Document Control

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1. Background

The aim of the policy is to provide advice on the inquest process and guidance to staff on the best practice to follow in the event of an unexpected death, including if they are requested to provide a statement for the Coroner and/or attend an inquest to give evidence.

It outlines the processes to follow for copying patient medical records where they are required for investigation purposes (SEA, SIRI or formal complaint for example).

In addition, it clarifies the process for receipt and recording of Coroner's post mortem reports.

The policy deals only with the handling of Coroner's inquest cases and post mortems.

2. Purpose

The Standard Operating Procedure (SOP) has been written to identify the procedure for the management of Trust Inquests together with the processes in place for copying medical records and receipt of post mortem reports.

3. Scope

This Standard Operating Procedure (SOP) relates to all staff groups.

4. Location

This Standard Operating Procedure applies to all staff groups who are involved in the process of a formal Inquest involving a patient in their care within their clinical setting; staff who require copy medical records in order to undertake an investigation; and staff who receive a copy of a post mortem report.

5. Equipment

On occasions where the HM Coroner requires removal and safe keeping of a piece of equipment staff must adhere to the requests from the HM Coroner via her Coroner's Officers.

6. Procedure

As stated in the summary, this SOP has been developed to provide information and guidance to all staff on the process and systems to follow in the event of an Unexpected Sudden Death. The protocol outlines legal requirements, individual responsibilities of staff and support and guidance available throughout the process. A full "Guide to Coroner Services" published by the Ministry of Justice, is detailed at Appendix A and available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/363879/guide-to-coroner-service.pdf

It is important to remember that the Coroner's court is not concerned with matters of civil or criminal liability.

Key Objectives:

- To inform staff of the purpose and remit of a Coroner's inquest.
- To inform staff of the process to be followed for the referral of a death to the Coroner.
- To inform staff of the process for copying medical records when a copy is required for investigation purposes.
- To provide staff with guidance on the procedure to follow when asked by the Coroner to prepare a statement, or attend a Coroner's inquest.
- To ensure staff are aware of the process for the receipt and recording of post mortem reports.

- To ensure Managers are aware of their responsibilities in relation to the inquest process.

6.1 Who is the Coroner and what is their role?

The Coroner may be a Lawyer or a Doctor (or hold both qualifications). They are independent judicial officers who must investigate sudden death, in which the cause is unknown, violent or unnatural. If the Coroner decides that a death is not due to natural causes, he must hold an inquest and give a verdict.

The Coroner's role is to investigate deaths that have been reported to them if they have reason to think that:

- the death was violent or unnatural;
- the cause of death is unknown; or
- the deceased died while in prison, police custody or another type of state detention such as an immigration centre or while detained under the Mental Health Act 1983

6.2 Certification of Death

If you are the attending doctor during the last illness of a person who dies, you have a statutory duty to issue a medical certificate of the cause of death (Death Certificate). Conversely, if you did not attend the deceased during his or her last illness, you must not complete the death certificate.

You must state the cause(s) of death on the certificate to the best of your knowledge and belief. You have a duty to deliver the death certificate to the Registrar of births and deaths; in practice, the certificate is often given to a relative of the deceased, then handed to the Registrar by the relative (or other informant) who visits the Registrar's office to have the death registered.

You should complete the death certificate as accurately as possible. In particular you should:

- Avoid the use of abbreviations, question marks, and vague terms such as 'probably'.
- Avoid giving 'old age' or 'senility' as the only cause of death; do so only if you cannot give a more specific cause of death and the deceased was aged 70 or over.

- Avoid giving a mode of dying (see table (a) below) such as 'heart failure' 'shock' or 'uraemia' unless you also give the underlying causal sequence; do not give a mode of dying as the only cause on the death certificate.

- Document in the patient's medical records what you have stated the cause of death is on the Death Certificate.

(Table a)

Statements which imply a mode of death rather than an underlying cause of death:		
Asphyxia	Exhaustion	Shock
Asthenia	Heart failure	Syncope
Brain failure	Hepatic failure	Uraemia
Cachexia	Hepatorenal failure	Vagal inhibition
Cardiac arrest	Kidney failure	Vasovagal attack
Cardiac failure	Liver failure	Ventricular failure
Coma	Renal failure	
Debility	Respiratory arrest	
The use of the qualification 'acute' or 'chronic' will not make these terms acceptable as sole cause of death		

There are three types of death certificate as follows:-

- Stillbirth Certificate (after 24 weeks of pregnancy).

- Neonatal Death Certificate (any death up to 28 days of age).

- Medical Certificate of Cause of Death (any other death).

A guideline has been given in table (b) setting out how to complete the Cause of Death.

