Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Inquest Policy

(Operational policy for staff to follow in the event of their involvement with an Inquest)

This procedural document supersedes: Inquest Policy (Operational policy for staff to follow in the event of their involvement with an Inquest) – CORP/RISK 22 v.2

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Please be advised that the Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version.

Author/reviewer: (this version)	Michele Corbett – Legal Services Manager
Date written/revised:	August 2018
Approved by:	Policy Approval and Compliance Group on behalf of the Patient Safety Review Group
Date of approval:	22 August 2018
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Next review date:	August 2021
Target audience:	All staff involved in the Inquest process

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 3 (amended April 2019)	11 April 2019	• Amendment relating to Regulation 28 within Appendix 9 – Healthcare Regulatory Inquest Risk Matrix.	Michele Corbett
Version 3	3 October 2018	Comprehensively reviewed and amended all sections. Policy will need to be read in full.	Michele Corbett
Version 2	17 December 2014	Coroner's (Inquests) Rules 2013 reflected throughout Roles and responsibility updates	Mandy Dalton/ Rachel Roberts
Version 1	26 November 2013	This is a new procedural document, please read in full	Rachel Roberts

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1. INTRODUCTION

A Coroner's investigation of a death is referred to as an inquest.

An inquest is a fact finding inquiry limited to establish who has died and when, where and how and in what circumstances the death occurred. An inquest does not establish matters of blame or liability. To assist the Coroner with their investigation, the coroner may request information, reports and protocols. The Coroner decides what evidence they need and from whom. When the coroner has all the information as part of the investigation, they will decide which witnesses to call to provide evidence at the inquest. The decision as to which witnesses are required to attend an inquest is entirely made by the Coroner and where witnesses cannot attend they are answerable to the Coroner on their reasons why.

The Coroner must aim to complete an inquest within 6 months from the date the coroner is made aware of the death. The Trust will be given strict deadlines by the coroner to submit information, statements and reports for an inquest. It is imperative that all staff fully cooperate and adhere to the deadlines set. The Coroner is at liberty within the rules to impose financial penalties on anyone they consider is not cooperating with their inquiries.

2. PURPOSE

2.1 Policy Statement

The Trust will cooperate with the Coroner in the preparation for and the carrying out of inquests. All members of staff are expected to provide reports/statements/information/ verbal evidence for the Coroner as requested. Lessons identified following the conclusion of an inquest will be fully implemented.

2.2 Scope and Aim of the Policy

The policy is to be used by all Trust employees, including bank, agency locums and contractors involved in inquests. Its aim is to advise staff on best practice to follow if they are required to provide a statement for HM Coroner and/or attend a Coroner's Inquest.

2.3 Policy Implementation

The Legal Services Manager will provide instruction and advice on the investigation of inquests. This policy and procedure is available via the Trust intranet and Legal Services department. Relevant clinicians and managers will be advised of its implementation.

3. DUTIES AND RESPONSIBILITIES

3.1 Chief Executive

The Chief Executive has ultimate responsibility for the Trust's management of inquests and the learning following their conclusion.

3.2 Medical Director/Director of Nursing Midwifery & AHP's

The Trust's Medical Director/Director of Nursing Midwifery & AHP's will have executive responsibility for overseeing the management function for inquests and for holding staff to account when statements and presence at the coroner's court is required.

In the event of a Prevention of Future Death (PFD) report, (Regulation 28) the Medical Director, Director of Nursing Midwifery & AHP's or a nominated deputy will respond within the 56 day timescale.

3.3 Inquest Panel

The inquest panel members include the following roles:

- Deputy Medical Director x 2
- Deputy Director of Nursing, Midwifery and Quality
- Deputy Director of Quality and Governance
- Head of Patient Safety and Experience
- Education Quality and Governance Manager
- Legal Services Manager

The panel meet predominantly on a weekly basis. The panel will monitor the current status of inquests, providing guidance to the case handlers and generally ensuring in liaison with the legal Services Manager the smooth running of the Inquest process from the point of notification of an inquest through to its conclusion.

3.4 Head of Patient Safety and Experience

The Head of Patient Safety and Experience:

- Has line management responsibility for the risk and legal services team who are coordinating and facilitating the Trusts involvement in inquest matters.
- Should ensure that the systems and processes are in place to optimise the timeliness and responsiveness to the Coroner's requests and will anticipate routine schedules for provision of reports.

- Should ensure that there are appropriate links between other risk, legal and complaint processes, to align investigation and appropriate communication between departments and outside of the organisation.
- Will advise and supervise the risk and legal service team to identify risks to, and mitigate against, potential future death reports.
- Should ensure that there are appropriate links to the Trusts governance arrangements, to enable feedback, learning and monitoring of the activity of inquests.

3.5 Legal Services Manager

The Legal Services Manager is responsible for the coordination of all inquest activities. The Legal Services Manager will act as a resource for Trust staff and maintain close liaison with the Coroner's office to facilitate the inquest process. The Legal Services Manager will:

- Receive and acknowledge all inquest notifications from the Coroner and will be the point of contact between the Coroner's office and the Trust.
- Inform the inquest panel and the relevant Care Group management team of all new inquest matters.
- Inform the Head of Patient Safety and Experience of any inquest matters that meets the threshold for reporting as a serious incident.
- Inform the Trust Executive team of all high risk inquest activity which may attract media attention.
- In conjunction with the inquest panel RAG rate all inquest matters and where considered appropriate instruct legal representation.
- Track and monitor the status of each inquest providing support to the case handlers, care group clinicians and managers with inquest activity.
- Where specific need is identified undertake case handler duties.
- When occasion requires, the Legal Services Manager may be required to attend an inquests to provide support to staff who are attending, and or represent the Trust and give evidence of organisational learning.
- Maintain a central database of all inquest activity ensuring that suitable arrangements are in place for business continuity and the archiving of case files.
- Undertake pro-active analysis of inquest activity and the identification of trends and emerging patterns to influence and inform Clinical Care Groups and Trust board.

3.6 Inquest Case Handler

Upon receipt of a formal notification that an inquest has been opened, a case handler will be appointed to manage the inquest through to its conclusion. The case handler will:

- Undertake fact finding activities to establish the course of events leading to the patient's death identify sub-optimal care; identify key witnesses and any actual

or potential risks to the organisation which may lead to the coroner issuing a Regulation 28 report.

- Work closely with Trust Solicitors where legal representation has been instructed.
- Ensure Care Group compliance with Duty of Candour.
- Support Care Group clinicians in the provision of witness statements. Proof read all inquest statements ahead of disclosure to ensure the statements are fit for purpose.
- Track and monitor the status of each allocated inquest and inform the Legal Services Manager of any delay with the disclosure of witness statements or associated risk management and serious incident investigation reports.
- Represent the Trust at the inquest providing support to staff who are required to attend to give oral evidence. When occasion requires, attendance at inquests may be required to give oral evidence of organisational learning.
- Complete an inquest outcome report (appendix 1) identifying any recommendations and or lessons learned and share with the Legal Services Manager, Care group Management team and witnesses involved with the inquest. All staff involved with an inquest should be offered the opportunity for further ongoing support and to receive feedback on their contribution to the inquest process and outcome. This will be facilitated by the Case Handler and or Legal Services Manager
- In conjunction with the Care Group Governance lead ensure timely implementation of any recommendations and actions arising from the inquest through monthly monitoring.

