Document Control

Title **Managing Inquests Standard Operating Procedure**			
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Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
0.1	Feb 2015	Draft	Initial version for consultation
1.0	Feb 2015	Final	Approved by Legal Claims Manager and Senior Governance Manager (Compliance)
2.0	Feb 2016	Draft	Incorporation of copying patients' notes for consultation
3.0	Sept 2016	Final	Approved by Mortality Review Committee
4.0	June 2020	Final	Approved by Legal Claims Manager & Head of Governance and Health & Safety Group
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Document Class Standard Operating Procedure			**Target Audience** All staff
Distribution List Mortality Review Group Head of Governance			**Distribution Method** Trust's internal website
Superseded Documents Managing Inquests Standard Operating Procedure V4.0			
Issue Date June 2020	**Review Date** June 2023		**Review Cycle** Three years
Consulted with the following stakeholders • Compliance Team • Head of Governance • Health & Safety Group • Director of Finance • Trust Solicitors • Head of Pathology • Incident Review Group			**Contact responsible for implementation and monitoring compliance:** Legal Claims Manager **Education/ training will be provided by:** Workforce Development Legal Claims Manager & Health & Safety Advisor

Approval and Review Process • Health and Safety Group	
Local Archive Reference G:\Corporate Governance/Policies Procedural Documents **Local Path** Legal Services/Claims Policy & Procedures **Filename** Managing Inquests Standard Operating Procedure V4 April2020	
Policy categories for Trust's internal website (Bob) Legal Claims	**Tags for Trust's internal website (Bob)** Coroner, Post Mortem, Inquest

CONTENTS

1. Background

The aim of the Standard Operating Procedure (SOP) 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 (72hr report, Concise Investigation Report, Serious Incident Reports or formal complaints for example).

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

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

2. Purpose

The 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 SOP 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.

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 his 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 details the following:

6.1. 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.

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

6.2. 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.

Coroners are appointed by local councils to investigate when the circumstances surrounding a death are unclear or unknown. This may include when:

- The cause of death is unknown
- The death was unnatural or violent
- The person died in prison or custody
- The identity of the person who has died is uncertain or unknown
- A medical certificate isn't available

The coroner's job is to find out how, when and where the person died for official records, as well as for the benefit of the bereaved.

In some cases, the coroner will decide that the cause of death is clear. They will then issue a certificate to the registrar stating that a post-mortem examination is not needed. You will then be able to register the death with the registrar.

A coroner may decide that a post-mortem examination is needed if the cause of death or circumstances surrounding the death are still not clear after an initial look into the death.

6.3. Post Mortem

Post-mortem examinations are conducted by a pathologist and involve studying the body for evidence of how the person died.

If the post-mortem is successful and reveals the cause of death, the coroner will send a form to the registrar stating the cause of death. They will then release the body so that a funeral can take place.

If the post-mortem report fails to find the cause of death or suggests that a crime may have been committed, then the coroner will begin an inquest.

6.4. Medical Examiner

Medical examiners are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

The Trust has appointed a Medical Examiner; this role is to examine deaths to:

- Agree the proposed cause of death and the overall accuracy of the medical certificate cause of death
- Act as a medical advice resource for the local coroner
- Inform the selection of cases for further review under local mortality arrangements and contributing to other corporate governance procedures.

As the introduction of Medical Examiners rolled out across England Wales, this is still a new arena the Trust is adopting primarily this role is to provide a greater scrutiny of deaths.

Initially the Medical Examiner officer will focus on scrutinising the certification of deaths that occur within the Trust she will be working with local NHS partners and other stakeholders to plan how she can increase the service to cover the certification of all deaths within North Devon. This will expand the service to cover deaths in other NHS and independent settings, as well as deaths in the community.

The purpose of the medical examiner system is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data.

As the role is in its current infancy stages, this SOP will be updated within the usual 3 years to provide further clarity.

6.5. Certification of Death

Under the Notification of Deaths Regulations 2019, doctors responsible for signing a death certificate should report a death to the coroner if the death involved:

- Poisoning or exposure to a toxic substance;
- Use of a medicinal product, controlled drug or psychoactive substance;
- Violence, trauma or injury;
- Self-harm;
- Neglect, including self-neglect;
- Treatment or procedure of a medical or similar nature;
- An injury or disease attributable to employment; or
- A suspicion the death was unnatural.
- Deaths should also be reported where the cause is unknown, the person died in state custody or detention, or their identity is unknown

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.

Terms that do not identify a disease or pathological process clearly are not acceptable as the only cause of death. This includes terminal events, or modes of dying such as cardiac or respiratory arrest, syncope or shock. Very vague statements such as cardiovascular event or incident, debility or frailty are equally unacceptable. 'Cardiovascular event' could be intended to mean a stroke or myocardial infarction. It could, however, also include cardiac arrest or fainting, or a surgical or radiological procedure. If no clear disease can be identified as the cause of death, referral to the coroner will be necessary.

