NHS

Milton Keynes Community Health Services

A Staff Guide to Inquests

The coroner and their role

A Coroner is a qualified solicitor, barrister or medical practitioner who has been practising for a minimum of five years.

Coroners are appointed to investigate any sudden or unexplained death. They are required to act in accordance with rules and procedures found in the Coroner's Act 1988. Coroners will seek to establish the medical cause of death. If the cause remains in doubt after a post mortem, an inquest will be held.

Her Majesty's Coroner for Milton Keynes is Mr Tom Osborne LLB, a solicitor who formerly practised in Milton Keynes for 30 years. Mr Osborne is supported by a Deputy Coroner, Elizabeth Grey, and a small team of Coroner's Officers, led by Sonia Brooks. In Milton Keynes there is a dedicated Coroner's Court based at the Crownhill Crematorium site, although the Civic Offices are still used to hold Inquests occasionally.

The purpose of an inquest

The purpose of an inquest is not to apportion blame, but to answer certain questions: who died, when they died, why they died, where they died and how they died.

On hearing about a death

Inform your manager who will contact the coroner's office at the earliest opportunity. Always inform your director, or the director on call, as soon as possible and start your Serious Incident process. Also, remember to contact the communications office.

Managers should remember to support staff and take immediate reports. Ensure contact is made with the family and carers and always offer them your condolences and support.

Tip for managers: The on-call director's number is 07500 952148. The coroner's office number is 01908 254327.

Before the Inquest

Managers

We recognise that preparation for inquests can be detailed and extra time may need to be set aside. Managers should feel that they can turn to their director for support and guidance. Managers should remember that the better prepared they and their staff are for an inquest, the smoother the process is likely to be.

You should oversee the Serious Incident process – this includes completing the chronology and clinical review/route cause analysis and submitting it to the Clinical Governance team. The coroner is likely to request a copy and will want assurance that lessons have been learnt and actions taken.

You should keep your director informed. They will make a decision as to whether a legal view is needed before the organisation submits all the reports to the coroner's office.

If legal representation is required at the inquest, make sure you meet with the barrister and go over everything that is needed. Put the date of the inquest in your diary and make sure all the staff who need to attend are able to – failure to turn up to an inquest when required could result in a contempt of court charge being made against you or your staff followed by a possible custodial sentence.

Make sure all the files are complete, professional in appearance and that the relevant reports are ready in good time and delivered to the coroner's office and received. The coroner may have issued directions for the disclosure of records and preparatin of reports. Ensure that all directions are complied with as directed.

The following points may sound obvious, but many managers have been surprised by the detail of questioning about their role, their team and its policies.

When attending an inquest always know your:

- service area in-depth
- staffing and resources
- policies and operational procedures
- relationship with other services
- organisational structure

Maintain regular contact with the coroner's office. Ask who is going to be at the inquest and for the post mortem results, if you have not seen these already.

It is a good idea for all the staff who are due to give evidence, to meet together beforehand and discuss the process, any learning and outstanding issues. Sometimes role playing helps.

Finally, be prepared. You may not have been called to give evidence, but you can be helpful and may be sworn in to give evidence if required.

Tip for managers: Introduce yourself to the coroner's officer and establish a relationship

Staff

Prepare your report for the Coroner in good time. If there is a delay, disccuss this with your manager as they may need to contact the Coroner's Office and explain why. Your manager should have sufficient time to check all your reports and liaise with the appropriate director to consider whether legal advice is needed. Make sure the inquest date is in your diary.

Staff support
Managers must accompany their staff to provide support, to manage the paper evidence and prepare to be a source of further evidence – policy, structure and learning. Staff, who have not attended an inquest before, can sit in and observe the proceedings of another inquest to understand how they run.

Staff should also expect to deal with the unexpected - distressed or angry family and the media.

Remember, MKCHS has a number of support mechanisms available to all staff. This includes supervision, speaking to your manager or director. You can also speak to Mary Ann Monaghan who has a wealth of experience of inquests. In addition, MKCHS funds AXA ICAS to offer a range of support to our staff on a variety of issues. They have a support telephone number - 0800 072 7072 - which is available 24 hours a day, 365 days a year.

Tip for everyone: Attend and observe an inquest as a member of the public.

At the Inquest

Before it starts
Make sure you arrive in good time. Remember to allow enough time to park your car – parking around the Civic Offices, and at the crematorium during a funeral, can be difficult.

An inquest commands respect and therefore you should wear appropriate clothes. Make sure your manager takes all the case records and that they are presentable. It is important that all staff giving evidence have a copy of their report – double-spaced and numbered, as required by the Coroner's Office.

On arrival, let the Coroner's Officer know you have arrived.

Inquest etiquette
Remember an inquest is a court hearing, open to the public. You should be respectful at all times and address the Coroner as Sir or Mam. It should go without saying that any mobile phones or pagers should be switched off.

As a witness in a Coroner's Court you must always be polite, courteous, truthful and professional at all times.

It is a good idea to make sure you are fully prepared and ready before giving evidence. It is important that you listen to the questions being asked of you and read from your report. When being questioned it is acceptable to refer to your report or case file. State only the facts unless you are expressly asked for an opinion. Finally, make sure you take your time and do not feel compelled to rush through your evidence.

What you will be asked

At the start of giving your evidence the Coroner's Officer will ask you to affirm or take an oath. You will then be asked your full name and to confirm the spelling. The Coroner will also ask for your qualifications, profession and job role. On occasions you may be asked for your address. If you are asked this, you should give your work address. This will help put you at your ease.

You will then be asked questions relating to your report and events leading up to the person's death. You may be asked about the organisation's processes and policies and whether these were adhered to. Do not talk negatively about the deceased nor give opinion, unless specifically asked for it.

