University Hospitals Sussex
NHS Foundation Trust

A Brief Guide to Inquests and Statement Writing

About this Guidance

- Being involved in the unexpected death of a patient may be one of the most difficult professional situations you face. The Medico-Legal Services Team are here to help you.
- You will have to deal with an event at both a personal and professional level that is likely to have caused you and your colleagues' great distress and shock.
- As well as now being asked to provide a statement for HM Coroner, you may well also be involved in an internal investigation [an SI].
- This guidance is intended to help allay any fears you have, give some background to the role of the Coroner, and outline why it is you need to be involved in this process.
- The Trust through, the Medico-Legal Services Department, (and your Line Manager if required), will help to ensure you receive the right advice and support.

Purpose of an Inquest

- Coroners' Courts and Inquests are governed by the Coroners Rules 1984, the Coroners Act 1988, and the Coroners and Justice Act 2009. The Coroners (Inquests) Rules 2013 and the Coroners (Investigations) Regulations 2013. The process is an inquisitorial one, and the remit of an inquest is limited.

- The Coroner decides which witnesses are called, or whether to read their statements. The purpose is to establish the facts in order to answer four factual questions:

(i) *Who* the deceased was
(ii) *When* the deceased came by his or her death
(iii) *Where* the deceased came by his or her death
(iv) *How* the deceased came by his or her death

- The question of "how" is the cornerstone of each Inquest. The *Middleton* case (2004) and the *European Convention on Human Rights* led to the interpretation of the question of "how" as meaning 'by what means' AND 'in what circumstances' the deceased came about his or her death.
- In practice, this has resulted in the need for some Inquests to explore in much greater detail the wider events leading to the death.

The Role of Her Majesty's Coroner

- The Coroner's Act 1988 details the circumstances in which a Coroner should hold an Inquest, i.e. where there is a body lying within their District and the death has been violent or unnatural, sudden with an unknown cause, or has occurred in prison, and in circumstances where he or she considers an Inquest is required.

- Sometimes the Coroner will call a Jury of between 7 and 11 people. This is when he or she believes that the death has occurred in circumstances of which raise issues of public safety. For example, if a death occurs in Prison (and is not natural causes) or when the deceased was subject to section of the Mental Health Act.

- If an Inquest is held with a Jury, the Coroner directs them on which verdicts (now known as conclusions) are appropriate. The Jury decides on facts, and the Coroner directs them on matters of law.

- The Coroner cannot make any determination of civil or criminal liability, i.e. blame. However, in enquiring into the circumstances of the death, issues can be raised in relation to how the deceased came by their death. This makes the clinical care and management of the service user relevant to the Inquest. It is not adversarial, there is no prosecution or defence, it is a fact finding inquiry.
- The Coroner has the power to make recommendations to help prevent future deaths. In the event the Coroner does make any such Regulation 28 / Prevention of Future Death Report (previously Rule 43), he or she must announce their intention at the Inquest that they are reporting the matter in writing to the person or authority that has power to take whatever action may be required.

Process

- When the decision has been taken by the Coroner to open an Inquest, the Coroner's Officer will contact the Trust, usually via an email to the Medico-Legal Services Department, and request a statement(s) from staff involved.
- Draft your statement/report as soon as possible and email it to the Medico-Legal Services Team in Microsoft Word, so it can be reviewed, before being finalised, signed, dated and sent to HM Coroner by Medico-Legal Services. This is to help ensure it includes as much relevant information as possible.
- The information sent to HM Coroner will help to set out the deceased's contact with the Trust and so inform their preparation for the Inquest.
- The Coroner will decide whether you are needed to attend the Inquest to give evidence or whether your statement can be simply introduced as evidence by reading it (Rule 23).
- You will be informed by Medico-Legal Services as soon as the Coroner has confirmed their decisions.
- By this point the Medico-Legal Services Team will have assessed the circumstances of the case in order to; identify the key 'issues' and any associated risks; and plan the necessary preparation.
- If you are required by the Coroner to attend the Inquest, and you would like a pre inquest meeting with Medico-Legal Services or to observe an inquest, please let us know.
- You can contact the Medico-Legal Services team via Switch if you have any questions or concerns.

Statement Writing

Providing a statement for HM Coroner can be a daunting task. However, having a good statement will not only act as a good reminder of your involvement, but it can also make life a lot easier for you and others at the inquest itself. You are assisting the Coroner in their investigation by giving them information known to you in a statement.

- Your statement should be typed on white, Trust headed A4 paper.

- It should clearly state your name, designation, place of work (not private address), and the full date the statement is made.

- It should be factual in content setting out your involvement in the care of the deceased. You are a witness of fact, and are not being asked to provide an expert opinion. It should include the **diagnosis, treatment (risks and benefits discussed and considered) and plan.**

- Each paragraph **and** page should be numbered.

