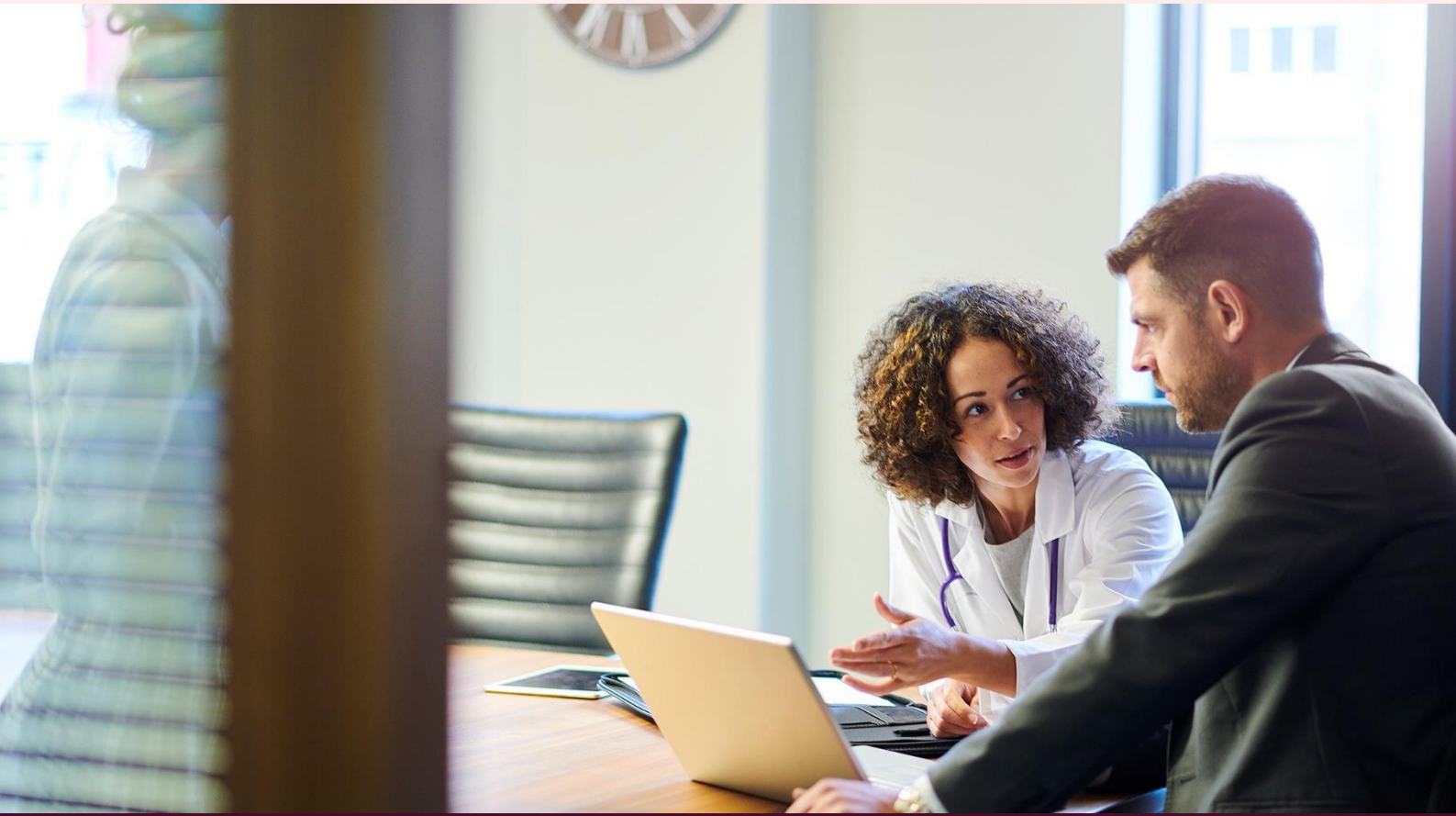
25 February 2025

Shared Insights

Coroner's Question Time

Panel of 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
Mr Christopher Stark, Assistant Coroner for Northamptonshire & Director of Legal Services for University Hospitals of Derby and Burton NHS Foundation Trust



Browne Jacobson

Introduction

This popular session of Coroner's Question Time, led by Nicola Evans along with three experienced coroners, focused on best practice for inquests.