Further Guidance from GOV.UK are available to assist Doctors in completing Death Certificates.

Therefore, 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 Asthenia Brain failure Cachexia Cardiac arrest Cardiac failure Coma Debility	Exhaustion Heart failure Hepatic failure Hepatorenal failure Kidney failure Liver failure Renal failure Respiratory arrest	Shock Syncope Uraemia Vagal inhibition Vasovagal attack Ventricular failure
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:-

- Medical Certificate of Cause of Death (form 66): Any death occurring after the twenty-eight days of life should be certified using the Medical Certificate of Cause of Death.
- Neonatal Death Certificate (form 65): Any death of a live-born infant occurring within the first twenty-eight days of life should be certified using the Neonatal Death Certificate.
- Certificate of Still-birth (form 34): Any death of an infant that has issued forth from its mother after the twenty-fourth week of pregnancy and which did not breathe or show any other signs of life at any time after being completely expelled from its mother should be certified using the Certificate of Still-birth

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	• 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.

• 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	diabetes mellitus that is difficult to control in a patient with widely disseminated malignancy.

6.6. 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 Doctor may report a death to the HM Coroner under the following circumstances:-

- Cause of death is unknown
- Death was violent or unnatural
- Death was sudden and unexplained
- Person who died was not visited by a medical practitioner during their final illness
- Medical certificate is not available
- Person who died was not seen by the doctor who signed the medical certificate within 14 days before death or after they died
- Death occurred during an operation or before the person came out of anaesthetic
- Medical certificate suggests the death may have been caused by an industrial disease or industrial poisoning
- 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	

6.8. How to Report a Death to the Coroner

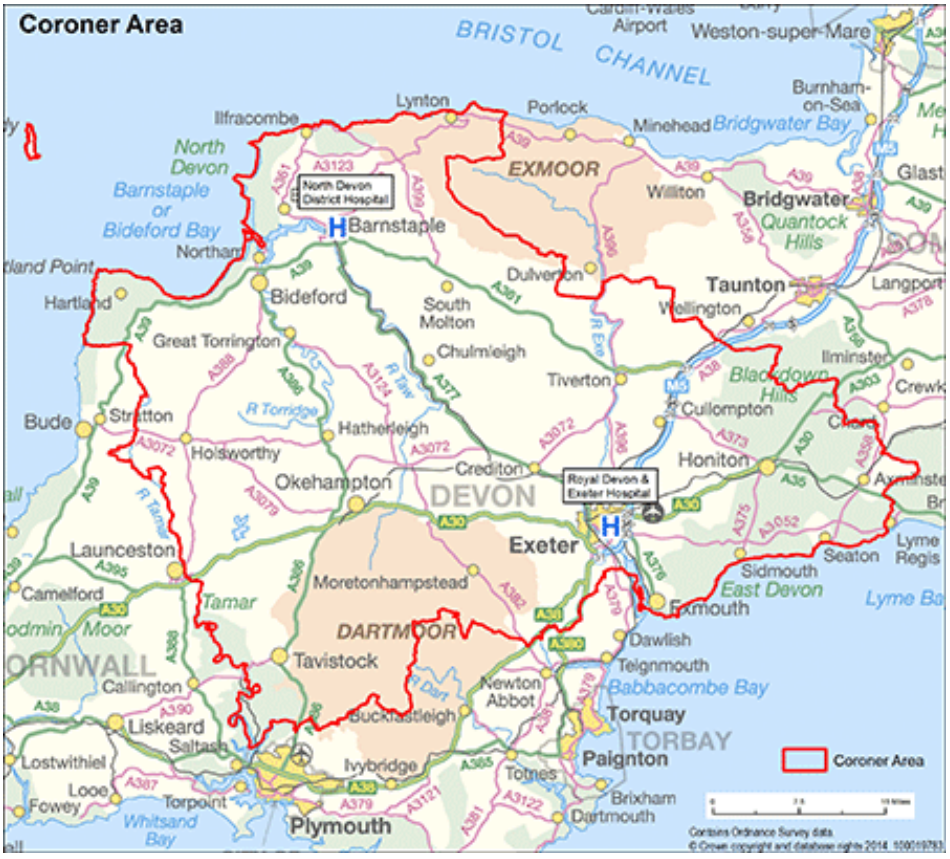
Northern Devon Healthcare NHS Trust reports deaths to the Coroner for the Exeter & Greater Devon District which includes North, West and East Devon. Contact details are:

Her Majesty's Coroner for the Exeter and Greater Devon District which includes North, West and East Devon is:

Philip Spinney
H.M. Coroner
Room 226
County Hall
Topsham Road
Exeter
EX2 4QD

Tel: 01392 383636
www.exgdcoroner.org.uk

The jurisdiction of the Exeter and Greater Devon Coroner covers the areas of east, north and west Devon (see map of jurisdiction below).



Assistant coroners: Alison Longhorn, Deborah Archer, Luisa Nicholson, Lydia Brown, Nick Brown.

