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The ins and outs of inquests

PART 2

Following a report of a death to the Coroner, it may be necessary for a consultant, or private practitioner to attend an inquest. Last month Dr Gabrielle Pendlebury, Medicolegal Consultant at Medical Protection, advised on how to prepare for an inquest. In part two she looks at the different ways you could be involved in an inquest hearing and what to expect on the day.

A Pre-Inquest Review Hearing (PIRH) and how it differs to an inquest

In complex cases the Coroner may hold a Pre-Inquest Review Hearing (PIRH) with interested persons, to decide on the scope of the investigation, identify witnesses, and to plan the inquest date and duration.

Pre-inquest review hearings were formally legislated for in the Coroners and Justice Act 2009 (Rule 6) and came into force in 2013.

The purpose is to assist in the management of the inquest itself. This is particularly useful in complex cases. The Coroner would normally alert you to a PIRH, this can sometimes be at very short notice, so it is good to alert your MDO as early as possible if you have been notified of an inquest, as they can then liaise directly with the Coroner and try to reduce the risk of a 'surprise' PIRH at short notice.

At the PIRH, the Coroner will want to determine:

- Identity of Interested Persons
- Scope of the Inquest
- Issues to consider
- Whether the Right to Life, Article 2 of the European Convention of Human Rights (ECHR) is engaged[1]
- Whether a Jury is required
- Witnesses (Rule 23 or live)
- Length of hearing and set hearing dates
- Disclosure.

Failure by the Coroner to hold a PIRH can lead to the ordering of a fresh inquest. The Coroner will provide an agenda in advance, and this can be requested if not offered.

Rule 23 (R23)

Something that is determined before the inquest or at the PIRH is whether the witnesses will give their evidence live or whether their statements will be merely read, pursuant to Rule 23.

This is something that is worth trying to lock down in advance, and your MDO can address this with the Coroner. If you are being called to give live evidence, but your MDO feels that

[1] Right to Life, Article 2 of the European Convention of Human Rights (ECHR), https://www.echr.coe.int/Documents/Guide_Art_2_ENG.pdf p.40

the statement could be read, an application in writing can be made to have the statement read under R23.

Attending an inquest as a witness

You can be called to attend an inquest hearing as a witness in two ways:

- As a "Witness of Fact": If you are called as a witness of fact, it would usually indicate that the coroner believes your involvement in the case to be peripheral. Your statement will form the basis of your oral evidence and you may be asked questions in order to clarify certain aspects.

- As an "Interested Person" (IP): If you are called as an IP it would indicate that the Coroner believes you to be more centrally involved in the circumstances leading to death. If you are granted IP status you are entitled to have legal representation; receive disclosure of the documents that the Coroner intends to rely upon at the inquest; and ask questions of other witnesses.

For these reasons, and because there is a higher risk of criticism, it is important to know if you have been granted IP status at the inquest. There are a number of statutory grounds under which a person can be given IP status. They are set out at section 47(2) a-m of the Coroner's and Justice Act 2009[2].

Doctors and medical professionals are usually recognised under section 47(2)(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".

Also the Coroner has a "catch all" discretion under section 47(2)(m) to grant IP status to anyone who is deemed to have "sufficient interest".

Witness evidence is given under oath, which means that you are under a legal obligation to tell the truth at an inquest.

On the day

In most courts the Coroner sits at the head of the chamber, with the witness box to one side. The advocates' bench is in front of the Coroner, and behind that is general seating. Inquests are held in an open (public) forum and some will generate media attention so reporters may be present. Additionally, all inquests are now audio-recorded.

Preparation

- Be prepared - reading statements that you have submitted, and any other relevant documents will refresh your memory of events. You may take case documents into the court room and refer to these while in the witness box. Consider marking or highlighting important sections in advance for ease of reference on the day.
- Dress smartly. This is a formal occasion and a suit or other business attire is considered appropriate.

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[2] http://www.legislation.gov.uk/ukpga/2009/25/section/47

- Arrive on time. Register your arrival with the Coroner's Officer or clerk. You will be shown into the Courtroom and be seated ready to be called to take the witness box.
- Switch your mobile phone off!
- Be polite and remember it is fine to give your condolence to the family if you see them at Court.
- When called, you will be asked to 'swear in' by reading an oath on a holy book, or a non-denominational statement of truth. After this point any failure to tell the truth would amount to perjury.
- Each witness will be questioned by the Coroner and then by interested persons, including the family.
- Direct your answers to the Coroner, whom you should address as 'Sir' or 'Madam'.
- Answer the question you have been asked, not the one you wanted to be asked. If you are unsure of the question, seek clarification.
- Keep your answers brief and factual.
- Use non-technical language whenever possible. Ideally you should answer in lay terms.
- Keep calm. The tendency is to speed up when nervous, but make sure you speak clearly and slowly.
- Remember that media may be in attendance, dependent on the level of press interest in the case. Statements made during an inquest may be covered by media outlets if the case is open for press to attend. If asked for additional statements by media before, during or after the inquest, contact your MDO before making any comment, to get media advice and support.

Avoid…

- Discussing the facts of the case outside the courtroom as this could be seen as interfering with the inquest process.
- The temptation to fill gaps in proceedings by speaking. The Coroner may be making notes from the evidence or preparing their next question.
- Straying into the remit of an expert unless you are qualified to give such an opinion. Remember that a witness of fact should confine evidence to facts within their direct experience.
- Leaving court before the Coroner releases you.

Post inquest

When the Coroner has heard all the evidence, they will 'sum up' and deliver their conclusion. This can be in 'short form' or a narrative verdict. It is important for you to obtain the outcome of the inquest, and if you are legally represented, the lawyer will make sure that this is received. However, in some instances, a doctor can give evidence without receiving the final outcome, thus never knowing about potential criticism or if a 'Regulation 28' report will be issued. If you are without legal representation, it is important to find out the outcome by contacting the Coroner directly.

Regulation 28 reports – Prevention of Future Deaths

Following the inquest, the Coroner has a duty to make recommendations in cases where the evidence suggests that further avoidable deaths could occur and that, in the Coroner's

opinion, preventative action should be taken. The coroner will prepare a report, which will be sent to the person or authority that may have the power to take the appropriate steps to reduce the risk; they have a duty to provide a response within 56 days of the date the report is sent.

If a doctor is concerned that they may be (or have been) criticised in the context of a Coroner's inquest, including in a Regulation 28 Report, then they should contact their MDO at the earliest opportunity to seek advice about the appropriate steps to take.

The Regulation 28 report may also be made available to the media, and your MDO can assist with preparing for any media reports and monitoring for coverage.

What to do if you are criticised by the Coroner

On occasion, a doctor may be criticised in the Coroner's report, or during an inquest. If this occurs, they are required to inform the GMC without delay. This may result in an investigation by the GMC. This is a rare occurrence but if it does happen, your MDO can guide you through the process and direct targeted CPD around the issues raised to demonstrate evidence of remediation to the GMC.

Where to turn for help and support during an inquest

Any involvement in an inquest can be incredibly stressful, prompting mixed feelings and potentially concerns about your own professional welfare.

These feelings can be managed with careful preparation and support.

Seek support from colleagues who have experienced inquests in the past, as they will be in a good position to empathise with any concerns you may have but also give relevant information, regarding the process.

If you experience feelings of being overwhelmed such as anxiety, alert your GP and do not be afraid of seeking psychological support, which may aid your ability to negotiate the inquest without too many sleepless nights.

Finally, remember to seek support from your MDO. As soon as you are aware of an inquest contact your MDO.

[Piece 2 ENDS]