The session focussed on the importance of preparation for advocates, factual witnesses and senior managers and the role that everyone involved in the inquest process has in helping the inquest to run smoothly. The discussion highlighted the significance of early engagement with families, appropriate court conduct and making appropriate admissions in advance of the inquest to narrow the issues and scope. It also addressed the importance of accurate and well-prepared statements and effective communication between health and care providers and coroners to ensure a smooth inquest process.

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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.

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 six 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 13 March to 3 April 2025. All modules are recorded and can be watched on catch-up to fit around clinical commitments. For further details and to register your place, click here: Click here for more details and to register your place on the Mock Inquest course

Inquest resources

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

Guide to coroners' inquest process for witnesses

Guide for clinical witnesses writing coroner's inquest statements

Guide to inquests for mental health patients

Inquests and Article 2 of the European Convention of Human Rights

Guide to preparing and delivering a prevention of future deaths report

You can access these and other resources here.

The importance of thorough preparation

Mr Zak Golombeck
Area Coroner for Manchester City

From a coroner's perspective, it is evident that when an inquest runs smoothly, it is down to preparation. It becomes apparent when interested persons and their advocates have adequately prepared for an inquest. This preparation begins well in advance of the final hearing, starting when statements are first gathered by the organisation's legal services department.

However, the bulk of the preparation goes into the weeks leading up to the inquest and it is crucial for witnesses to work with the legal team during this time. Witnesses may need to familiarise themselves with the court room and the procedural aspects of an inquest if it is their first inquest. They should familiarise themselves with their own statement and have some knowledge of the other evidence that will be presented at the inquest – whether that be from colleagues, other professionals involved or the family. Familiarity with the deceased's medical or social care records is also essential.

Mr Golombeck highlighted a recent inquest that had proceeded smoothly and successfully. Five clinicians from an NHS Trust were called to give evidence and each one was on top of their evidence. They brought copies of their statements with them but did not need to refer to them as it was clear that they had prepared very thoroughly by reviewing the medical records and documents before the inquest and giving careful thought to the evidence they would give in the witness box. The medical records were available in court, yet the clinicians knew them inside out. They answered questions clearly, were aware of the expert evidence provided and offered informed views on both the expert's evidence and the Trust's internal investigation. Additionally, they spoke warmly about the deceased, sharing stories that resonated naturally with both Mr Golombeck and the family.

It was clear that significant preparation had been undertaken by the witnesses, the legal services department and the Trust's advocate. The Trust made some admissions and acknowledged certain errors in care whilst refuting other alleged shortcomings, but did so with professionalism. As a result, the inquest was conducted smoothly and respectfully.

Unsurprisingly, insufficient preparation has been a common factor in other inquests which have not run as smoothly. Mr Golombeck noted instances where witnesses were not advised on appropriate court attire or behaviour, resulting in unprofessional appearances. Witnesses fumbling through their statements – potentially due to nervousness but also indicative of inadequate preparation – suggested a lack of preparation on both the part of the individual and the organisation. Additionally, a lack of preparedness on the part of the advocate, such as not knowing when to pose specific questions, highlighted the importance of thorough preparation.

In summary, effective preparation is key. Adequate preparation helps individuals feel more at ease, even in challenging situations. It reduces the number of questions that are likely to be asked of witnesses and ensures the evidence will run more smoothly and easily.

Professional conduct and courtroom preparedness

Miss Louise Pinder
Senior Coroner for Rutland and North Leicestershire

Miss Pinder agreed that preparation is crucial for successful inquests and that witnesses often face difficulties in court when they have not prepared sufficiently.

A coroner's inquest is a fact-finding enquiry, where the coroner answers four statutory questions – who the deceased was, where, when and how they died. The primary focus of the inquest hearing is usually on how the deceased died. When a health or social care provider is involved, and witnesses are called to give evidence in court, it is usually because there are concerns about the treatment or care provided. Witnesses need to be prepared to address these concerns, which are often identified in pre-inquest review hearings. Witnesses need to thoroughly understand the concerns in order to be prepared for the inquest itself.

