



MDU

Medico-legal guide to Coroners' inquiries

2.1

Introduction

An inquest is a fact-finding inquiry, not a trial. It is held by the coroner when he decides that a death may not be due to natural causes. You may be asked to submit statements to the coroner about the care and treatment you have provided to patients who have died and, if required to, attend inquests as a witness.

Producing a statement and giving evidence at an inquest are usually straightforward.

The MDU answers an average of 900 calls a year from members seeking advice or assistance with inquests. We can advise members at each stage of the inquiry process – from the production of the statement to legal representation at the inquest itself, if that is necessary.

Our medico-legal advisers are always happy to discuss any issues of concern with you.

An evolving institution

The powers and duties of the coroner are set down in the Coroners and Justice Act 2009, much of which came into force in July 2013, the Coroners (Investigation) Regulations 2013 and the Coroners (Inquest) Rules 2013. A Chief Coroner has now been appointed, in accordance with the Act, to lead the service in England and Wales.

The 2009 Act introduced a new concept of a coroner's investigation. A coroner is bound by the legislation to open an investigation where there is reason to suspect that a person has died a violent

or suspicious death or has died in custody or where the cause of death is unknown and the body is within his or her area. Such an investigation may lead to an inquest.

A new role of medical examiner has also been introduced but has yet to be rolled out nationwide. The medical examiner's role will be to scrutinise and confirm the cause of death in all cases not investigated by the coroner.

It is proposed that the medical examiner service will work closely with the coroner service to ensure that only appropriate deaths are referred to the coroner.

Both the medical examiner service and the death certification process are under review.

Referring a death to the coroner

The coroner receives notifications from a number of sources, including doctors, the police, medical referees and the registrar of births, deaths and marriages. Only the registrar is obliged to refer a death to the coroner², in any of the following circumstances:

- if it appears that the deceased was not attended during their last illness by a registered medical practitioner
- if the registrar has been unable to obtain a duly completed certificate of cause of death

- if it appears from the certificate that the deceased was not seen by the certifying medical practitioner either after death or within 14 days before death
- if it appears that the cause of death is unknown
- if the death appears to have been unnatural, violent or suspicious
- if the death occurred during an operation or before recovery from anaesthesia
- if the death appears to have been due to industrial disease or industrial poisoning.

Types of cases to refer

As a doctor you are not legally obliged to report a death to the coroner, though in practice you should do so if there is any doubt or suspicion regarding the cause of death. You should also be aware of the circumstances in which the registrar is required to refer to the coroner. Many coroners publish local guidelines advising doctors in their jurisdiction of the categories of cases which they expect to be referred. These usually include:

- deaths which may be due to an accident, suicide, violence or neglect
- deaths which may be due to an industrial disease
- deaths in or shortly after release from prison or police custody
- deaths during or shortly after an operation or anaesthetic
- drug abuse
- non-therapeutic abortion
- still births where there is a possibility that the child may have been born alive, or there is cause for suspicion
- cases where the cause of death is unknown or uncertain.

Some coroners require notification of all deaths which occurred within 24 hours of admission to hospital.

You should be familiar with the requirements for completing medical certificates of the cause of death (MCCD) and only sign statements which

you believe to be true³. If you cannot complete the MCCD, you should refer the matter to the coroner and inform the deceased's family.

The coroner's investigations

Once a death has been referred, the coroner will investigate the circumstances of the death. Inquiries are usually conducted by the coroner's officer, who is often a police officer. You should cooperate fully by providing medical records and information as required.

The 2009 Act introduces a new power⁴ to require the production of documents. Non-compliance may result in the imposition of a fine or may constitute a criminal offence⁵.

What about confidentiality?

Although the duty of confidentiality survives the death of the patient, the provision of information to the coroner (or procurator fiscal in Scotland) is a justifiable exception⁶.

If the coroner asks for information about living patients in the course of his inquiry, you should not normally disclose this in advance of the inquest without the patient's consent. You may be ordered to do so by the coroner during the course of the inquest.

