially) caused or contributed to by specific circumstances, which are listed in the Regulations

There is an incorrect assumption that notification to the Coroner automatically leads to an inquest. That is not the case but the doctor's role is not to second guess a Coroner's judicial decision. Where a death falls into one of the categories listed in the Notification of Deaths Regulations 2019 the Coroner should be notified, and it is the Coroner who makes a decision about how to proceed from there.

We have discussed the role of the Medical Examiner in this referral process at our previous Shared Insights session with the National Medical Examiner for England and Wales.

Mr Golombeck explained that referrals to the Coroner come from a number of sources, including:

- Hospital Trusts
- The community (for example, the police or GP)
- The Registrar, following the rejection of the medical certificate cited cause of death.

Hospital referrals tend to be made by a treating clinician who reports the death when they consider that the death falls within the Notification of Deaths Regulations 2019.

Community deaths are usually reported where no attending doctor can offer a cause of death. These can come in through the out of hours service and include:

- Road traffic accidents
- Special Procedure Investigations i.e. drugs/suicide
- Prison deaths
- Suspected homicide
- Faith deaths

Referrals are reviewed and assessed by a Coroner who considers whether the Coroner's statutory duty to investigate is triggered. This is set out in Section 1 of the Coroners and Justice Act 2009, which states that the Coroner has a statutory duty to investigate a death if he or she has reasonable cause to suspect that:

- the deceased died **a violent or unnatural death**. Even if a death was due to a natural disease process, there may still be issues such as delays in care or missed opportunities which may have caused or contributed to the death. If so, this will trigger the Coroner's duty to investigate as this will be categorised as an unnatural death:
- the **cause of death is unknown**, or
- the deceased died while in custody or otherwise in state detention.

Once the Coroner has been notified of a death, a decision will be made by the Coroner as to what investigations (if any) are required. Not every case referred to the Coroner requires an inquest. Investigations may simply involve making further enquiries with the family or post-mortem investigations such as autopsy or toxicology.

After that, if the Coroner is of the view that the person has died an unnatural or violent death, the cause of death is unknown or the deceased died in custody or state detention then the case proceeds to inquest.

All inquests have to be formally opened in Court. The Coroner will set directions for future management of the inquest outlining factors such as interested persons, whether a jury is needed, the scope of the inquest and what evidence is required. This can also be done at a Pre Inquest Review Hearing.

Once all the evidence is available it is reviewed and a decision is made whether more evidence is required or to go to a final inquest hearing.

The purpose of the inquest hearing is set out in Section 5 (1) of the Coroners and Justice Act 2009, which states that the Coroner must ascertain **who** the deceased was, **how**, **when** and **where** the deceased came by his or her death. This means that at the final hearing of the inquest, irrespective of the complexities of the case, the Coroner makes the same determinations on the four statutory questions about the death – **who, when, where, how**.

The question of "how" might change depending of the scope and whether Article 2 of Human Rights Act is engaged.

Question – What length of delay in treatment merits investigation?

This is addressed on a case by case basis. The question for the Coroner will be whether there is reasonable cause to suspect that the delay has more than minimally contributed to the death. If so, the duty to investigate will be triggered on the basis that there is reasonable cause to suspect that the deceased died an unnatural death. This will be the case even if the cause of death was natural causes – if delay in treatment has contributed to the death then this becomes an unnatural death.

Timings that would merit investigation depend entirely on the case e.g. in an obstetric case it might be a few minutes or with delays in scanning or diagnosis it might be months that would have an impact on the outcome.

Hospitals have got better at highlighting to the Coroner at an early stage where there might have been some delay or missed opportunity in the treatment.

Medical Examiners often refer these types of cases to the Coroner. Our note of a previous Shared Insights session here sets out the Medical Examiner perspective on notification of deaths.

Question – Do all unexpected child deaths automatically trigger an inquest?

No. There are no special rules for neonatal or child deaths. The Notification of Death Regulations 2019 apply to all deaths and do not differentiate between children/neonates and adults. The Coroner's statutory duty to investigate remains as set out in Section 1 of the Coroners and Justice Act 2009. If a child has died a violent or unnatural death, the cause of death is unknown or the deceased died in custody or state detention then there will be an inquest just as there would if the deceased is an adult.