3.7 Patient Safety Coordinator

The Patient Safety Coordinator will administer all aspects of the inquest process in liaison with the case handler. This will include:

- Retrieval and copying of medical records (see inquest scoping flow chart)
- The provision of timely information to employees in the requesting of reports and statements required by the coroner;
- The timely disclosure of reports and statements to the Legal Services Manager within defined timescales as set by the coroner;
- Information sharing to employees involved in inquests;
- Tracking and monitoring of inquest activity, ensuring the inquest file on the Trust Incident reporting system (Datix) is kept up to date.
- Filing of all inquest documentation within the central inquest database.

3.8 Clinical Director, Head of Nursing/Midwifery/Therapy Clinical Governance Lead (Care Group management team)

The Care Group management team will provide staff with appropriate support during and following an investigation of an inquest. The management team will ensure that staff are available to assist the case handler with the inquest process and to provide relevant support and guidance. The team will ensure that there are systems in place to monitor completion of any associated recommendations and or actions arising out of an inquest and that clinical governance arrangements within the care group enable shared learning and can demonstrate the embedding of any changes to practice.

When occasion requires, a member of the management team may be required to attend the inquest give oral evidence and assurance to the Coroner of organisational learning.

3.9 All Staff

All staff involved in the investigation and learning from inquests should ensure that:

- Inquests are investigated in a timely manner under the direction of the Legal Services department to ensure that deadlines set by HM Coroner are met;
- Witness statements, following the Trust's template are provided within 10 days of their written request (**Appendix 5**).
- The Risk & Legal Services department are informed where correspondence is received directly from the Coroner in respect of an inquest.

3.10 Education Quality and Governance Manager

The Education Quality and Governance Manager will identify staff that are involved in an inquest who are on Health Education England (HEE) training schemes and all recognised learners within the organisation (e.g. work experience learners, Trainee ACP's and those on direct commissioned programmes between DBTH and the Higher Education Institutes (HEI)). In doing so, appropriate support will be provided via the individuals clinical supervisor/college tutor/mentor/personal tutor/clinical tutor or link lecturer. Relevant reports will be completed for the Further/Higher Education institute or HEE as outlined in our responsibilities as a local education provider (LEP).

4. PROCEDURE

4.1 The Coroner

The Coroner is an independent judicial officer of the crown appointed and paid by the relevant local authority. The Coroner may also have Assistant Coroners.

The Chief Coroner is head of the coronial system, has overall responsibility and leadership for coroners in England and Wales.

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust covers 2 coronial jurisdictions. The Coroner's for this Trust are:

Her Majesty's Senior Coroner, South Yorkshire (East District).
All reportable deaths from Doncaster Royal Infirmary and Mexborough Hospital are to be reported to the Doncaster Coroner (See **Appendix 2** for full contact details and **Appendix 3** for the list of reportable deaths to the Doncaster Coroner).

Her Majesty's Senior Coroner, Nottinghamshire.
All reportable deaths from Bassetlaw Hospital and Retford Hospital are to be reported to Nottingham Coroner's Office (See **Appendix 2** for full contact details and **Appendix 4** for the reportable deaths to the Nottingham Coroner).

Inquests involving the Trust may sometimes be held in neighbouring jurisdictions such as Sheffield, Leeds and Wakefield by the respective Coroner for these areas.

4.2 The Coroner's Role

Under the law of England and Wales, an inquest must be held to investigate certain deaths. Coroners will lead this investigation and are obliged by law to investigate deaths where a person:

- has died a violent death
- has died a sudden death of unknown cause
- has died whilst in custody

A full list of reportable deaths can be found in **Appendix 3** for Doncaster & Mexborough only and **Appendix 4** for Bassetlaw and Retford only. The two coroner's have different criteria for reportable deaths.

An inquest will be opened soon after the death. This allows the death to be recorded, the deceased to be identified and the coroner to give authorisation for a burial or cremation to take place as soon as possible.

After the inquest has been opened, it may be adjourned (postponed) until after any other investigations have been completed. The average length of adjournment is 27 weeks, although in some cases it may be longer if the case is particularly complex.

In some cases, the coroner may hold one or more additional hearings before an inquest begins, known as pre-inquest hearings or reviews. These allow the extent of the inquest to be considered. The purpose of a coroner's investigation is directed solely to ascertain the following matters:

a) **who** the deceased was
b) **when** the deceased came by their death
c) **where** the deceased came by their death
d) **how and in what circumstance** the deceased came by their death, and
e) medical cause of death

A coroner's authority to inquire comes from the reporting of a death within the coroner's jurisdiction. The coroner will determine whether an inquest is required.

A doctor must refer a death to the coroner if any of the above in 4.2 or **Appendix 2 and 3** applies. If you are unsure if a death should be reported to the Coroner, speak with a senior member of staff and/or the Coroner's Officer and/or the Legal Services Department.

Coroner's officers work under the direction of coroners. The coroner's officers receive reports of deaths and make inquiries under the direction, and on behalf of the coroner. They will also liaise with bereaved families, police, doctors, witnesses, mortuary staff and Trust representatives.

Unlike criminal trials, inquests don't try to establish whether anyone was responsible for a person's death. Evidence is given by witnesses but there's no prosecution or defence.

When an inquest is held, the coroner must inform the deceased person's next of kin or personal representative.

4.3 Management and Handling of Inquests

4.3.1 On receipt of a notification of an inquest, the Legal Services Manager will inform the inquest panel as well as the Clinical Director, Head of Nursing/Midwifery/Therapies, Clinical Governance Lead for the relevant Care Group. The inquest panel will appoint a case handler.

The case handler will undertake a scoping of the case notes and identify the clinicians who are required to provide statements for the matter. The case handler supported by a Patient Safety Coordinator(s) will formally request statements within a timeframe that ensures compliance with the Coroner's request (this will normally be within 10 working days).

If the statement is not received within the stated timescale the situation will be escalated to the Clinical Director/Head of Nursing for the speciality who will ensure that the relevant staff member completes the statement.

4.3.2 The case handler will support staff in providing witness statements and on receipt of the same will review them to ensure they are fit for disclosure. Statements will be disclosed to the Coroner by the Legal Services Manager in advance of an inquest. Throughout the process of preparing for an inquest, the Legal Services Manager will communicate with

the Coroner to affect disclosure of documents, identify required witnesses and facilitate the date of an inquest dependant on witness availability. The Legal Services Manager will work in collaboration with the Trust's nominated solicitor to effect disclosure where appropriate.