(Table b)

Cause of Death Statement	
Part 1	***Part 2***
State the disease or condition directly leading to death on the first line (Part Ia) • Complete the sequence of disease(s) or condition(s) leading to the death on subsequent lines • State the Underlying Cause of Death on the last completed line of Part I • The disease or condition directly leading to the death and the Underlying Cause of Death may be the same. In this case you only need to complete the first line of Part I	• If there is some significant condition or disease that contributed to the death, but which is not part of any sequence leading directly to death, you should record it in Part II, e.g. diabetes mellitus that is difficult to control in a patient with widely disseminated malignancy.

6.3 Which Deaths Should be Reported to the Coroner?

In practice of all the deaths reported to the coroner, 50-60% originate from hospitals. If a doctor fails to refer a relevant death to the Coroner, the Registrar has a statutory duty to do so. A death can be caused or contributed to or accelerated by any event, process, intervention or act and this does not have to be the main cause. The Coroner will consider whether this contributed to the patient's death. A death should be referred to HM Coroner under the following circumstances:-

- All deaths caused or contributed to by Healthcare Acquired Infections.
- When a doctor is unable to issue a death certificate.
- The cause of death is unknown or cannot readily be certified as natural causes
- When no doctor has treated the deceased during their last illness.
- The deceased was not attended by a doctor during the 14 days prior to their death.
- Where the death may be related to an accident, fall, violence, neglect or any kind or poisoning.
- Where the death is sudden or unexplained or attended by suspicious circumstances.
- If the patient dies within 24 hours of admission to hospital.
- If the death occurs following or as a consequence of any procedure, operation, treatment or anaesthetic.
- Where there is a possibility that the death was related to an industrial injury or disease.
- Deaths due or contributed to by a defect or failure in system or procedure.
- All alleged medical or nursing mishaps / inappropriate treatment or where a failure in systems or procedures has occurred and a Critical Incident / Significant Leaning Event or Serious Untoward Incident Review Procedure has been implemented.
- All deaths in which the patient is under the age of 18.
- Deaths due to or contributed to by Drugs (Including therapeutic) where overdose, idiosyncrasy, route of administration or addiction is involved.

- Where there is any doubt as to a Stillbirth or evidence that the foetus breathed or showed any other signs of life.
- Deaths contributed to by neglect or self-neglect.
- Deaths attributable to Suicide, malnutrition, hypothermia.
- All deaths within the Trust where there is or has been a Deprivation of Liberty application made.

It is important to be aware that **this is not an exhaustive list of reportable cases**, and if in doubt advice and guidance can be sought from Senior Clinicians involved in the patient's care, the Trust's Legal Services Department or direct from the Coroner's office.

When reporting a death to the Coroner please ensure that you:

a) Inform the family that you are referring the death to the Coroner including an explanation of the reason for the referral.

b) Advise the family that they will receive a telephone call from the Coroner's Officer the same day.

c) Have to hand the information that you require. This will include the following:

Patient Details	***Spouse's Details***
Name Address Date and Place of Birth Date of Death Occupation (including previous occupation if retired) Marital Status Next of Kin Contact Details / Telephone Number	Name Address Date of Birth Occupation Contact Details / Telephone Number
CIRCUMSTANCES OF THE DEATH	
Time, Day, Date & Location where deceased was confirmed dead by doctor confirming death Name Surgery Address & Telephone No of Deceased's GP Whether a Death Certificate can be issued or not Circumstances surrounding the death (including Previous Medical History / Details of surgical procedures / treatment) Name and Contact details of referring doctor and Consultant Where the deceased is now lying Name and Address of Funeral Director Name and Address of Registrar and district of registration of death	

6.4 How to Report a Death to the Coroner

Northern Devon Healthcare NHS Trust reports deaths to the Coroner for the Exeter & Greater Devon District which includes North, West and East Devon. Contact details are:

Dr Elizabeth Earland (Her Majesty's Coroner)
Raleigh Hall
Fore Street
Topsham
Exeter EX3 0HU

Telephone: (Exeter) 01392 876575

Local Coroner's Officers covering North and West Devon can be contacted on 01271 335359

NB: Referrals may be made to the above offices between 9am and 4pm

For all offices outside of these hours an emergency service operates whereby deaths can be reported via the Police Control Room.

The Control Room will refer them to the appropriate office.

6.5 Post Mortem Reports

The Coroner may request a Post Mortem to assist with preliminary investigations into the cause of death. All Post Mortem Reports requested by the Coroner are thus the possession of the Coroner. Post Mortem Reports which are undertaken following a death in a different jurisdiction will therefore be the possession of the requesting Coroner.

The Trust may require a copy of the Coroner's Post Mortem Report for the purposes of an internal Investigation. Authorisation for the release of a copy Post Mortem Report is done so through a single point of contact. If a copy Post Mortem is required, Trust staff must contact the Legal Claims Manager who will liaise with the Exeter Coroner's Office.