Question – What happens if no cause of death is found at post-mortem?

This does sometimes occur but is case specific – just because there is no medical cause of death does not necessarily mean the Coroner is unable to make determinations about whether the death is natural or unnatural. E.g. there might be a case where the body is decomposed and the pathologist is able to determine that there was no unnatural element to the death but they are not able to determine specifically on the balance of probabilities what the medical cause of death was.

Interested Person (IP) status

Individuals and organisations can be awarded IP status by the Coroner, despite the "person" terminology. An IP is defined by Section 47(2) of the Coroners and Justice Act 2009. Organisations and individuals 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

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.

Being granted IP status confers important rights – it means the IP will be at the centre of the process; whether a family member or organisation e.g. an NHS Trust. The IP:

- Will have access to all disclosure as part of the inquest process
- Can play an important role at the final hearing (if they wish to do so)
- Can make submissions to Coroner
- Can ask witnesses questions
- Can decide whether to have independent legal advice.

How a Coroner determines who is an IP:

- The Coroner decides who the IPs are in accordance with section 47 Coroners and Justice Act 2009. Family members are automatically an IP.
- If someone died without family but had a will it would be the executor.
- If there is evidence which suggests that there was an act or omission by an organisation contributing to the person's death, that organisation will be afforded IP status.
- A hospital Trust might have an individual doctor whose act or omission is thought likely to have contributed to the death. There is some debate as to whether that doctor or the employing Trust should be an IP. This is dealt with on a case by case basis. It might be that both are granted IP status.
- Occasionally organisations that might be linked to some form of investigation e.g., the GMC or IOPC might be granted IP status.
- In respect of user groups per se, this is uncommon but they could be an IP if relevant to the inquest. However, whilst the Coroner does have some discretion regarding IP status, their role is fact-finding in relation to a particular death, not conducting a public inquiry.
- Coroners conduct reasonable and proportionate enquiries to establish the answers to the 4 statutory questions outlined above. IP status is determined by who has sufficient interest in that death.
- It may be that the witnesses are called simply to help establish the facts so the organisation does not need IP status.
- If an organisation has not been granted IP status they can ask for it to be considered by the Coroner.
- In most cases, the IPs are obvious from an early stage but this can evolve throughout the process and further IPs can be added.

The role of the family and the role of lawyers

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

The role of the family

The family has an automatic right to IP status under the Coroners and Justice Act 2009 and is at the heart of what Coroners do. Most families do not have legal representation at the inquest so the Coroner ensures that the family is given an opportunity to ask questions at the pre inquest review hearing and at the inquest and that they understand the process.

Usually a single point of contact for the family is identified but this can sometimes be challenging.

Right at the outset, the family will be asked if they have concerns about the treatment provided and are encouraged to write down questions and concerns at an early stage.

It is important for organisations to remember families are often unrepresented and it can be intimidating for families when organisations have legal representation. The Coroner will help the family to ask questions or reframe questions within the context of the scope of the inquest.

You may find this note of our recent Shared Insights session with the Chief Coroner, NHS Resolution and Irwin Mitchell of interest. The panel discussed practical steps that organisations can take to improve communication with families throughout the inquest process and shared their insights from each of their different perspectives to help shape and inform best practice in this area.

The role of lawyers in the inquest process – granting rights of audience to in house legal teams

As there is no legal aid for inquests, families have to pay privately if they want representation. Hospital Trusts use members of their in house legal team or instruct externally for complex inquests. Miss Pinder explained that there are no hard and fast rules as to who has rights of audience for in house legal teams and practice varies from Coroner to Coroner. The fundamental principle is that it is a fact finding process and is not supposed to be adversarial. The panel confirmed that having lawyers involved can sometimes

- Change the tone of the inquest.
- Can sometimes be a distraction
- However, it can be really helpful when advocates remember that their role is to assist the Coroner.

The SRA Solicitor's Toolkit is an important resource for anyone practising advocacy in the Coroner's Court.

It is important to remember how your conduct can be perceived by the family both in the courtroom and in the vicinity of it. Banter and joviality are not appropriate.