As part of his investigations, the coroner may direct that a post mortem examination is carried out. Where there has been or may be criticism of the medical or nursing care provided at a particular hospital, it is usual for a pathologist from a different site to carry out the post mortem. In certain circumstances a Home Office approved pathologist will be instructed.

In the case of a suspected murder or manslaughter, the coroner will pass the investigation of the death to the police and you may then disclose the medical notes directly to the police. If there is to be a prosecution, the inquest is deferred until after any criminal prosecution has taken place, or a clear decision has been made by the Crown Prosecution Service not to prosecute.

Scotland – Fatal Accident Inquiries (FAIs)

There is no coroner's office in Scotland. Instead, the procurator fiscal investigates all sudden, suspicious, accidental, unexpected and unexplained deaths.

The procurator fiscal can compel doctors to see him (or his officers) in person and provide an oral statement, in response to a series of questions. This is known as a precognition. Often the procurator fiscal will be prepared to accept a written statement. He is only obliged to arrange for a post mortem if he considers that the circumstances justify it.

Under Section 1 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, the procurator fiscal may hold a public inquiry before a sheriff. There is no automatic right to a public inquiry unless the death occurred in custody or in the course of the deceased's employment. Inquiries may be held into any death which is sudden, suspicious or unexplained, or gives rise to serious public concern. The inquiry is held in public and the proceedings are transcribed in shorthand.

Doctors can be ordered to give evidence at the fatal accident inquiry and must answer the questions put to them, though no witness is obliged to answer any question which could result in an incriminating answer.

Any party who can show a relevant interest in the proceedings may attend the FAI, be legally represented, present evidence and question witnesses.

At the conclusion of the FAI, the sheriff issues a final report (known as the sheriff's determination) which includes details of the time, place and cause of death; any reasonable precautions by which death might have been avoided; the defects in any system of working which contributed to the death and any other facts relevant to the circumstances of the death.

There are some differences in the way the coronial system operates in Northern Ireland and further details can be obtained from the MDU's medico-legal advisers.

References

1. dh.gov.uk/health/2012/09/death-certification-issue1/
2. *Registration of Births and Deaths Regulations (1987) SI 1987/2088, v41*
3. *GMC, Good Medical Practice 2013, paragraph 71*
4. *Coroners and Justice Act 2009, Schedule 5, paragraph 1(1)(b)*
5. *Coroners and Justice Act 2009, Schedule 6, paragraphs 6,7*
6. *GMC, Confidentiality (2017), paragraph 135*

For individual medico-legal advice:

24-hour advisory helpline

T **0800 716 646**

E **advisory@themdu.com**

W **themdu.com**

MDU Services Limited (MDUSL) is authorised and regulated by the Financial Conduct Authority for insurance mediation and consumer credit activities only. MDUSL is an agent for The Medical Defence Union Limited (MDU). MDU is not an insurance company. The benefits of MDU membership are all discretionary and are subject to the Memorandum and Articles of Association.

MDU Services Limited, registered in England 3957086. Registered Office: One Canada Square, London E14 5GS
© 2017 ADV202-a-1704 - Coroners' Inquiries 2.1



Medico-legal guide to Coroners' inquiries

Guide to report writing

2.2

Most doctors will have to produce at least one written report for a coroner during their professional career. A good report is worth the effort. The 2009 Act introduces a power to require a witness to provide a statement¹. It will minimise the risk of the coroner asking for clarification and could mean that you do not need to attend the inquest. Your report may, however, be read out at the inquest in your absence.

Writing a good report requires skills which differ substantially from those needed to produce a report for clinical purposes.

General principles

The report should be a detailed factual account based on the medical records and your knowledge of the deceased. The report should be typed on headed paper where possible.

You should identify yourself by your full name and professional medical qualifications written in full, eg Bachelor of Medicine rather than MB. Describe your status - GP registrar or consultant surgeon for 10 years, and so on.