4.4 Preparation of evidence

Preparing your witness statement

4.4.1 Almost certainly the Coroner will request that witnesses are asked to submit an original typed and signed written statement some time before the inquest. Occasionally the Coroner may direct his or her request to the medical staff involved. 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 Services Manager to ensure that legal representation is available if required. The Legal Services Manager will correspond with Panel Solicitors who liaise directly with the Coroner and in the event of a Serious Incident Investigation, will advise him or her of the Investigation. The Trust Solicitors will continue to liaise with the Coroner and Staff thereafter to compile pre-inquest evidence.

When a request for a statement is received from the Legal Services Department, it is important that you act straight away and provide your statement within the timeframe you are given. The Coroner has the power to issue a witness summons and a fine in the event that this timescale is not complied with, requiring the witness to explain in person the reason for the delay. It is therefore imperative that you plan sufficient time to read the medical and nursing notes and prepare your statement using the template (appendix 5).

It is essential to have read the medical records and any other relevant documentation before commencing your statement. In the unlikely event that clinical records are not available it is essential that it is clearly stated within the statement that the information contained within the statement is from memory only.

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 the case handler or the Legal 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) **Appendix 5** provides some key tips on preparing a statement.

4.4.2 If you experience any delays in providing a statement, please inform the appointed case handler immediately so that the Coroner can be informed.

4.4.3 All requests for information concerning an inquest for the coroner should come directly from an appointed case handler via the Legal Services Department. If you receive a request for information directly from the coroner or the police or any other authority you should inform the Legal Services Department as soon as possible on extension 642167

4.4.4 Once your statement has been submitted to HM Coroner, the case handler will endeavour to keep you updated and informed with progress on the case.

4.5 Preparation and support of staff attending an Inquest

4.5.1 Preparation

It is important that staff feel well informed and supported during the inquest process. 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 (Smart Dress). 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. Do take the time to read your statement prior to the inquest to ensure that you are fully familiar with its content. 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 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 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 by the case handler and or legal services manager to provide advice and support throughout the process.

Before an inquest, ensure that you have read the clinical records. Re-read your statement to ensure you are familiar with your statement and the issues in hand. In most cases the Legal Services Department will ensure the clinical records are at court. However, if they are in your possession for review before the inquest it is your responsibility to bring the medical records to court and to ensure they are tracked to yourself and returned to the Trust.

4.5.2 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. Unless instructed otherwise, you should arrive at court at least 30 minutes before the start of an inquest. If a witness is late, it can delay the start of the inquest and inconvenience everyone. A coroner can hold a witness in contempt of court and a coroner's court has the same powers as any other legal court. You must ensure that mobile devices are switched off before entering the courtroom. If you wish to have your statement on an electronic device such as an iPad, you may do so but the device must be on silent. Recording is not permitted under any circumstances.

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. 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.

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

4.6 Conclusion of an Inquest

Once the Coroner or jury has heard all the evidence, the Coroner will sum up the facts and provide a conclusion (previously known as the verdict) to the inquest. If there is a jury, the Coroner will direct them on the law.

4.6.1 Conclusions of *unlawful killing* and *suicide* must be proven beyond 'all reasonable doubt'. All other conclusions are dealt with on a 'balance of probabilities', e.g. 51% certain.

4.6.2 One of the following short form conclusions (or verdicts) may be adopted;

1. accident or misadventure
2. alcohol/drug related
3. industrial disease
4. lawful/unlawful killing
5. natural causes
6. open
7. road traffic collision
8. stillbirth
9. suicide

A narrative conclusion which is a short paragraph detailing what happened, can be used as an alternative or in addition to an above short form conclusion.

4.6.3 As well as providing a conclusion on how a person came by their death, the coroner will also determine the medical cause of death from the evidence he or she has heard.

4.7 Prevention of death reports (Regulation 28)

A prevention of future death report, Regulation 28 of The Coroner's (Investigations) Regulations 2013, provides that Coroners have a statutory duty to issue a report to any person or organisation if evidence during the course of an inquest gives rise to a concern that action should be taken to prevent future deaths.

Organisations that receive a report are under a duty to respond within 56 days from the date the report was sent to the organisation. The Lord Chancellor will receive copies of all reports and responses. This will enable emerging trends to be identified and lessons that could be applied at a national level to be highlighted.

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.

5. TRAINING/SUPPORT

The Training & Education department will support development of educational tools to support any identified learning. Learning identified will be shared within the identified speciality and/or Trust wide, dependant on issue, following established clinical governance processes and structures.

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

An annual report of compliance with this policy will be performed by the Patient Safety Co-ordinator/Legal Services Manager and received by the Patient Safety Review Group to review and note recommendations.

Where it is anticipated that compliance with this policy will not be achieved the Patient Safety Coordinator will notify the Legal Services manager who will consider the circumstances and take action to minimise the associated risk.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Compliance with the Coroner's statement/report deadlines	Legal Services Manager	Annual	Patient Safety Review Group
A quantitative analysis of the types of inquests against each Care Group, the number of inquests opened and closed and their outcomes;	Legal Services Manager	Annual	Patient Safety Review Group
A qualitative analysis of inquests and a review of learning from inquest activity over the preceding year.	Legal Services Manager	Annual	Patient Safety Review Group

7. DEFINITIONS

HMC: Her Majesty's Coroner

Inquest: A legal investigation to ascertain the circumstances surrounding a person's death

IP: Interested person. Those persons involved with the case, e.g. deceased family, witnesses, hospital, etc

PFDR: Prevention of Future Death Report

PIB: Pre Inquest Brief (Internal Trust meeting with all witnesses)

PIR: Pre Inquest Review (undertaken at the Coroner's Court with the coroner)

Pathologist: Carries out a post mortem examination. They are a medical professional who specialises in the diagnosis of disease after death and identifying causes of death.

Post mortem examination: A detailed medical examination of a deceased body conducted by the pathologist. The purpose of the post mortem examination is to establish the cause of death.

Regulation 28 (r28) of The Coroner's (Investigations) regulations 2013: Prevention of future death report.

Rule 23 (r23) of The Coroner's (Inquests) rules 2013: Witness statement to be read into evidence. Witness does not have to attend court to provide oral evidence.

Witness: is someone, who under oath or affirmation at an inquest provides evidence or whose statement is read into evidence.

8. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 13)

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Complaints, concerns, comments and compliments - CORP/COMM 4
Being Open and Duty of Candour Policy - CORP/RISK 14
Incident Management Policy - CORP/RISK 33
Serious Incidents (SI) Policy - CORP/RISK 15
Processing Requests for Access to Health Records Procedure - CORP/REC 3
Information Records Management - Code of Practice - CORP/ICT 14
Learning from Deaths Policy - CORP/RISK 32
Fair Treatment for All – CORP/EMP 4
Equality Analysis Policy – CORP/EMP 27

10. REFERENCES

Dorries, C., 2004. *Coroners' Courts A Guide to Law and Practice.* Second ed. Oxford University Press

The Coroner's and Justice Act 2009:

The Coroner's (Investigations) Regulations 2013

The Coroner's (Inquests) Rules 2013

www.legislation.gov.uk

www.dirct.gov.uk

APPENDIX 1 – INQUEST OUTCOME REPORT

1.	**Reference** **Deceased** **Date of birth** **Date of death**	
2.	**Statements/ documents provided to coroner**	
3.	**Witnesses called**	
4.	**Statements read (rule 23)**	
5.	**Internal investigation**	
6.	**Representation**	
7.	**Press**	
8.	**Background**	
9.	**Medical cause of death**	
10.	**Conclusion**	
11.	**Prevention of future deaths report? (rule 28)**	
12.	**Summary**	
13.	**Recommendations**	
14.	**Comments**	

APPENDIX 2 – HM CORONER CONTACT DETAILS

Coroners - Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

The main Coronial jurisdictions for this Trust are:

South Yorkshire East District
Her Majesty's Senior Coroner.
Coroner's Office and Main Court
College Road
Doncaster
DN1 3HS

t: 01302 320844, 321581, 556614
e: hmcdoncaster@doncaster.gcsx.gov.uk

Nottinghamshire
Her Majesty's Senior Coroner.
Coroner's Court and Office
Council House
Old Market Square
Nottingham
NG1 2DT

t: 0115 841 5553
e: coroners@nottinghamcity.gov.uk

APPENDIX 3 – REPORTABLE DEATHS – DONCASTER & MEXBOROUGH

DONCASTER ROYAL INFIRMARY AND MEXBOROUGH MONTAGU HOSPITALS ONLY

A death must be referred to **Doncaster Coroner** in the following circumstances:

1. The cause of death is unknown;
2. It cannot readily be certified as being due to natural causes;
3. The deceased was not attended by the doctor during his last illness or was not seen within 14 days or viewed after death;
4. There are any suspicious circumstances or history of violence;
5. The death may be linked to an accident (whenever it occurred);
6. There is any question of self-neglect or neglect by others;
7. The death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station);
8. The deceased was detained under the Mental Health Act
9. The death is linked with an abortion;
10. The death might have been contributed to by the actions of the deceased (such as a history of drug or solvent abuse, self-injury or overdose);
11. The death could be due to industrial disease or related in any way to the deceased employment;
12. The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred);
13. The death may be related to a medical procedure or treatment whether invasive or not;
14. The death may be due to lack of medical care;

15. There are any other unusual or disturbing features to the case;
16. The death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care);
17. It may be wise to report any death where there is an allegation of medical mismanagement.

This note is for guidance only, it is not exhaustive and in part may represent desired local practice rather that the statutory requirements. If in any doubt, contact the Coroner's Office for further advice.

APPENDIX 4 – REPORTABLE DEATHS – NOTTINGHAM AND RETFORD

BASSETLAW DISTRICT GENERAL HOSPITAL ONLY

A death must be referred to the **Nottinghamshire Coroner** in the following circumstances (updated September 2014):

1. The cause of death is not known
2. Deceased had not been seen by a medical practitioner within 14 days prior to death
3. Deceased had not been seen alive by certifying doctor
4. Cause of death may be due to trauma or unnatural cause e.g. Road Traffic accident, apparent taking of own life, poisoning, self-harm, fracture, evidence of violence.
5. Cause of death may be related to an industrial disease e.g. pneumoconiosis if the deceased was a miner, mesothelioma if the deceased had been exposed to asbestos, farmer's lung or the deceased had died due to an injury sustained in employment (Please refer to the reverse of the death certificate to see a comprehensive list.)
6. Patient had been in hospital for less than 24 hours.
7. Cause of death is due to a fall or there has been a fall in the three days prior to death.
8. At time of death, a grade 3 or grade 4 pressure ulcer is present or more than one grade 2 pressure ulcers are present.
9. Surgery or invasive procedure involving general or local anaesthetic performed within the preceding 12 months (including endoscopies).
10. Significant medical procedure or treatment (inc chemotherapy or radiotherapy) during index admission.
11. Person deprived of their liberty or liberty was restricted by law at the time of death, in seven days preceding death, including a serving prisoner or a person detained pursuant to Mental Health legislation.
12. Alcohol or any prescribed or non-prescribed drug is mentioned as contributing to the cause of death in part 1 of the death certificate
13. Death during pregnancy or within a year of giving birth.
14. All deaths that would be referred to the Child Death Overview Panel (CDOP) i.e. all paediatric deaths.

15. Allegations of negligence during or prior to admission regardless of whether these are considered to be substantiated.

16. Death associated with (or after) a clinical incident.

17. If the patient is under the age of 80 and Old Age is given as the sole cause of death then you must report the death to the Coroner (please see note below)

18. Any other unusual circumstances.

If there is any doubt about whether a Coroner's referral is required, the first point of contact should be the Consultant in charge of the care. The Consultant has the ultimate responsibility for decisions on referral.

Deaths certified as Old Age

Please note that to give old age as a cause of death without referring to the Coroner you must:

a. Have personally cared for the deceased over a long period of time
b. Have observed a gradual decline in the patients general health and functioning
c. Not be aware of any identifiable disease or injury that contributed to the death.
d. Be certain that there is no reason that the death should be referred to the Coroner

APPENDIX 5 – STATEMENT TEMPLATE

Statement template

Inquest into the death of [Patient A]

Statement of [A B, JOB TITLE]

PLEASE NUMBER EVERY SINGLE PARAGRAPH IN YOUR REPORT. DO NOT JUST FOLLOW THE NUMBERING SEQUENCE BELOW

1. I am a [TITLE] employed by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. I have held this post since [INSERT DATE]. My professional qualifications are [INSERT QUALIFICATIONS].

2. I have been asked to provide a statement regarding the treatment provided to [patient A]. My only involvement with [his/her] care was between [INSERT DATE] and [INSERT DATE]. The remaining information in this statement regarding [his/her] treatment I have obtained from reviewing the medical records made by myself and other staff involved. I have [clear recollection], [vague recollection] or [no recollection whatsoever] of my involvement with [patient A].

3. Summarise relevant past medical history leading up to key admission.

4. Detail events related to key issues. Make it clear what was your involvement and what was your colleagues'. Include the names of colleagues. Include dates and times of your involvement. Remember that the coroner will need someone to deal with the death itself [hearsay is ok if no particular issues relating to it], even though it may be peripheral to earlier management issues.

5. Explain your recollection/records clarifying any abbreviation or medical terminology.

6. Conclusion - Summarise the key issues.

7. I would like to take this opportunity to offer my condolences to [Patient A's] family and friends.

Should you need any further assistance, please do not hesitate to contact me.

