

## Attending coroner's court: a practical guide

### Introduction

It will happen to many of us during our medical careers. We will receive a summons to give evidence at a coroner's inquest, and the nerves will start to run riot. The first time we give any thought to what goes on in the court room, and what we will be required to do, is when the court date is looming. Standing in court to give evidence is not routinely addressed in medical training and often doctors are reticent to discuss their experiences of appearing in court. An inquest is not a trial and does not try to apportion blame for a death. Rather, it is a fact-finding exercise in which the coroner seeks to understand the circumstances that led to the death of a person.

This article outlines the structure and processes of the coroner's court and provides practical details about preparing for a hearing. It is hoped that this will allay many of the fears associated with giving evidence.

### The coronial system

The coroner's court is entirely separate from the criminal and civil processes and is governed by legislation set out in the Coroners and Justice Act 2009. This act changed eligibility for appointment as a coroner, such that a person must hold a legal qualification of 5 years standing. It is no longer sufficient to be only medically qualified as was the case under the previous Coroner's Act 1988. The coronial service is funded by local authorities, and a coroner is appointed by the local authority to investigate certain deaths within a geographical area.

Section 1 of the Coroners and Justice Act 2009 sets out the circumstances in which the coroner has a duty to investigate a death, including where the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died in custody or otherwise in state detention.

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### What happens at the inquest?

The purpose of the inquest is to determine the answers to four limited factual questions: who the deceased was, and how, when and where the death came about. To do this, the coroner calls upon witnesses who can provide factual information to answer these questions. This may include doctors and health-care staff who treated the deceased, a pathologist who has performed an autopsy, and police officers or other witnesses who attended the scene of death.

Also present in the court room may be relatives of the deceased and legal representatives of the 'interested parties'. Rarely, in specific cases, a jury is required. (Circumstances which need a jury include deaths in custody or state detention, as a result of an act or omission of a member of a police force, as a result of a notifiable accident, poisoning or disease, or if there is 'sufficient reason' to do so.) Depending on the complexity of the case, the proceedings can vary from a small gathering in a meeting room, to a full house in a large, formal and perhaps more intimidating court room. An inquest is a public hearing, and high profile cases may attract media attention or a reporter from the local press.

When it is determined that an inquest is to be held, you will be contacted by a coroner's officer and informed of the date for the court hearing. The coroner will ask you to write and submit a statement describing your involvement with the deceased. This should be a clearly written account in the first person, stating what you did, where and when. It should be factual and specifically describe your actions and involvement, not those of anyone else. If your evidence is unlikely to be controversial a clear statement may reduce the likelihood of having to attend court in person.

The coroner opens the hearing by introducing the case and describing the format that the proceedings will take. He/she will call witnesses in the order he/she chooses. When it is your turn to give evidence, you will be asked to step up to the witness stand and read out an oath stating that the evidence you are about to give is 'the truth and nothing but the truth'. The coroner will invite you to read from your state-

ment, or guide you through the evidence he/she wants to hear with questioning.

If you receive a formal summons your presence in court is mandatory. Failure to attend will place you in contempt of court, which may be punishable with a fine or term of imprisonment. If you have a legitimate reason for being unable to attend at the designated time, it is important to discuss this with the coroner's office and seek advice from your trust legal team or medical defence union.

When you have completed giving evidence, the coroner may ask further questions and will then invite the other interested parties, e.g. the family or their legal representatives, to question you as the witness.

### Do I need legal representation?

In most cases, the evidence you will be giving at inquest will be non-controversial, so legal representation is not required. However, if, for instance, there has been a perceived shortfall in medical care, the family may choose to seek legal representation and in this case you may prefer to do likewise. If you are working in a hospital, this will usually occur via the trust's legal department. However, if you are self-employed or work in general practice, your medical defence union can be the first port of call.

In spite of the non-adversarial approach of the inquest process, questions from the family and barristers can feel confrontational when something has gone wrong. A witness cannot be compelled to answer questions, and therefore you may choose not to answer a question which you feel may be incriminating. As one north London coroner said: 'barristers will have their client's agenda in mind and will unpick inconsistent evidence. This can feel adversarial'. The important message is to be clear about your statement and simply to tell the truth at all times.

### Giving evidence: practical tips

- Re-read the medical notes before the inquest so you are reminded of the context of your involvement in the case
- Have a copy of your statement with you so that you can refer to it easily on the witness stand

- Before the hearing starts, the coroner's officer will show you where to sit and where you need to stand to give evidence
- The coroner should be addressed as Ma'am or Sir. Address your answers to the coroner, speaking clearly so that all in the court room can hear you
- Explain any medical terminology which you think a lay person may not understand, and avoid abbreviations
- Take time in answering questions, giving them due consideration. Keep answers concise and relevant. Further questions may be asked if elaboration is required
- If you do not know the answer to a question, simply be honest and say so
- Remain composed and professional even if questioning seems repetitive or confrontational
- When you are not in the witness stand listen to what other witnesses say – this may be relevant when you give evidence.