Coroners may become frustrated when organisations provide irrelevant reports or statements during the early stages of the investigation. Organisations should carefully examine any concerns about the care or treatment provided and collate reports that address these issues.

If a coroner calls a particular witness but the organisation feels that another witness would be better suited to address the issues, it is advisable for the organisation to contact the coroner and suggest an alternative, more suitable witnesses. This demonstrates an understanding of what the coroner and family need. There is no point turning up to an inquest not being ready to answer key questions.

Perception in court is also important. Small details, such as whether a witness is appropriately dressed, can affect a family's experience and perception. Actions that can seem innocuous, such as advocates or witnesses sitting on laptops emailing in court, can in fact demonstrate a lack of engagement in the process, which can negatively impact the family's view. In one instance, an advocate representing an NHS Trust turned to witnesses and gave a wide smile when the coroner made a finding against the family's wishes, which looked very inappropriate. Witnesses and advocates should continually consider how their behaviour and demeanour in court is perceived by the coroner and the family, and whether it helps or hinders their position and appearance.

Best practice tips for inquests

Mr Christopher Stark – Assistant Coroner for Northamptonshire & Director of Legal Services for University Hospitals of Derby and Burton NHS Foundation Trust

Identifying the right witnesses

Mr Stark explained that he is Director of Legal Services for University Hospitals of Derby and Burton NHS Foundation Trust and also sits part-time as an Assistant Coroner. He reiterated the importance of identifying the most appropriate witnesses, acknowledging that it can be challenging during the initial stages to determine who the most suitable witness is. However, as the investigation advances, it usually becomes apparent which issues require further examination. Part of the role of the legal services team is to address this proactively by obtaining supplementary statements or speaking to the coroner's office about what additional evidence is needed. When Mr Stark sits as a coroner, he welcomes such proactive engagement from organisations. In his role as Director of Legal Services, the Trust's inquests are dealt with by two different coroner districts, both of which are receptive to this approach. It is important to build that kind of proactive relationship with your local coroner service(s).

Conduct in court

Regarding Miss Pinder's point about conduct in court, Mr Stark said that this applies to everyone both in and outside of the courtroom. Senior managers attending to support staff should not sit in court using their laptops and appearing disengaged in the process. Everyone should be mindful of their journey into court, as they may pass by or sit next to family members, so behaviour in and around the courtroom should be appropriate. Even for remote hearings, similar considerations apply, and witnesses need to be careful and considerate, such as ensuring that when they are not giving evidence they have muted their microphone throughout to avoid saying something which is then inadvertently broadcast in the courtroom.

Good quality statements

Good quality statements are crucial. Following a bereavement, your statement is the family's first impression of you. They may have unanswered questions, and if your report is thorough, clearly explaining the decisions made and the reasons behind them, and provides a holistic overview of the care provided, it will reflect well on both you and your organisation.

Initial investigation reviews

When completing a 72-hour report or other initial investigation in response to an incident, it is unlikely that all the facts will be available at that point. However, it is important to be as accurate and comprehensive as possible. If there are unknowns, this should be reflected in the documentation, and it should be noted that the investigation may evolve as new information becomes available. Feedback from families indicates that it can be confusing if there are two investigation reports (an initial report and a final investigation report) with differing information. Whilst there is no issue with an investigation evolving as new information becomes available, this should be explained at the outset.

SMART recommendations arising from investigations

There can be insufficient diligence around recommendations that are set following investigations. Recommendations should be SMART – specific, measurable, achievable, relevant and time bound. They must be achievable and have realistic deadlines. Mr Stark has seen incredibly tight, impractical deadlines, such as conducting simulation training for a large cohort of staff within one month. Unrealistic timeframes will simply result in the organisation having to explain why the action plan has not been completed at inquest.

Achievable and sensible recommendations should be set, and the action plan regularly monitored to ensure these are being progressed within the agreed timescales.