……

Full name: Date:

Job title:

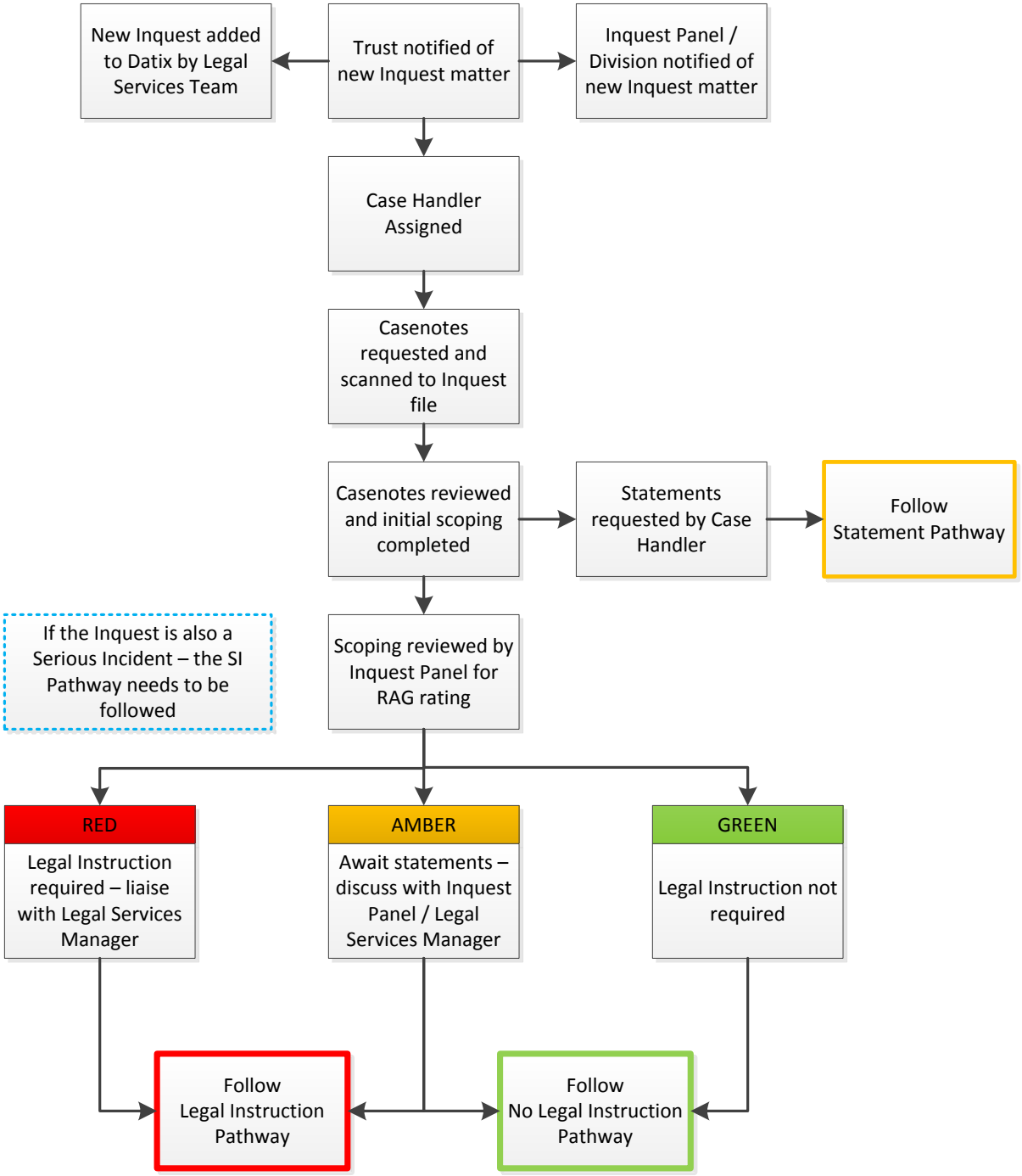
APPENDIX 6 – STATEMENT TIPS

Statement tips:

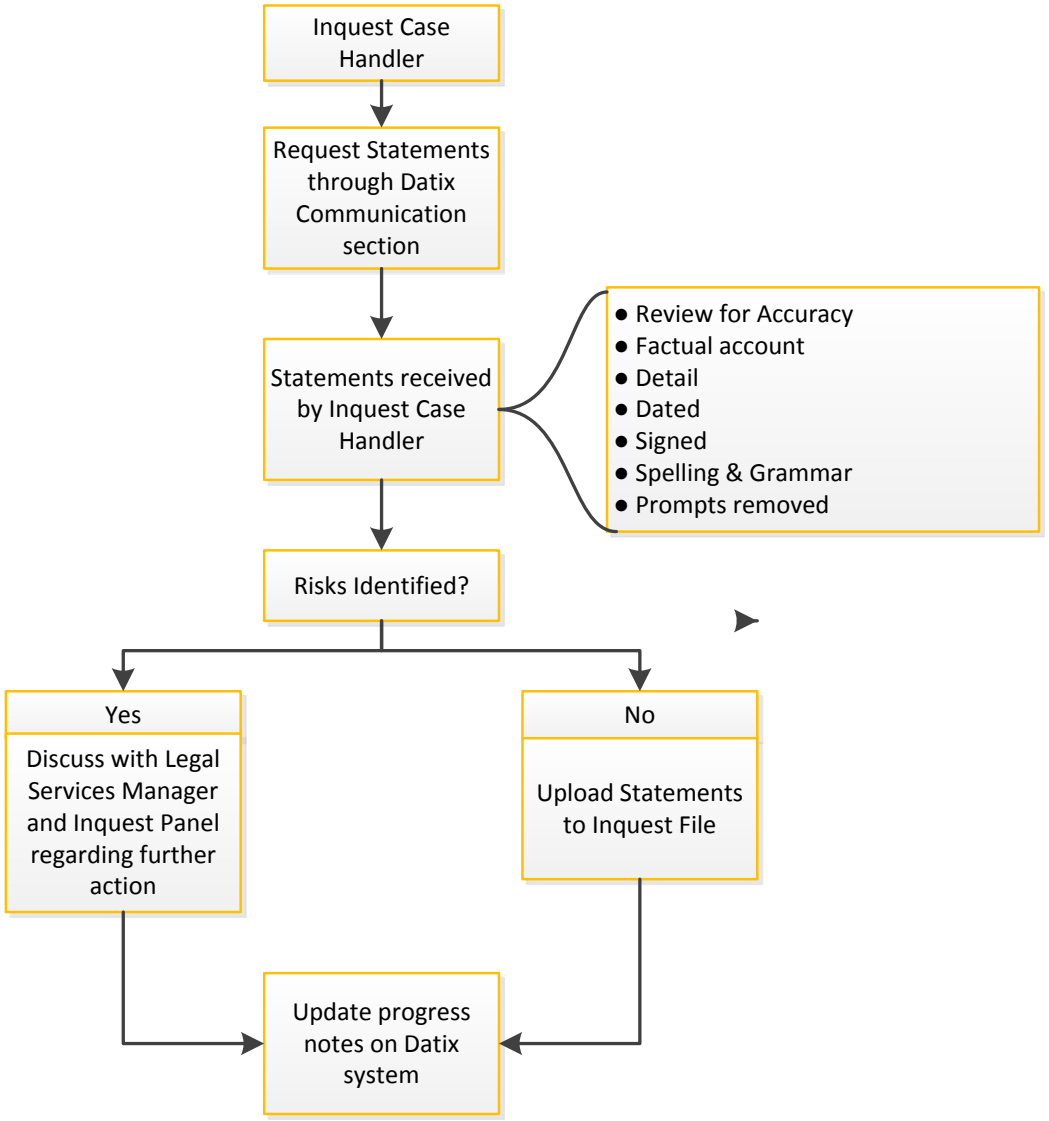
- A statement for the coroner should be typed not hand written
- All staff are advised to use the witness statement template in appendix 5 as a guide
- Do not write a joint statement. You must write your own statement
- Your statement must be written with access to the medical and nursing notes and any other useful, relevant documentation such as incident report forms, ward diary, protocols etc. **Do not** start your statement without having thoroughly read the medical/nursing notes and any other relevant documentation
- Number every paragraph in the statement. This enables points in your statement to be easily referred to by various officers of the court at inquest
- The statement should consist of double line spacing
- Provide a factual account and stick to the facts as you know them. Do not speculate or interpret information
- Do not stray outside your area of expertise, do not express an opinion about another professional's clinical competence
- Be honest and tell the truth
- Be sensitive, refer to the deceased by their name, never state *'the patient'*; remember the deceased's family will read and/or hear your statement
- Be clear, coherent and work in chronological order
- Clearly state dates, timings and locations
- If you refer to other staff, state their name(s) and their position
- Do not use jargon or abbreviations
- Ensure medical terminology is explained. Are the family and/or the coroner going to understand what you are saying?