The role of independent expert evidence at inquest

Mrs Debbie Rookes
Assistant Coroner in the County of Dorset, Assistant Coroner for Avon

The role of independent expert evidence

This is case specific. Expert evidence is not obtained by the Coroner routinely.

- The Coroner's investigation needs to be reasonable and proportionate.
- It is not a court of blame – the inquest is a fact-finding exercise and is separate from civil litigation.
- The Coroner relies heavily on factual witnesses to establish the facts of a particular case.
- The "how" question is often harder to establish. In certain more complex cases the Coroner may commission independent expert evidence to assist with this e.g. where medical cause of death is unascertained but it is considered that a clinical toxicologist may be able to assist, instructing an expert may help determine how the death came about.
- The Coroner will sometimes seek opinion evidence from the Trust to assist them to answer the question of how the deceased came by their death. There may be an individual who is independent of the care but not independent of the Trust, whose evidence is sufficient in answering "how". Whilst the family may be concerned that they are not independent, they understand the dynamics within the hospital and can speak on those issues better than an independent expert. They are speaking under oath and must be honest and candid.

Duties under Regulation 28 Prevention of Future Deaths (PFDs)

Mr Zak Golombeck
Area Coroner for Manchester City

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.

See Chief Coroner's Guidance on PFD Reports 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

This generally happens at the end of the inquest, however the rules state that it can be done at any point in the investigation.

Coroners should highlight concerns rather than making recommendations for change. Suggestions from clinicians at the inquest can be included but it should be made it clear where these have come from and that they are not recommendations by the Coroner.

The PFDs issued after the London bombings are a good example of the Coroner highlighting concerns.

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. The response usually highlights steps taken such as a review carried out or new process introduced. This is then shared with IPs.

You can read all published PFD Reports and responses here and use the search function to look for PFD Reports which are relevant to your area of practice.

A PFD report is not punitive. It is seeking to work together, in order to prevent deaths happening and should not be seen as a black mark against an organisation.

Where a Coroner's investigation gives rise to a concern that future deaths will occur, the Coroner must make a PFD Report. This is a statutory duty and if it is triggered the Coroner does not have any discretion about whether or not to issue the report.

The Chief Coroner's Guidance (paragraph 40) also envisages that in exceptional circumstances, the duty to make a report does not arise but the coroner may nevertheless wish to draw attention to a matter of concern. The usual reason that no duty to make a PFD arises is because the matter does not relate to a risk of future deaths. In these circumstances, the coroner may write a letter expressing the concern to the relevant person or organisation. This could be discussed with interested persons at inquest and the correspondence could be copied to them. However, this does not mean that the Coroner can write a letter instead of a PFD Report. If the statutory duty is triggered, there is no discretion to send a letter instead of a PFD Report.

Question – What if the Coroner doesn't get a response to a PFD report?

- Very unlikely – not happened so far in the panel's experience.
- Where a response is unsatisfactory there is little the Coroner can do as the limit of the Coroner's duty is to highlight a concern.
- However, the risk to an organisation of not acting on a PFD is if a death occurs later as a result of a risk previously highlighted.
- All PFD reports and responses go to the CQC so if a weak response is provided this may trigger further investigation by the CQC.
- Work has been done by the Chief Coroner's office with government departments about the importance of responding to PFD reports.

Tips for assisting the Coroner when considering organisational learning

Mrs Debbie Rookes
Assistant Coroner in the County of Dorset,
Assistant Coroner for Avon

Tips for assisting the Coroner's consideration of organisational learning

Where your organisation may be at risk of a PFD, providing evidence of organisational learning at an inquest is important.

In complex cases where there have been shortcomings in care an organisation will often disclose written evidence in advance of the inquest to provide the Coroner with assurance that their statutory duty to issue a PFD is not triggered. This may take the form of an internal investigation report or an organisational learning report from someone senior, setting out relevant changes made since the death or plans to implement such changes.

Often the family wants to see lessons learned from a death and things changed for the future. That links into the organisation's investigation after the death. Internal investigations need to be robust, consider the right issues, involve staff and make relevant and appropriate recommendations.