Reviewing the medical or care records

The importance of witnesses familiarising themselves with the medical or care records before attending court was emphasised. Witnesses should also check that their understanding of the care or treatment provided is accurately reflected in the records. For example, if an ECG was requested by the witness, they should check it was performed, or if medication was prescribed, they should check it was administered.

Mr Stark was involved in an inquest where a witness assumed prescribed medication had been administered, but the prescription chart indicated otherwise. Witnesses need to be aware of the factual events prior to the hearing, so they can consider if they differ from their understanding of what happened and, if so, whether it made a material difference to the outcome. If a witness only becomes aware of these facts during the hearing itself, they will come under pressure and their evidence may not be considered or presented effectively.

Engagement with families

It's crucial to consider whether it's possible to contact the bereaved family before the inquest and, if so, to engage with them respectfully and compassionately. Such engagement must also respect the coronial process, so if a meeting between the organisation and family is to take place, the coroner should be informed. It must also be explained to the family that the coronial process will consider all the evidence and there may be questions that cannot be answered before the hearing.

As an advocate, Mr Stark ensures he approaches families before the hearing to introduce himself. This can be challenging or unfeasible in virtual hearings, making the return to in-person hearings beneficial from that perspective.

Discussion and questions from the chat

Detailed statements potentially avoiding the need for an inquest

Nicola provided an example of a family with numerous questions concerning the death of a loved one. These questions were submitted in writing to the NHS Trust that treated their family member via the coroner. Shortly thereafter, a comprehensive report was provided by the consultant in charge of the deceased's care. It was evident that the consultant had carefully considered the questions and responded in a thoughtful and diligent manner. The family greatly benefitted from this report as it addressed all their questions and the Coroner was also satisfied that the concerns had been addressed and there were no shortcomings in the care. For that reason, the Coroner was able to conclude the inquest on the papers and none of the clinical team were required to give oral evidence in court.

Similarly, a delegate's comment in the chat highlighted a situation where a detailed statement from a consultant obviated the need for them to provide oral evidence at an inquest. The statement thoroughly addressed all the family's questions and concerns, leading the coroner to determine that no further evidence from the consultant was required.

When is the best time to offer condolences and can this be done from the witness box?

There was an interesting discussion around the appropriate timing and manner of offering condolences to family members. Mr Golombeck considered that, in situations where multiple clinicians are called to provide evidence, there is a concern that each clinician offering condolences individually in the witness box may inadvertently result in a negative reaction from the family.

As a coroner, he prefers for condolences to be extended at the outset of proceedings, either by the advocate or a spokesperson on behalf of the organisation, rather than by every witness. He believes there should be a clear distinction between the emotional aspects (with the organisation offering their condolences) and the focus on presenting evidence and fulfilling the statutory requirements of the inquest. Whilst his preference is for condolences to be offered outside of court, he would never direct this. Additionally, Mr Golombeck finds that offering condolences at the conclusion of a witness's evidence can appear unnatural, potentially coming across as an afterthought. In one inquest involving an NHS Trust, the family presented a pen portrait of their loved one, after which the witness shared a touching anecdote about the deceased playing a practical joke on another patient. Although no formal condolences were offered, the story itself was moving. A delegate commented in the chat that, in their role as family liaison officer, they often hear families saying that they are fed up with everyone offering condolences, especially if the family has complained about the care provided.

Other panel members suggested that organisation should approach the family or the family's advocate to ask how they would prefer condolences to be extended, if at all. Miss Pinder considered this approach fed into a helpful, collaborative approach between advocates, which is welcomed by coroners. Further, if organisations have taken the time to meet with the family prior to the inquest, then they are likely to have a clearer understanding of the family's preferences. Some families may harbour anger towards the organisation and respond negatively to condolences being offered either in or out of court; it is crucial for the organisation to be aware of this before the hearing.

Delegates also noted that witnesses might feel very nervous about offering condolences, making it important to consider what feels natural for them as well. It reflects poorly if witnesses "parrot" condolences because they have been instructed to do so.