- If you need to refer to any Trust policies or protocols refer to the policy/procedure that was in place at that time and attach a copy with your statement
- If formal policies/procedures were not followed, state why they were not followed and what the normal practice is
- Before a statement is submitted to the coroner, it must be forwarded to the Patient Safety Lead, who will review and/or forward to the Legal Services Manager and/or the Trust's nominated solicitor for advice before submission to the Coroner.
- Retain a copy for yourself

APPENDIX 7 - INQUEST PROCESS



APPENDIX 8 - REQUESTING STATEMENTS



APPENDIX 9 - HEALTHCARE REGULATORY INQUEST RISK MATRIX

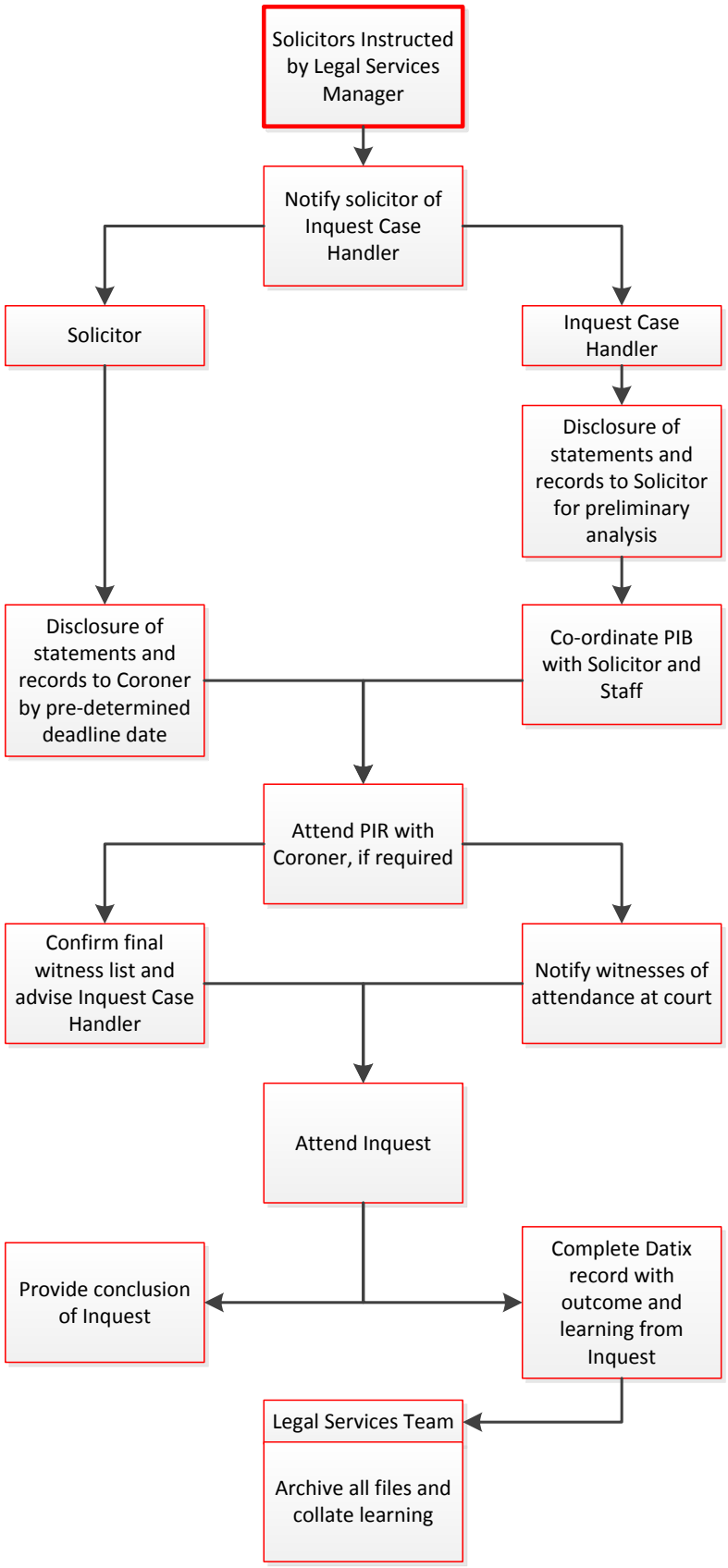
The criteria for high profile cases is worked out by reviewing the nature of the death combined with evidence of significantly compromised care where substantial media and social media attention has or may be generated and with a claim anticipated post inquest. Each of these criteria would not necessarily make it high profile, nor warrant major legal input. Each Inquest should be considered on a case by case basis to determine whether it comes under the remit of high profile. The risk matrix below should assist with this process.