Who will ask the questions?

The Coroner will lead questioning and, if you have produced a detailed, accurate and concise report, you are likely to be asked fewer questions. Remember to only give an opinion, if you are asked for one and ensure it is evidence-based.

The Coroner is extremely sensitive to the needs of the family of the person who has died and will invite them, or their representative, to also ask questions or clarify your evidence.

Sometimes an inquest is heard in front of a jury. A jury will usually be appointed if the inquest is regarding a death in custody (including a person sectioned under the Mental Health Act), an industrial accident or poisoning. It will also be appropriate where deaths occurred in circumstances that, if repeated, could prove prejudicial to public safety.

Sometimes you may be asked questions by barristers representing the family of the deceased, MKCHS or other interested organisations. The Coroner may also invite members of the jury to ask questions at a jury inquest.

Giving evidence

The way you give your evidence and present yourself to the court can have as much impact as the content of your evidence.

Your should be prepared and not complacent. Speak clearly, do not waffle and give a professional response that a lay person would understand. Make sure you come across as being confident, but not arrogant. Make sure you understand the question – if you don't understand, say so. Remember your evidence may be distressing for the family to hear – show the appropriate emotion and NEVER become defensive or angry.

Inquests are held at a place that is relevant to where the person died. Therefore you may have to give evidence in another city or region where the Coroner takes a different approach to the running of their court.

Tip for managers: Stay until the end to support your staff, even if invited to leave.

Outcome of an inquest

The verdicts of cause of death available to a Coroner include natural causes, accident/misadventure, a narrative verdict, neglect contributed to the death or unlawful killing.

Although an inquest should not apportion blame, the Coroner does have powers if he/she feels that the evidence given during the inquest raises concern that there continues to be a risk of other deaths. He/she may make a Rule 43 report which is sent to the Secretary of State and the organisation which has responsibility for the circumstances. The Coroner may send a copy of his report to the Care Quality Commission (CQC). A recipient of a Rule 43 report must send a written response within 56 days.

The response must give details of any action which has been taken or is proposed, or provide an explanation when no action is proposed.

After the inquest

An inquest may be held sometime after the person's death. It is often a traumatic and upsetting process for the family. Remember to extend your condolences to family and carers again and offer support.

Continue to remain professional. Do not discuss the inquest outside the court as there may be somebody else listening. After you leave the inquest take some time to debrief with your colleagues, but again remember confidentiality. Arrange a timely debriefing with your manager and the organisation's barrister (if used). If the outcome of the inquest included a Rule 43 report, inform the relevant director and communications department immediately.

If you are approached by a reporter do not speak to them unless you have a statement, prepared and signed off by the Head of Communications. If you do not have a prepared statement and are asked to comment on the verdict, do not respond and ask the reporter to contact the communications office. Never comment on an inquest before the verdict is given, even if you have a prepared statement.

Tip for everyone: The communications office number is 01908 243538.

And finally

The conclusion of an inquest may not be the end of your involvement. Other organisations, such as our regulatory bodies, may require further assurance that future deaths can be prevented. The Coroner may have issued a Rule 43 letter which will require a response from the organisation within 56 days. In addition, there may possibly be civil action against the organisation. The family may still contact the organisation looking for answers or actions. Being prepared – having provided everything the Coroner asked for in a timely manner, knowing your role, responsibilities and preparing a good report – and being professional, clear and sensitive on the day will ensure the best outcome.

Other sources of information

Milton Keynes Council
www.milton-keynes.gov.uk/coroners/

Department of Health
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_115629

Health Talk on Line
www.healthtalkonline.org/ConditionsList

Health and Safety Executive
www.hse.gov.uk/enforce/enforcementguide/wrdeaths/coroner.htm
www.hse.gov.uk/enforce/enforcementguide/wrdeaths/chronology.htm

Ministry of Justice
www.justice.gov.uk/guidance/docs/coroners-reports-future-deaths.pdf
www.justice.gov.uk/guidance/docs/coroners-local-safeguarding-children-info.pdf

Root Cause Analysis Investigation Tools
www.npsa.nhs.uk/nrls

Trust Headquarters
Hospital Campus
Eaglestone
Milton Keynes
MK6 5NG
Telephone: 01908 243933
Email: communications@mkchs.nhs.uk

We would like to acknowledge the support provided in producing this document by Her Majesty's Coroner for Milton Keynes and his Office.

Managers' Checklist

	Yes	No
Immediate action upon death		
Have you:		
Contacted the coroner's office?		
Started the Serious Incident process?		
Informed your director or the director on call?		
Taken immediate report?		
Allocated a lead to work with the family and carers?		
Offered condolences tand support o the family and carers?		
Offered support to staff?		
Before the Inquest		
Continued to liaise with coroner's office, understanding any areas of concern?		
Checked all reports to ensure they are clear, accurate and consistent?		
Prepared and submitted all reports in good time?		
Liaised with your director who will consider if legal advice is required?		
Met with staff to discuss the inquest process and rehearsed?		
Given staff opportunity to observe another inquest prior to giving evidence?		
Made sure everyone required to give evidence has the date(s) in their diary?		
Established whether the inquest will be held in front of a jury?		
Liaised with communications office to ensure there is a prepared statement?		
On the day of the inquest		
Dressed appropriately?		
Allowed enough time for parking etc?		
Told the Coroner's Officer that you have arrived?		
Ensured all staff have hardcopies of the reports?		
Acknowledged the family and carers?		
Been respectful and addressed the Coroner appropriately?		
Given evidence in a clear, calm and professional way?		
After the inquest		
Continued to be available to the family and carers?		
Learned from the experience, supported team learning and needs?		
Updated your director?		
If a Rule 43 letter has been sent, worked with your director to develop a response?		