6.6 The Purpose of an Inquest

An inquest is a fact finding exercise and is not to apportion blame. The inquest will determine the following:

- The identity of the Deceased.
- How, when and where they died.
- The circumstances in which they died.
- The medical cause of their death.

6.7 Preparation of Evidence & Preparation and Support of Staff Attending an Inquest

Preparation of Evidence

Almost certainly the Coroner will request that witnesses are asked to submit an original typed and signed written statement some time before the inquest. This request is generally submitted via the Trust's Solicitors. Occasionally the Coroner may direct her request to the medical staff involved. In the event that the Coroner asks you directly for a statement, please contact the Trust's Legal Claims Manager. If there is any possibility of a death occurring as a result of treatment or procedures carried out by the Trust, or the possibility of clinical negligence, a formal complaint, a Significant Event Audit (SEA) or Serious Incident Investigation (SIRI), staff should immediately notify the Legal Claims Manager to ensure that legal representation is available. The Legal Claims Manager will correspond with Trust Solicitors who liaise directly with the Coroner and in the event of a Serious Incident Investigation, will advise her of the Investigation. The Trust Solicitors will continue to liaise with the Coroner and Staff thereafter to compile pre-inquest evidence.

Copying patient notes

Where the death has occurred following an inpatient admission and there is a requirement to record the cause of death, clinicians completing the cause of death must ensure that when referring a death to the Coroner's Office the notes/relevant inpatient stay must be copied prior to the patient notes accompanying the deceased to the mortuary. During the working day this should be completed by the Ward Clerk (or similar) and out-of-hours assistance should be sought from the patient management team. These copy notes to be provided to the Legal Claims Department for safe custody.

Where access to the patient's notes is required (i.e. typically for an internal Investigation) and they have not been copied prior to them becoming the custody of the Coroner, arrangements must be made with the Coroner's Office to arrange a viewing and/or make copies under police supervision. The Investigation Lead (for either a SIRI or an SEA) is responsible for obtaining these copy notes, retaining these within the divisional team(s) for the purpose of the internal investigation.

Any difficulties relating to accessing patient notes stored with the Coroner's Office should be escalated to the Trust's Legal Claims Manager in the first instance for further assistance.

Statements

Statements will be collated from all relevant medical / nursing and administration staff and a guideline on statement writing is attached at Appendix 1. **These statements must be provided to the Coroner within 14 / 21 days of the request via the Legal Claims Department. The Coroner has the power to issue a witness summons in the event that this timescale is not complied with, requiring the witness to explain him / herself**.

The statement should begin with your name, professional qualifications, length of service and what post you hold within the Trust.

The author must assume that the reader of their statement knows nothing of the facts of the case, of the patient's medical history or of hospital routines. The statement will thus form a story, which will tell an intelligent lay person the circumstances of the incident from the author's recollection of events.

The statement should contain a full but concise, factual account in chronological order of your personal involvement. It is important that you stick purely to facts and avoid expressing opinions. **Only include facts or conversations that you have actually witnessed or taken part in**. Do not include things that other people told you happened or conversations reported to you. Advice and guidance is available from your line manager or the Legal Claims Department should you require it.

You should always retain a copy of your statement to refer to in the event that you are subsequently called to the inquest as a witness. If the Coroner is of the opinion that the evidence contained in your statement is unlikely to be controversial, he / she may decide to dispense with the need for you to attend. (It is therefore beneficial to provide a well written statement promptly)

Preparation and Support of Staff Attending an Inquest

Witnesses will be advised in good time of the date and place of the inquest and should ensure that they are punctual and appropriately dressed. The order in which witnesses are called is determined by the Coroner. The Coroner usually calls the Pathologist first, followed by the remainder of witnesses in a chronological order; however where there are clinical commitments which cannot be altered, the Coroner may call witnesses out of sequence. Each witness should take a copy of their statement to the hearing with them. All witnesses go into the Court at the same time, so you will be able to hear the evidence given by other witnesses.

If the Trust is legally represented by the Legal Department or Panel Solicitors, a pre-inquest meeting will be arranged usually approximately 1 week prior to provide guidance on the process and what to expect at the hearing. Any queries or concerns may be raised direct with the Legal Claims Department who will be happy to assist you. Legal Representatives cannot tell you what to say as your evidence should be a factual account and cannot therefore be influenced**. It is important to remember that the evidence that you give is your own evidence, which is given on oath and as such must be an open, honest and factual account of events which is not influenced by the opinions, or accounts given by anyone else**. There are occasions when staff have conflicting recollections and this is to be expected, it is not an issue that you should be concerned about.

The Trust recognises that giving evidence at an inquest can be a very stressful and daunting experience and every effort will be made to provide advice and support throughout the process.