Risk Factors	Weighting	Unlikely	Likely	Certain	Total for case
Family represented	1	0	1	2	
Article 2 Inquest	1	0	1	2	
Multiple interested persons	1	0	1	2	
Potential for Regulation 28 report to be issued by HMC due to system failures.	1	0	1	2	
Previous Regulation 28 report issued by HMC where similar systems issues have been identified to the current case	2	0	2	4	
High risk near miss inquests were a Regulation 28 was narrowly avoided or where HMC has been given assurance that actions are being put into place and or where HMC has requested a follow up progress letter detailing actions implemented	2	0	2	4	
Jury	2	0	2	4	
High risk complaint	2	0	2	4	
Pre-inquest reviews	2	0	2	4	
Need for written submissions	2	0	2	4	
Multiple clients and/or > 5 witnesses	2	0	2	4	
Claim intimated	3	0	3	6	
Medial interest or other profile issues	3	0	3	6	
SUI	3	0	3	6	
Multiple day listing	3	0	3	6	
Conflict of Evidence	3	0	3	6	
Regulatory or criminal interest – GMC/NMC/HSE/MHRA/Police	5	0	5	10	
Experts in case	5	0	5	10	
Risk of neglect or unlawful killing conclusion or damning narrative	5	0	5	10	
				Total	

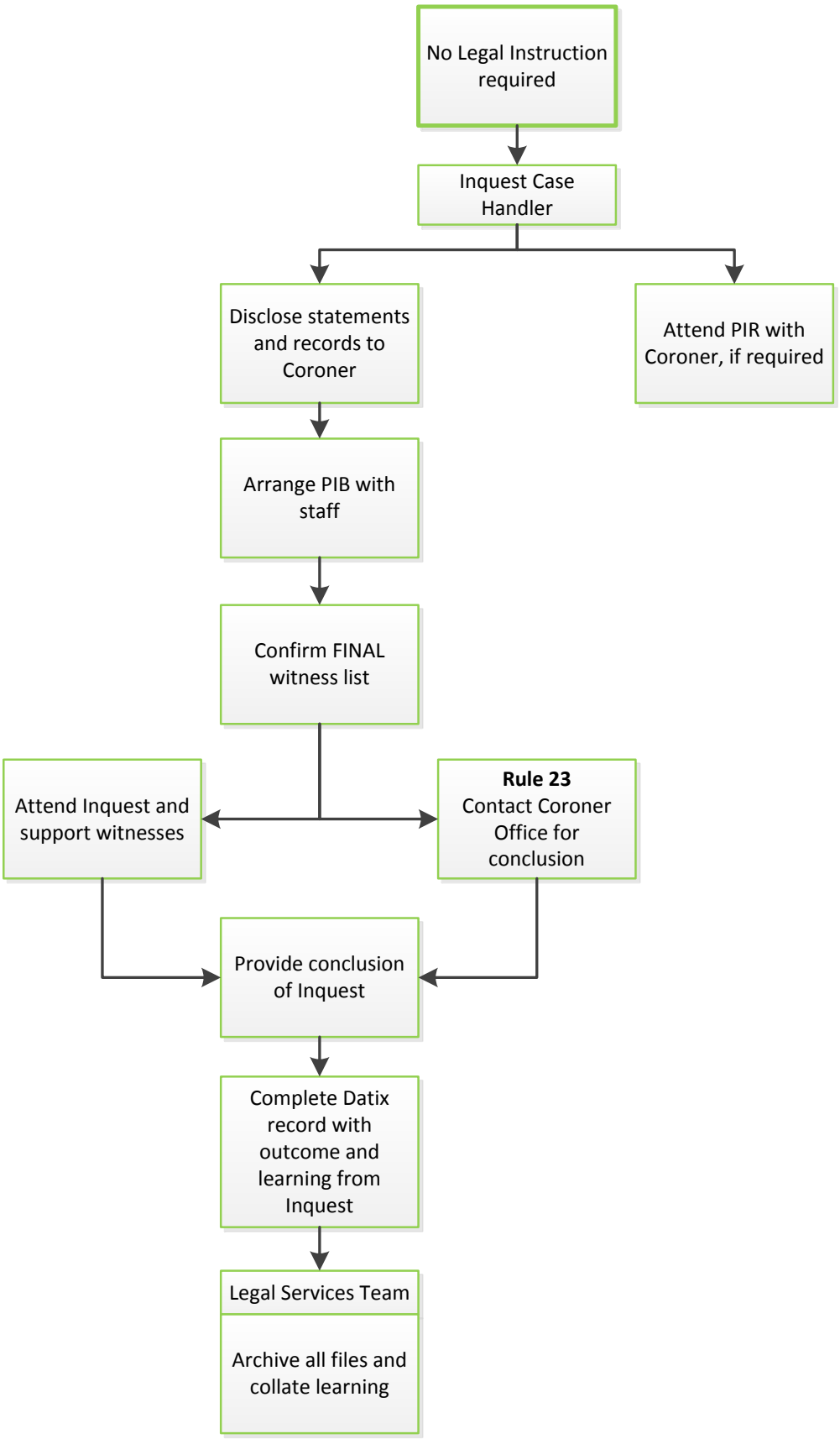
Risk Rating:

