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# Webinar: Inquests training (in the current COVID-19 era)


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*"They are just so well established. They are a cut above the rest."*

Chambers UK Guide 2019

# This online training will cover:

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- Louise's first-hand experience
- Inquests: what are they?
- Why am I the 'chosen one'?
- Giving evidence: effective witness statements/ reports
- Professional responsibilities
- What to expect during an Inquest: remote participation?
- Supporting colleagues
- Any questions?

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# Louise and Elspeth: where it began

Background:

- 15 years old (P)– referred to RMCH Child and Adolescent MH services for suicidal ideation
- Referred on to Rapid Response Team
- Prior to allocation to a case worker, P died from jumping from a balcony.
- Inquest at Bolton Coroner's Court
- February 2020
- Multiple 'interested parties'
- Conclusion: suicide. No Reg 28 findings.

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# Inquests: what are they?

- Duty to report a death to the Coroner in certain circumstances e.g.
  - 'Unnatural' death
  - Medical treatment

  (see Notification of Death Guidance 2019)

- So what does this mean for a death caused by COVID-19?
  - COVID-19 is a naturally occurring disease and may be treated as a **natural cause of death** for registration purposes, **in the absence of other features**, if it is the probable cause of death.

  BUT....

  - If there is reason for the coroner to suspect that the ostensibly natural death might actually be **unnatural**, owing to there being evidence of some **culpable human failure,** but for which the death would have been avoided.


Duty to Investigate…

(1)*A senior coroner who is made aware that the body of a deceased person is within that coroner's area must as soon as practicable* ***conduct an investigation into the person's death*** *if subsection (2) applies.*

*(2)This subsection applies if the coroner has reason to suspect that—*

*(a)the deceased died* ***a violent or unnatural death****,*

*(b)the cause of death is* ***unknown****, or*

*(c)the deceased* ***died while in custody or otherwise in state detention****.*

(Coroners and Justice Act 2009 (CJA) s1/s2)

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# Inquests: who, when, where, how?

The Coroner needs to answer four statutory questions (Form 2):

1. **Who** died?
2. **When** did they die?
3. **Where** did they die?
4. **How** they died?

Civil standard of proof
(more likely than not e.g. >50%)

Conclusion

Jury Inquest? E.g.
- Violent death/unknown causes in state detention
- Result of act / omission of police officer
- Caused by a notifiable disease…COVID-19 – a notifiable disease?

Prevention of Future Deaths Report – Reg 28
- 'real and continuing' risk of death…

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# Inquests: why am I the 'chosen' one?

- A Coroner has a wide discretion to request <u>whomever they like</u> to:

  - provide a witness statement/ report
  - produce relevant documents in your control
  - attend an Inquest to give evidence

  The witness evidence will be used to answer the 4 statutory questions:

  1. Who the deceased was?
  2. When and where they died?
  3. Medical cause of death?
  4. How (and in what circumstances) they came about their death?

  The decision can be challenged but ultimately it's the Coroner's decision.

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# Inquests: preparing your report

- Investigation report/root cause analysis:
  - Think about the terms you use e.g. “urgent/emergency”, “pain”, “suicidal ideation”
  - Explain what standard practice would be e.g. all referrals looked at by the end of the day, developing a risk plan, timescales for communication with primary care, timescales for a follow up appointment
  - Remember that you are looking at practice with the benefit of hindsight


A good report should include:

- A title page.
- Numbered pages, short numbered paragraphs and appropriate subheadings.
- Your personal details, name, current post, summary of previous experience, your GMC/NMC registration number (if applicable) and whether you hold a current license to practice.
- details of your relevant knowledge/experience enabling you to comment on the issues.
- List of documentation considered and relied upon
- Chronology and summary of the relevant evidence.
- If you have undertaken an examination or performed other investigation(s).
- The outcome of that investigation/ your clinical opinion - **Understand the difference between 'probable' (>50% likely) and 'possible' (<50% likely)**
- The concluding paragraph.

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# Professional Obligations

- Duty to provide '**full and frank' disclosure** – includes documents that are not helpful to your position but relevant to the investigation

- You are providing evidence under oath/affirmation / statement of truth – **your duty is to the court** / not to the parties

- **Regulation 20: Duty of candour** – Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity

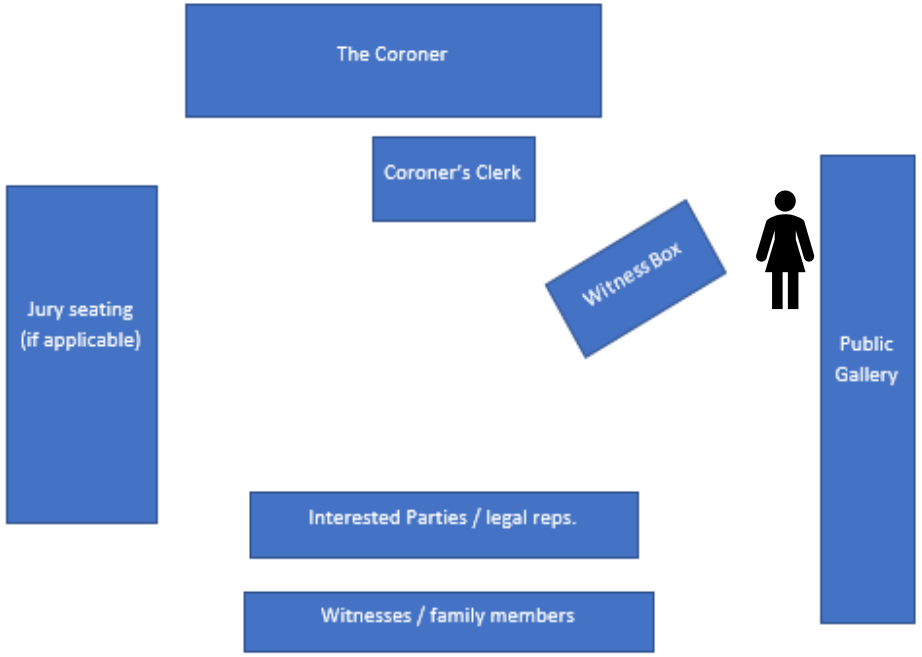
- **GMC / NMC / SRA obligations**
  - E.g. Para 73 of Good Medical Practice - *You must co-operate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality.*

  - Para 75(a) GMP - a doctor to inform the GMC without delay in circumstances when they have been criticised by an official inquiry – which would include a coroner's inquest.

# What to expect during an Inquest?

## Chief Coroner's Guidance

- Remote participation
- Comply with social distancing
- Coroner will be in Court
- Press can attend / audio transmission




- Remember:
  - No recordings / screenshots
  - Smart clothes / uniform
  - Quiet/ private location
  - Phones on silent
  - Good WIFI
  - Appropriate background
  - Have notes accessible
  - Your location is extension of the court room

# Supporting colleagues

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- Assist with the preparation
- Collate documentation
- Allow time for witness to prepare prior to the Inquest
- Ask the witness what would help them
- Debrief following the Inquest

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