Specify the nature of your contact with the patient. Did you see the patient on the NHS or privately; for clinical or forensic purposes; or for a combination of reasons? Where appropriate, state if you saw the patient alone or accompanied by another person during each and every consultation. Give the name and status of the other person, for example, spouse, mother, social worker.

Style

The report should be capable of standing on its own. Do not assume the reader has any background knowledge of the case. Several people may have to read the report apart from the coroner.

Avoid the use of jargon or medical abbreviations. Many lay people understand the term 'BP' (blood pressure), but fewer will know 'SOB' (shortness of breath) for example. All medical terms are best written in full. If you mention a drug, give an idea of what type of drug it is, e.g. antidepressant, antihypertensive. Give the full generic name, dosage and route of administration, such as capsules, inhaler, intra-muscular injection or suppository.

Write in the first person. The reader should have a good idea of who did what, why, when, to whom, and how you know this occurred. So, rather than writing 'The patient was examined again later in the day', it is far more helpful to say 'I remember asking my registrar, Dr John Brown, to examine the patient again later on the same day, and according to the notes he did so.'

Concentrate on your observations and understanding rather than quoting word-for-word what the patient told you happened. However, your understanding of a case will be significantly influenced by the history the patient gave you.

A description of the presenting symptoms is important, but this information is to put the interpretation of your examination into context. It is less likely to be part of

the evidence which the coroner will rely on. This emphasis contrasts with a good clinical report, where the history is central to any consultation.

Clinical notes

Give a factual chronology of events as you saw them, referring to the clinical notes whenever you can. Describe each and every relevant consultation or telephone contact in turn and include your working diagnosis or your differential diagnoses.

Outline any hospital referrals, identifying the name of the relevant practitioner or consultant.

The coroner will often require disclosure of the whole medical record. Take a full photocopy set for your own files before disclosing or returning the records, including a print-out of all information held on computer.

Even when not requested, it is often helpful to disclose a photocopy of the contemporaneous clinical notes. It may be necessary for you to provide a word-for-word, typewritten transcript with abbreviations written out in full. It is helpful to give the exact dates spanned by the notes because this is not always obvious from the entries.

The absence of an entry may be important. To illustrate the point, you may be reporting on a case of a child who has died. If the pathologist finds healed fractures at post mortem, but the notes do not indicate that the parents had sought medical advice for these injuries, then this would

raise the question of non-accidental injury and could have serious and immediate implications for surviving children in the family.

Say not only what you found, but also what you looked for and failed to find. If your evidence is challenged, it may be on the basis that you failed to put yourself in a position to make an adequate assessment. If your report clearly demonstrates that your history and examination were thorough, you are less likely to be called to explain your evidence at an inquest.

Your notes will usually not contain the negative information, but it is perfectly acceptable to quote from memory.

Specify which details of your account are based on memory, the contemporaneous notes you or others wrote, or your usual or normal practice. A coroner will not expect you to make copious clinical notes of every last detail, nor will you be expected to remember every detail of a consultation that at the time appeared to be routine. It is perfectly acceptable to quote from memory, but if you cannot recall the details of a case, then state what your usual or normal practice would have been in the circumstances of the case.

Identify any other clinician involved in the care of the deceased by their full name and professional status. Describe your understanding of what they did and the conclusions they reached on the basis of your own knowledge or the clinical notes. You should not, however, comment on the adequacy or otherwise of their performance.

Reference

1. *Coroners and Justice Act 2009, Schedule 5, paragraph 1(2)*

For individual medico-legal advice:

24-hour advisory helpline

T 0800 716 646

E advisory@themdu.com

W themdu.com

MDU Services Limited (MDUSL) is authorised and regulated by the Financial Conduct Authority for insurance mediation and consumer credit activities only. MDUSL is an agent for The Medical Defence Union Limited (MDU). MDU is not an insurance company. The benefits of MDU membership are all discretionary and are subject to the Memorandum and Articles of Association.