Low Risk	Score 0 – 10
Medium Risk	Score 11 – 20
High Risk	Score >21

APPENDIX 10 - RISKS IDENTIFIED – LEGAL INSTRUCTION

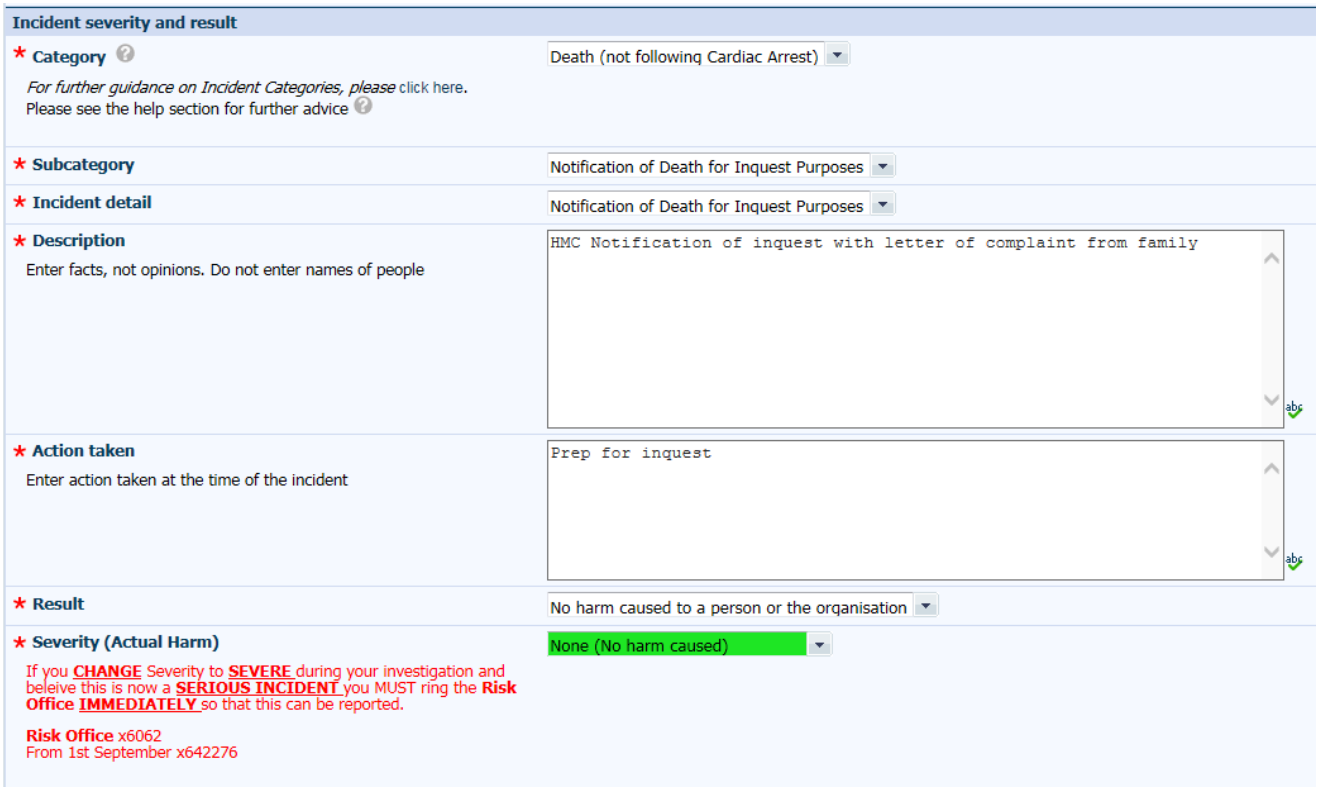


APPENDIX 11 - NO LEGAL INSTRUCTION



APPENDIX 12 - DATIX FIELDS

Incident Severity and Result



Incident severity and result

* **Category**
  For further guidance on Incident Categories, please click here.
  Please see the help section for further advice
  Death (not following Cardiac Arrest)
* **Subcategory** — Notification of Death for Inquest Purposes
* **Incident detail** — Notification of Death for Inquest Purposes
* **Description**
  Enter facts, not opinions. Do not enter names of people
  HMC Notification of inquest with letter of complaint from family
* **Action taken**
  Enter action taken at the time of the incident
  Prep for inquest
* **Result** — No harm caused to a person or the organisation
* **Severity (Actual Harm)** — None (No harm caused)

If you **CHANGE** Severity to **SEVERE** during your investigation and beleive this is now a **SERIOUS INCIDENT** you MUST ring the **Risk Office IMMEDIATELY** so that this can be reported.

Risk Office x6062
From 1st September x642276

Inquest Section - Initial completion:

Risks Identified

Insert Risks identified from the Scoping Document

Inquest Opened date

Risk Office Case Manager

Inquest Investigation Lead

Team / Consultant

Coroners Reference:

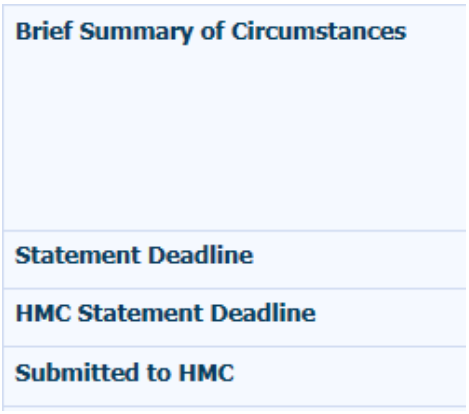
Location of Inquest

Inquest Date:

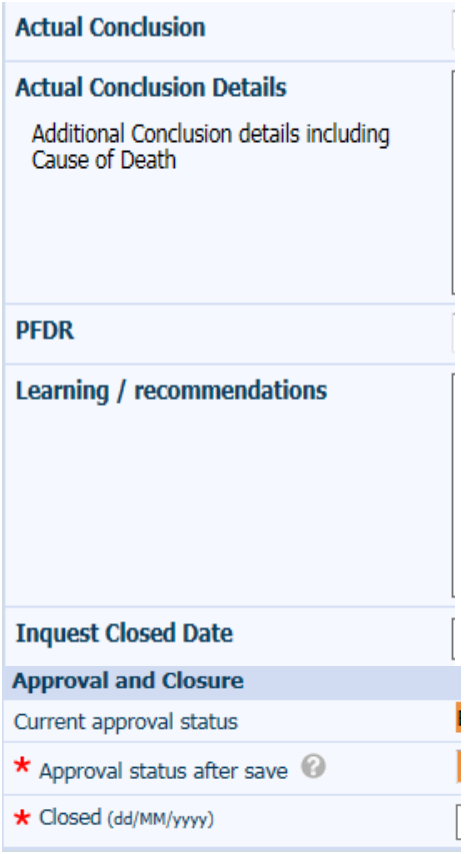
Inquest Time:

Inquest End Date

Risks will include concerns raised by family members to HMC or those identified through the scoping of the death.
Inquest opened date will always be the date HMC opened the process and can be found on the HMC notification letter.
Coroner's reference is located on the top left hand corner of the notification letter.
Date and time of the Inquest will be specified within the HMC letter. This section may need to be completed retrospectively if a court date has not yet been confirmed. Not all HMC notifications will lead to an inquest being held.



Summary of events can be lifted from HMC letter.
Statement deadlines. HMC deadline date is the absolute date by which statements must be disclosed. All statements must be with the case handler **ten days** prior to the deadline disclosure date unless in very exceptional circumstances.



Choose Inquest conclusion from drop down box.
Conclusion details will need to be completed as a short summary including HMC's findings of fact and any salient points which have come to light during HMC's summing up.

In the event of a Regulation 28 or Prevention of Future Death Report being issued by the Coroner Complete this section using the Y/N drop down box.

Lessons learned section to include reference to any PFDR matters, and or matters identified during the course of the Inquest which the organisation may learn from for the benefit of other patients and or their relatives and which may positively impact on the quality of care or service delivered to other patients and their families. These do not need to directly relate to or be causative of the patient's death. If there is no learning "no learning for DBTH" should be entered into the box.

Remember to complete the Inquest closed date on the Inquest section. Remember to also change the approval status at the bottom of the first page of the incident section to finally approve.

APPENDIX 13 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/ Project/Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Inquest Policy – CORP/RISK 22 v.3	Director of Nursing, Midwifery and Quality	Michele Corbett	Existing Policy	May 2018

1) Who is responsible for this policy? Name of Care Group/Directorate: Director of Nursing, Midwifery and Quality

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? Staff involved with Inquests

3) Are there any associated objectives? Legislation, targets national expectation, standards Coroner's Inquest Statutory Rules 2013

4) What factors contribute or detract from achieving intended outcomes? None

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] No

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: August 2021

Checked by: Mr Cuschieri **Date:** August 2018