It will be important for organisations to ensure that the right people have been involved in the investigation. Often, this will include the witnesses at the inquest as well as the family.

It is important that witnesses are reflective and can talk about recommendations made and actions taken as a result of the internal investigation.

The organisation should also be able to demonstrate how actions are being monitored and audited to ensure changes have been effectively embedded and are driving meaningful change.

The panel agreed that the quality of internal investigations is not always where it needs to be and some PFD Reports have related to the processes in place for investigating patient safety incidents within organisations.

Communication with the family is also so important. Some clinical witnesses give evidence really well, offer condolences and are really good at listening to questions and giving thoughtful responses. This makes a real difference in terms of how those questions are answered, and to the family feeling heard during the inquest hearing.

To read more about PFD Reports, see the note of our previous Shared Insights session on preparing and delivering organisational learning evidence in the Coroner's Court

Questions from the chat

This was a packed session and there were a handful of questions we were unable to cover, so we have set these out below:

Question – What are the Coroners' experiences of PSIRF in the inquest process?

The panel have not seen many PSII reports yet and so it is too early to comment on what impact these are having at inquest but generally the Coroner's Duty to make a PFD Report under Regulation 28 Duty is as set out in the legislation and the format of the investigation does not change this duty. The Trust will need to provide evidence to assure the Coroner that the statutory duty is not triggered. As set out above, that means ensuring the investigation covers the relevant issues and that the clinicians and family are involved in the investigation so that it addresses key learning and is robust and fit for purpose.

See our note from a previous Shared Insights session on organisational learning evidence and Browne Jacobson's Guide on the same topic.

Question – There were some questions about organisations engaging with families during the inquest process.

See our note of the previous Shared Insights session we delivered with the Chief Coroner, Irwin Mitchell and NHS Resolution.

Question – Have you noticed an impact on the quantity and quality of referrals since the introduction of the Medical Examiner Service?

We have previously done a Coroner's Question Time with the National Medical Examiner and this question is covered in our note of that session which you can read here.

Question – When and why the Coroner will engage Article 2 of the Human Rights Act?

Browne Jacobson's Katie Viggers has drafted a really useful article which helps shed some light on this question and you can read that here - Inquests and Article 2 of the European Convention of Human Rights (brownejacobson.com).

Question – For benchmarking purposes, Boards sometimes ask in-house legal teams to compare their Trust with similar Trusts in terms of how many inquests per year have been opened or completed, etc. Is there any way of accessing such information without submitting a request under the Freedom of Information Act 2000 to the relevant Trust and contributing to the resource pressures?

We are not aware that there are statistics held on individual Trusts in terms of the number of inquests they are involved in annually – as far as we know the only way for Trusts to benchmark against each other is to request this data from each other. There is some data on legal teams compiled by NHS England's Model Health System but not enough to provide detailed benchmarking for Boards or to build a Business Case for additional resources. We would be happy to connect Heads of Legal who want to work together on benchmarking, so please do let us know if you would like us to put you in touch with other Heads of Legal for these purposes.

Question – The Child Death Review Process, suggests the Child Death Review Meeting (CDRM) should take place prior to the inquest, and then the outcome/feedback of the Child Death Review Meeting should be shared with the Coroner to feed into the inquest (if this is to take place). Once the inquest has taken place, the case can then be referred into Child Death Overview Panel for a final review. As CDOP are not an IP, we would not be entitled to further information about the inquest, therefore we are finding it difficult to time the CDRM prior to inquest. We have been told the CDRM may not reflect the items under consideration by the Coroner.

Any advice on this? Do other areas have a formal process where the analysis form from the CDRM is shared with the Coroner?

Mr Golombeck explains minutes from a CDRM are not always shared with him; it is hit and miss. He thinks they always should be, but of course the scope of an Inquest will differ from what the CDRM needs to focus on. A formal process would be beneficial moving forward**.**

Question – With the unparalleled spike in PFDs is there a national directive on actions to be taken by all to reduce the occurrence of preventable deaths? Thinking about triangulation of information and dissemination of learnings.

PFDs are published as are the responses and in the health and care sector they will be shared with the regulator (CQC) and can lead to further action.

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