Coroner's Officers can be contacted on Tel: 01392 225696.

NB: Referrals may be made to the above offices between 9am and 5pm

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.

6.9. Post Mortem Reports (PM)

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.

You cannot object to a coroner's post-mortem - but if you've asked the coroner must tell you (and the person's GP) when and where the examination will take place.

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.

The HM Coroner is keen to assist the Trust with their investigations and will in most cases release a copy of the PM for the sole purpose of that investigation. Please note the Post Mortem MUST NOT be shared for any other purpose or to any other persons. If a third party wishes a copy of the PM report you cannot share your PM you must advise the individual to separately request a copy directly from the Coroner.

You must not embed the PM report to any documentation and ensure the audience of your report is limited to only those investigation leads and teams who were allocated at the beginning of the investigation.

6.10. 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

The inquest is a public hearing and so anyone can attend and listen to the evidence. Interested Persons may take part in the inquest and make suggestions or representations to the Coroner concerning the inquest. In complex cases, there may be a hearing before the actual inquest, to allow the Coroner to make sure that everything necessary for the inquest hearing is ready. This is called a 'Pre-Inquest Review', and can make decisions on things like:

- What issues or events the inquest will consider – often referred to as the 'scope' of the inquest.
- Which witnesses should attend the inquest to give evidence, and whether any further written statements or reports are needed from witnesses.
- Whether any further documentation needs to be provided to the Coroner, for example medical records.
- When the inquest should take place.

Some Inquests require the need for a Pre-Inquest Review hearing, the family and any other Interested Party including the Trust can comment on the above issues and makes suggestions to the Coroner, but the Coroner makes the decision.

Any Interested Party is entitled to copies of any documents held by the Coroner. Many Coroners will arrange for statements and other documentation to be automatically sent to the family, or a lawyer on their behalf, while in some areas, copies of documents will only be provided upon request.

6.11. 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 his 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.

It is important that staff providing statements DO NOT respond directly to the Coroner but respond back to the Trust Solicitors or Trust's Legal Clams Manager, where the request was originated.

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 Concise Investigation (CI) or Serious Incident Investigation (SI), 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 him 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 CI or SI) 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)

Once all statements are received the Trust Solicitors will advise the Legal Claims Manager of their disclosure to await an announcement from the Coroner of the intended Hearing date.

Preparation and Support of Staff Attending an Inquest

Witnesses (both current and those who may have left the Trust) 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 Trust 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.

Although the Trust has vicarious liability for its employees an individual may wish to discuss the Inquest with his/her own medical defence society or professional organisation.

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.

6.12. 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 currently under Section 7 of the Coroner's and Justice Act 1990 (this may change during 2020) 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 7(3) of the Act, the Coroner has discretion to summon a Jury even if a case falls outside of the criteria highlighted above.

6.13. 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.

6.14. Possible Conclusions at a Coroner's Inquest:

The Coroner will usually give a verbal conclusion of the Inquest, however the following conclusions may be given

- 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.

6.15. Regulation 28 (Prevention of Future Death Report)

The Coroner may in his verbal and subsequent written report, propose action by the Trust to change or improve practice.

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"**.

REGULATION 28 OF THE CORONERS RULES
Action required:
The Regulation 28 report will set out the concerns and requests that action should be taken. From the date the Trust formally receives this report (usually addressed to the Chief Executive), the Trust has 56 days to provide to the Coroner with their response to include details of the actions taken and to reassure the Coroner that their concerns have been addressed to prevent future deaths. All Regulation 28 Reports and the responses are sent to the Chief Coroner. In most cases the Chief Coroner will publish the reports and responses on the judiciary government website found here. 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 the 56 may involve: • Reporting the issue via STEIS as a Serious Incident retrospectively • An internal Concise Investigation

6.16. What Happens Next?

Following an inquest it may be necessary for the Legal Representatives and Communications Department to prepare and agree a Press Release.

As the Coroner's Hearing is a public court the media often attend. All enquiries by the media should be directed to the Legal Claims Manager or the Trust Solicitors. Staff should not engage in any dialogue with the media.

Families often find the outcome of an Inquest disappointing or upsetting as it may not answer all their questions or produce a satisfactory conclusion. It is sometimes appropriate for staff to talk to the family after the Inquest but extreme caution needs to be taken therefore 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.

Throughout the Inquest through to the conclusion the Legal Claims Manager and/or Trust Solicitors will liaise with those staff involved including providing regular reports for divisional governance groups for noting, learning and triangulation of themes against other related Government processes.

Please see this processed summarised within the flowchart at Appendix 1.

7. References

- The Coroner and Justice Act 1990
- www.coronerssociety.org.uk

8. Associated Documentation

- Northern Devon Healthcare NHS Trust Policies for:
- Management of Legal Claims
- Incident reporting, analysing, investigating and learning policy and procedure

Appendix 1 – Managing Inquests Process Flowchart