- Your statement should be chronological starting at the beginning and ending when you last had contact / the date of death.

- The statement should be in the first person singular (e.g. “I saw…”).

- Record facts – actions, dates, and times – as clearly as possible. For example, 18.00 hours on 25 January 2016, rather than 6.00 on 25/1. Do not cut and paste from elsewhere.

- Your statement should **detail your involvement, including a rationale for decisions** made. If you are unsure or do not recall what happened at a particular time then say so. If it relates to something you may have done or decided on then you should document what your normal practice is/would have been.

- If a decision was made jointly this should be set out in the statement. For example, “I agreed that I should do this with (name of person)…” rather than “it was decided we should…”

- When referring to other people, state clearly their full names and designations.

- You may be asked to provide a statement some time after the event, so you must refer to the records to ensure that your statement is correct. Do not just rely on your memory.

- If any shorthand notes or abbreviations are being referred to then these should be fully explained and a translation provided. Use lay terms. Your statement will be read by people not clinically trained.

- Before finalising and signing your statement, think – is my statement styled and formatted properly? Does it make sense? Would I be happy with the deceased’s family reading it? Ensure that you have checked your spelling, paragraph numbering and that your statement is not formatted in a way which makes it difficult to read.

- It should conclude with a Statement of Truth, *"I believe that the facts stated in this statement/report are true, based on my personal recollection and matters which are recorded".* Sign and date your statement

It is now a criminal offence to:

- Do anything that is intended, or is likely, to have the effect of distorting, altering, or preventing any evidence or document that is given for the purposes of a Coroner's investigation.

- Intentionally suppress, conceal, alter, or destroy a relevant document. A document is relevant if it is likely that a Coroner conducting an investigation would, if aware of its existence, wish to be provided with it.

Carefully consider all of the information which might be relevant for the Coroner, enclose a copy of relevant documents with your statement and make reference to any event which you believe contributed to the death.

- **Please remember,** your statement will be reviewed before being sent to HM Coroner. If you are unsure about what to include or have any questions at all please contact the Medico-Legal Services team.

The Inquest Hearing

Take a copy of your final signed statement and the health records with you and any relevant policies to the inquest. If you need glasses to read – remember to bring them.

All Inquest hearings are held in public so members of the public and press may be present. Everyone giving evidence is in the room together and can hear all the evidence.

Please ensure you dress smartly. This will not only help you to convey a professional image, but demonstrate respect for the family of the deceased.

The Inquest is not a criminal or civil trial and the Coroner is not there to judge, but to explore the issues to ensure a full, fair and fearless inquiry.

You will be asked whether you wish to take the oath (swearing on the Bible) or affirm (non-religious declaration) to tell the truth.

The Coroner is likely to follow your statement and ask you questions followed by questions from Interested Persons. All questions must be relevant to who, where, when and how the deceased came by their death. You are not obliged to answer any incriminating questions (Rule 22).

Avoid medical jargon and acronyms – give factual evidence a lay person can understand

Refer to a male Coroner as Sir and a female Coroner as Ma'am or Madam

Speak loudly, clearly, slowly and answer only the question you are asked. Never guess or lie.

If you don't know or don't remember say so. If you don't understand the question say so / ask for clarification.

After your evidence when the Coroner releases you, you are free to go or stay until the end of the inquest as you wish.

Conclusions (previously known as verdicts) and Learning

After hearing the evidence the Coroner will sum up and give a final cause of death and conclusion.

The *balance of probabilities* is the burden of proof applied to all evidence and each of the possible conclusions.

The Coroner may give a short form conclusion such as, took own life, accidental death, drug and alcohol related death, misadventure, natural causes, open. Coroners may alternatively give a narrative conclusion which is a brief factual statement describing the findings.

In some cases where the Coroner feels a future death may be prevented if systems are reviewed, a Coroner will make a Prevention of Future Deaths Report to the Trust. (Regulation 28).

Whether it is appropriate to approach the family after the Inquest will very much depend on how the family are at the inquest. However, try and express your condolences and offer them the opportunity to make contact with the Trust should they wish.

If Press approach you, refer them to the Trust's Communications Department.

Following the inquest if you wish for a debrief meeting with your manager and / or the Medico-Legal Services team then email or call to request this.

It is important any lessons learned from inquests are taken forward and shared Trust wide. The Medico-Legal Services Department will email the Coroner's conclusion and lessons from the inquest to witnesses and key governance leads.

All staff have a responsibility to ensure the action plan from any associated SI is completed and learning from inquests is implemented – discuss this with your manager / team and feedback to Medico-Legal Services.