6.8 The Inquest:

It is not the Coroner's role to probe into potential causes of clinical or medical negligence although the family may pursue a formal complaint against the Trust prior to or following the inquest. They may also subsequently go on to pursue a claim against the Trust. The inquest is not a trial and therefore the Coroner will not apportion blame. Unless the inquest involves issues of national security it will be held in public and the media may be present. You should not speak to reporters after the inquest. In the event that it is necessary a Press Release will be made by appropriate representatives on behalf of the Trust.

As stated earlier, it is important that you are punctual and smartly dressed. Not only will this help you to convey a professional image, but will also demonstrate respect for the family of the deceased. Do take the time to read your statement prior to the inquest to ensure that you are fully familiar with its content.

The degree of formality in the court depends largely on the individual Coroner, although all evidence will be given under oath (religious or otherwise). Witnesses will then either be asked to read out their previously supplied statement, or they may be asked to recount the events leading up to the patient's death. They may then be asked to address specific questions by the Coroner or to provide clarification of particular points. The deceased's family or their legal representatives may then ask questions and finally any legal representative of the Trust.

When responding you should address your answers to the Coroner or Jury if there is one. When addressing the Coroner address him or her as Sir or Ma'am. Evidence is usually given standing up, although you may ask the Coroner if you can be seated.

When answering specific questions the following suggestions are provided for guidance:

- **The evidence given is given under oath and should be factual and true** so if you do not know the answer to a question, do not be afraid to say so – Never guess.
- The hospital records will be available and should you wish to consult them in order to respond to please ask the Coroner. There should be no difficulty in permission being given for this.
- Speak clearly, try to keep your answers concise and avoid medical jargon that the Coroner or the family may not understand.
- If you are asked a question that you believe would be better addressed by someone else, such as the pathologist or another medical witness, tell the Coroner that you believe another witness would be better placed to address this.
- If you are asked questions by the family or their representative, try to address your response to them if you feel able to do so. Remember, that the family is grieving and it is very important to ensure that any answers given are non-confrontational. **Avoid being defensive**.
- Remember whatever happens, never lose your temper. (You are at risk of being in contempt of court).

Most inquests are heard by the Coroner sitting alone. However in certain circumstances a Jury may be called under Section 8(3) of the Coroner's Act 1988 which sets out the circumstances where an inquest must be held before a Jury. These include:-

- Deaths in Prison.
- Deaths in Police custody or following an injury caused by a police officer in the execution of his / her duty.
- Deaths reportable to a Government Department, e.g. factory accident or death on a railway.
- Deaths concerning public safety – (A death in which the death occurred in circumstances, the continuance or possible recurrence of which is prejudicial to the health or safety of the public or section of the public.

However, under Section 8(4) of the Act, the Coroner has discretion to summon a Jury even if a case falls outside of the criteria highlighted above.

6.9 The Role of a Jury:

The Jury should listen to all the evidence, ask appropriate questions and reach a verdict. The Coroner and an advocate or interested party may assist the Jury by asking questions of the witnesses. The Coroner controls the proceedings, sums up the evidence for the Jury and directs them on the relevant law.

6.10 Possible Verdicts of a Coroner's Inquest:

- Natural Causes
- Industrial Disease
- Accidental Death
- Misadventure
- Lawful Killing
- Unlawful Killing
- Open Verdict
- Neglect or Lack Of Care
- Self-Neglect
- Road traffic collision
- Stillbirth
- Dependence on Drugs / non-dependent abuse of drugs
- Suicide
- Narrative (a sentence describing the circumstances of the death)

A narrative verdict can also be given and is usually given at the time of the inquest. Although on occasion the inquest will be reconvened at a later stage to give the verdict.

6.11 What Happens Next?

Following an inquest it may be necessary for the Legal Representatives and Communications Department to prepare and agree a Press Release. Where appropriate, representatives of the Trust may liaise further with the family and or any representation that they have to address issues raised in a complaint or claim.

A Coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held, may announce at the inquest that he is reporting the matter in writing to the person or authority that may have power to take such action and he may report the matter accordingly. This would be a **Formal Notification by the Coroner to the organisation under Rule 28 of "The Coroners Rules 1984"**.

RULE 28 OF THE CORONERS RULES
Action required:
A full investigation is required to identify what actions if any could be taken to prevent any recurrence. A written response must be provided to the Coroner outlining any investigation, and actions to be taken within 90 days; this may involve: • Reporting the issue via STEIS as a Serious Incident retrospectively, • An internal Critical Incident Review

7. References

- The Coroner's Rules 1984
- www.devon.gov.uk
- www.coronerssociety.org.uk

8. Associated Documentation

Northern Devon Healthcare NHS Trust Policies for:

Management of Legal Claims