MDU Services Limited, registered in England 3957086. Registered Office: One Canada Square, London E14 5GS © 2016 ADV202-b-1612 - Coroners' Inquiries 2.2



Medico-legal guide to Coroners' inquiries

2.3

Attending an inquest

The inquest is usually held in court premises, but may be held in some other public place. Witnesses are called by the coroner, not by interested persons. The coroner may call an expert witness, whose report will be disclosed in advance of the inquest. The object of the inquiry is to determine the answers to four questions only:

- who was the deceased?
- how,
- when, and
- where did death occur?

The coroner is not concerned with matters of civil or criminal liability.

Witnesses may agree to attend voluntarily or may be served with a summons. Failure to answer a summons can result in a fine for contempt of court.

Juries

The coroner usually sits alone but may, in certain circumstances, sit with a jury.

A jury is necessary where:

- the deceased died while in custody or otherwise in state detention, and either the death was a violent or unnatural one, or the cause of death is unknown
- the death resulted from an act or omission of a police officer, or a member of a service police force, in the purported execution of the officer's or member's duty
- the death was caused by a notifiable accident, poisoning or disease
- the senior coroner thinks that there is sufficient reason for doing so.¹

Legal representation

In most cases where doctors are called to give evidence at an inquest, legal representation is not necessary. However, where you believe there may be criticism of the medical care provided, you should discuss the need for legal representation. GPs and private practitioners should seek advice from the MDU. Hospital doctors should usually approach the trust's legal department, but in cases where you think you may need separate legal representation, please call the MDU to discuss.

Preparing for the inquest

As the inquest may not take place for some time after writing the report, it is advisable to read your report again carefully beforehand and take a copy with you to the hearing. It is also helpful to review the records. If they have not already been sent to the coroner, you should ensure that the original contemporaneous paper records or a print-out of the electronic record are available at the inquest.

The media

The media may attend and will report any newsworthy inquest. If someone from the media contacts you, remember that you have a duty of confidentiality to the deceased patient and it is usually advisable not to comment.

The MDU press office can assist with press enquiries. For assistance please call the press office direct on 020 7202 1535/1504.

Giving evidence

Evidence is given on oath or affirmation. Some coroners will ask you to read your report; others will ask a series of questions based upon it. At the conclusion of the coroner's questions, a member of the deceased's family or a legal representative may question you. In the case of a jury inquest, members of the jury may also ask questions. Lastly, if a solicitor or barrister represents you, they may ask you further questions.

The coroner is obliged to exclude any inappropriate questions that are not relevant to the limited scope of the inquiry.

If you sense that your professional conduct or competence is called into question, you may ask the coroner for an adjournment of the inquest and contact the MDU or your trust legal team for advice.

This is an unusual occurrence and practitioners will normally have already sought advice in advance of the inquest where they anticipate criticism in relation to the care and treatment given to the deceased.

No witness is obliged to answer any question that may incriminate them. If you are questioned in a manner that suggests that you may have committed a criminal offence, you may be advised by the coroner to decline to answer. Again, it would be unusual for such a situation not to have been anticipated in advance.

Advice on answering questions

- Listen to the question carefully. It's easy to try to answer the question you want or expect to hear.
- Do not try and interpret the question by assuming that the words used are imprecise.
- If the question is unclear, do not hesitate to ask for clarification.
- It is usually better to keep your answers short. Further questions can be put if more detail is required.
- Answer as clearly, honestly and succinctly as you can.
- Do not be afraid to say that you do not know the answer, or to ask to refer to the records if you need to.
- Avoid speaking too fast as the coroner and others in the court may be making a hand written note of what you say.
- Avoid medical jargon if at all possible. The inquest is an opportunity to provide the family of the deceased with a clear, factual account of the care and treatment given to their relative.
- Sometimes the questioning may seem to be repetitive, but you are expected to respond to each question and to retain a professional composure.

Fees and expenses

Immediately after the inquest, the coroner should pay the fees of every medical witness and reimburse all reasonably incurred expenses. You can contact the coroner's officer or the clerk to the court after the hearing to arrange for reimbursement.

The coroner will pay an expert witness a fee according to the nature and difficulty of the case and the preparatory work involved in giving evidence. An expert witness may also be entitled to a travel allowance.