There is no one size fits all approach and each case should be dealt with on the facts. The important thing is that if condolences are offered this is done sincerely, using the witness's own words and directed at the family compassionately and in a way that reflects what that family wants.

Can the complaints process run in parallel with the inquest process?

Mr Stark acknowledged the concerns that organisations might have about the complaints and inquest processes running in parallel. However, if the family makes a complaint about the care or treatment provided to the deceased, the complaints process can proceed provided it respects the coronial process. Early engagement with the family is desperately important, and there can often be a delay between the date of death and the inquest. Therefore, organisations will miss a vital opportunity to engage with families early if they wait for the conclusion of a hearing before responding to a complaint.

Miss Pinder agreed that organisations should continue with the complaints process even if there is to be an inquest and should keep the coroner updated. Many natural causes deaths are referred to coroners because of concerns about the care provided. Early engagement and resolving the family's concerns may in fact eliminate the need for an inquest, which can be beneficial for all parties.

Mr Golombeck also agreed that the complaints process can run parallel to an inquest and reiterated the importance of keeping the coroner updated. He pointed out that family concerns often fall outside the scope of an inquest and must be addressed separately by the organisation in any event. He reminded delegates to share complaint letters and responses with the coroner's office.

Family liaison

A delegate from a mental health trust noted that a member of the Trust's incident investigation team, accompanied by the Trust's family liaison officer, always meets with the family when an internal investigation into a death is initiated. This practice is generally found to be very beneficial for families. Families are given the option to participate in the investigation, which helps them understand the process better. They feel more informed about the Trust's actions and assured that the investigation is transparent.

Mr. Stark expressed his support for family liaison services, highlighting their role in providing continuous support to families throughout both the investigation and inquest processes.

Another delegate emphasised the PSIRF family engagement principles, which aim to encourage meaningful contact, offer inclusion in the investigative process, and support them throughout the journey to a coronial inquest. Greater organisational engagement with families will build trust, enhance understanding, and help meet their expectations.

Is there anything that Coroners wish legal or medical representatives understood better about the inquest process?

Admissions

Mr Golombeck stated that pre-inquest admissions are very important. An admission occurs when an organisation accepts that there were shortcomings or failings in the care or treatment provided. Sometimes witnesses clearly indicate in their evidence that certain actions should have been taken or been done differently. However, when the coroner asks the advocate if the organisation is willing to make an admission on that point, there is often confusion as to what is meant. Admissions can result in fewer witnesses being called to give evidence. They can also narrow down the issues on which the coroner needs to make factual findings. The importance of admissions is not always fully recognised by advocates and organisations.

Miss Pinder agreed and noted that a formal letter regarding admissions from an organisation can be helpful. If pre-inquest admissions are made, it is likely that not all the witnesses will need to give evidence. There is a notable difference in how organisations respond to the suggestion of admissions. Some are very defensive and unwilling to make any comments or admissions regarding shortcomings, even when the deficiencies are obvious. When organisations make admissions early and accept their shortcomings, it can alter the tone of the inquest.

Mr Stark clarified that there is a distinction between admissions of shortcoming of care and civil litigation admissions. It is challenging at times to appreciate this difference because the same facts are being examined.

Staying within your scope of expertise

Miss Pinder noted that witnesses sometimes stray outside their area of expertise. Whilst this is often motivated by desire to help the family understand what happened, it can be risky for witnesses to do this. It is important for witnesses to notify the coroner if they don’t know the answer or if it is outside their expertise. This is very different from being unable to respond due to lack of preparation.

Key takeaways

- Preparation for witnesses, advocates and organisations is crucial to ensure a smooth and effective inquest process.
- Professional conduct and proper courtroom behaviour greatly influence how the coroner and family perceive witnesses and organisations.
- Identifying the most suitable witnesses and ensuring they are thoroughly familiar with the case details, including their statement and medical or care records, is essential.
- Good quality statements and early engagement with the family to resolve any queries or complaints can sometimes prevent the need for an inquest hearing.
- Offering condolences should be done thoughtfully and in a manner that respects the family’s preferences.
- Making pre-inquest admissions of shortcomings when appropriate can help narrow down issues and positively influence the inquest's tone.

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