### Determination of the inquest

At the end of the inquest the coroner must reach a conclusion to enable registration of the death. The standard of proof is 'on the balance of probabilities', although verdicts of unlawful killing or suicide must be reached 'beyond reasonable doubt'.

In normal circumstances the conclusion will be a short finding such as: accident or misadventure, suicide, industrial disease,

natural causes, drug-related death, or an open verdict (where there is insufficient evidence to determine how the death occurred and the case is left open pending the appearance of further evidence). However, coroners are increasingly using narrative verdicts to sum up how a person came to die. These narratives can be detailed and may be useful in complex cases, particularly in those of controversial deaths.

If the coroner believes that action needs to be taken to prevent future deaths occurring in similar circumstances, he/she is required to send a report to the chief coroner and every other interested person or organization who he/she believes should receive it.

There is no typical case which results in an inquest hearing, but two example scenarios are given below.

#### Scenario 1

A 76-year-old nursing home resident developed symptoms of a chest infection, which became worse over a 7-day period. After this time, nursing home staff contacted the local out of hours GP service to assess the patient. The GP found the patient's observations were satisfactory. He prescribed antibiotics, but did not think referral to hospital was warranted. The next day, however, the patient became acutely unwell and was transferred to hospital by ambulance. He was treated for a severe pneumonia and sepsis, but in spite of maximum therapy, died 3 days later. The patient's family was unhappy with the care delivered by the nursing home and the GP.

Evidence was heard at inquest from the nursing home staff, GP and hospital doctors. The coroner considered whether any gross failure or neglect contributed to bringing about a premature death, but concluded this was not the case. A verdict of death by natural causes was recorded.

#### Scenario 2

A 67-year-old woman underwent elective laparoscopic cholecystectomy for chronic cholecystitis. Owing to problems with availability of hospital beds, she was taken to an outlying ward for postoperative care. She developed a bile leak and on the second postoperative day became profoundly unwell with sepsis secondary to biliary peritonitis. Later that day she was taken back to theatre. This confirmed the bile leak, but she suffered a cardiac arrest and died.

Concerns were raised about several aspects of the patient's care including her postoperative care on an outlying ward with infrequent observations and an inadequate level of nursing staff, the failure of medical staff to recognize sepsis, chase up blood results and start antibiotics in a timely manner, and the delay in taking the patient back to theatre for re-exploration. There was also criticism of poor documentation in the medical notes.

At the inquest evidence was heard from several of the doctors and nursing staff involved in the patient's care. The coroner made a narrative verdict giving details of the case. He was sufficiently concerned by the conduct of one doctor to refer him for professional review, and recommended that the hospital trust involved should review its outlier policy for postoperative patients.

### Conclusions

The purpose of the inquest is to determine the factual circumstances of a death. It does not make judgements about criminal or civil liability. Despite this, giving evidence in court can be a daunting prospect so knowing what to expect on the day, along with good preparation, can help. The coroners office, your trust's legal department and medical defence unions can all provide information about what is required of you before and during the hearing so do not be afraid to approach them. **BJHM**

*Conflict of interest: none.*

#### Further reading

- Brooks J (2012) Going to coroner's court. <http://careers.bmj.com/careers/advice/view-article.html?id=20006182> (accessed 20 August 2013)
- Medical Protection Society (2013) Inquests. [www.medicalprotection.org/mps-eng-wales-factsheets-inquests.pdf](http://www.medicalprotection.org/mps-eng-wales-factsheets-inquests.pdf) (accessed 20 August 2013)
- Ministry of Justice (2012) Guide to Coroners and Inquests and Charter for coroner services. [www.justice.gov.uk/downloads/burials-and-coroners/guide-charter-coroner.pdf](http://www.justice.gov.uk/downloads/burials-and-coroners/guide-charter-coroner.pdf) (accessed 20 August 2013)

### TOP TIPS

- There is no specific dress code, but your attire should be smart and professional.
- Plan your journey to the courtroom and aim to arrive in plenty of time.
- On arrival, the coroner's officer will direct you to the court room or waiting room, which you may share with the deceased's relatives.
- Read through your statement and the relevant medical notes before the hearing.
- Practice giving your statement with a colleague beforehand or try to attend an inquest to see how the process works.
- Ensure that you have cover at work and that you will be able to leave on time.
- If you work in hospital have a pre-inquest meeting with the trust legal department.
- As a medical witness, you are entitled to payment of a fee and reimbursement of travel expenses following the inquest.

### KEY POINTS

- Understanding what the coroner's inquest entails will help ease the anxiety of giving evidence in court.
- Be prepared – an inquest is a formal process which requires a professional attitude and adequate preparation.
- Approach your trust's legal department or medical defence union for advice.
- Know your case and the details of your statement.