Reference

1. *Coroners and Justice Act 2009, section 7*

For individual medico-legal advice:

24-hour advisory helpline

T 0800 716 646

E advisory@themdu.com

W themdu.com

MDU Services Limited (MDUSL) is authorised and regulated by the Financial Conduct Authority for insurance mediation and consumer credit activities only. MDUSL is an agent for The Medical Defence Union Limited (MDU). MDU is not an insurance company. The benefits of MDU membership are all discretionary and are subject to the Memorandum and Articles of Association.

MDU Services Limited, registered in England 3957086. Registered Office: One Canada Square, London E14 5GS
© 2016 ADV202-c-1612 - Coroners' Inquiries 2.3



Medico-legal guide to Coroners' inquiries

The determination

2.4

At the end of a jury hearing, the coroner will sum up the evidence which has been given and direct the jury on any points of law that arise. The question of how the person died should be answered by a brief summary of the circumstances leading to the death, as determined by the jury, in view of the evidence given.

When the coroner sits alone, he will summarise and record his own findings and determination on the formal record of the inquest.

The term "verdict" is no longer used in the context of coroners' investigations and inquests. The coroner will record:

- the deceased person's name
- the injury or disease causing death
- the time, place and circumstances in which the injury occurred
- the conclusion as to death
- the registration particulars.

The determination may consist of a conventional short form conclusion such as:

- natural causes
- accident/misadventure
- industrial disease
- lawful killing
- unlawful killing
- suicide
- neglect or self-neglect.

Increasingly, coroners are using narrative determinations which set out a factual summary of what occurred and may include references to failings or omissions on the part of medical staff.

A finding of "neglect" may arise where grossly inadequate medical care was provided and led to the death. This is a serious finding but you should be aware that this term does not necessarily equate to a finding of negligence. Indeed, the Act states that no determination should be framed in such a way as to appear to determine the civil or criminal liability of an individual.¹

The completed inquest record is signed by the coroner and, where there is a jury, by those jurors who agree with it.

Reports and recommendations

At the conclusion of the inquest the coroner has power² to report matters to a relevant authority to enable action to be taken to prevent similar fatalities in future and will usually announce his intention to do so at the inquest. For example, reports may be made to a local hospital or to the manufacturer of a drug or appliance.

Judicial review

In rare cases, where anyone with a 'sufficient interest' is dissatisfied with the way in which an inquest has been conducted, or with the coroner's decision not to hold an inquest, he or she may apply for judicial review or make an application under the terms of Section 13 of the Coroners Act 1988. This may result in an inquest being held or in a new inquest with a new coroner sitting.

References

1. *Coroners and Justice 2009, Section 10 (2)*
2. *Coroners and Justice Act 2009, Schedule 5, paragraph 7*

For individual medico-legal advice:

24-hour advisory helpline

T **0800 716 646**

E **advisory@themdu.com**

W **themdu.com**

MDU Services Limited (MDUSL) is authorised and regulated by the Financial Conduct Authority for insurance mediation and consumer credit activities only. MDUSL is an agent for The Medical Defence Union Limited (MDU). MDU is not an insurance company. The benefits of MDU membership are all discretionary and are subject to the Memorandum and Articles of Association.

MDU Services Limited, registered in England 3957086. Registered Office: One Canada Square, London E14 5GS
© 2016 ADV202-d-1612 - Coroners' Inquiries 2.4



Medico-legal guide to Coroners' inquiries

2.5

Your questions answered

Q I recently attended an inquest into the death of one of my patients. The coroner was very critical of my management and said so quite bluntly. To my mind, his comments were inappropriate. I feel that I have been defamed and I would like to take legal advice.

- The coroner is entitled to judicial immunity regarding civil proceedings and in connection with words spoken while exercising his judicial duty, except where the words are in excess or outside his jurisdiction. In the circumstances that you describe, it would not be advisable to pursue an action for defamation.

Q I have been asked by a policeman for a report about a recently deceased patient. Can I comply with the request?

- The duty of confidentiality extends beyond the grave. It is important to find out whether the policeman is, in fact, the coroner's officer. If he is making inquiries on the coroner's behalf, it is appropriate to co-operate with him. Any other police officer making inquiries into the circumstances of a person's death would need the consent of the executor of the estate or the personal representative before such information could be released, unless you believe the situation justifies a breach of confidentiality (i.e. it is in the public interest).

Q The coroner has asked me to produce a statement and to send him my patient's original medical records. Can I do this without the consent of the family?

- Yes. The coroner, or procurator fiscal in Scotland, is obliged by law to investigate the circumstances of certain deaths. The originals of medical records and relevant information about the deceased must be disclosed to the coroner or the coroner's officer on request. Make sure that you keep copies of anything you send. The MDU can assist members with the preparation of a statement to the coroner.

Q I am a GP. The relatives of my deceased patient are to be legally represented at a forthcoming inquest and their solicitors have asked for copies of the records. I have retained a copy set as the originals are with the coroner. Am I obliged to disclose the records?

- The coroner should be informed of this request. The Access to Health Records Act 1990 entitles the patient's representative to have copies of any medical records made on or after 1 November 1991. Access to the records of a dead patient can, however, be withheld if you believe the information was provided by the patient in the expectation that it would not be disclosed to the applicant. This caveat should be noted on the records.

Q I am due to go on holiday in three weeks, but have been asked to attend an inquest during the period that I will be abroad. Can the coroner compel my attendance?

- Yes. The coroner has power to compel the attendance of witnesses under pain of fine or imprisonment for contempt. Depending on how crucial your evidence is, or how central to the case, the coroner may well look sympathetically at receiving your evidence simply in the form of a statement. Alternatively, he may consider postponing the inquest. He has the authority to compel you to attend, regardless of any inconvenience, but this is rarely exercised.

Q My patient, a woman in her 60s, died recently. She had only been on my list for six months and I saw her on one occasion three months before her death. I was aware from her notes of a problem with alcohol abuse and her relatives now tell me that she was neglecting herself. In short, I do not know whether I could sign a death certificate. Should I ask the coroner's permission?

- The coroner cannot give you authority to sign a death certificate. A doctor attending the deceased patient in her last illness is required by statute to complete a death certificate, giving the cause of death to the best of his knowledge and belief. If, as it appears, you feel you are without the knowledge and belief to complete the certificate, then it can be completed to show that the death has been reported to the

coroner. The registrar cannot register the death until the coroner has finished his inquiries.

Doctors may wish to avoid delay by reporting a death informally to the coroner and seeking reassurance to issue a death certificate. However, on receiving this reassurance, the doctor should not initial the certificate to indicate that the coroner has been informed. If it is initialled, the death cannot be registered without the coroner's authority, which produces the very delay that the doctor sought to avoid.

Q After the inquest on one of my patients who died tragically at the age of two, I spoke to the parents to express my condolences. It was rather awkward, as during the inquest they had criticised my management. Have I compromised myself by doing this, if they try to sue me? Have I in some way admitted liability?

- Expressing sympathy to the family is not an admission of liability. It is a common courtesy that anyone would wish to extend to relatives who have been bereaved recently. The GMC advises doctors, 'If a patient under 16 has died you must explain, to the best of your knowledge, the reasons for, and the circumstances of, the death to those with parental responsibility'.

For individual medico-legal advice:

24-hour advisory helpline

T 0800 716 646

E advisory@themdu.com

W themdu.com

MDU Services Limited (MDUSL) is authorised and regulated by the Financial Conduct Authority for insurance mediation and consumer credit activities only. MDUSL is an agent for The Medical Defence Union Limited (MDU). MDU is not an insurance company. The benefits of MDU membership are all discretionary and are subject to the Memorandum and Articles of Association.

MDU Services Limited, registered in England 3957086. Registered Office: One Canada Square, London E14 5GS
© 2016 ADV202-e-1612 - Coroners' Inquiries 2.5