# Mock Inquest

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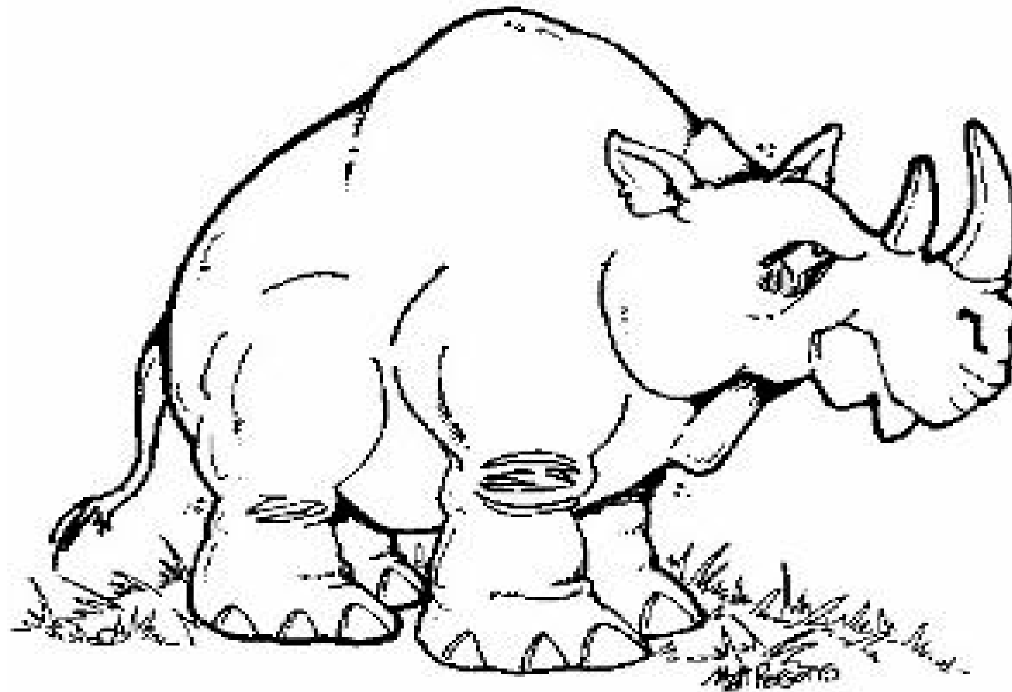

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# An Introduction to Inquests and the Coroner's Court

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# Issues to consider

- The role of the Coroner
  - When will the Coroner hold an Inquest/Investigation?
  - What is the purpose of the Inquest?
  - What Verdicts/Conclusions are available?

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# The Coroner

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- Oldest Judicial Office in UK dating back to 1194
- Independent Judicial Officer, appointed and paid by Local Authority
- 5 years qualified as a lawyer
- Only a small number currently appointed are medically qualified

# When to Notify the Coroner

Sudden death

Industrial accidents

Alcoholism

Homicide

Death in custody

Suicide

Domestic accidents

Doubtful doctor

Drugs and poisons

Coroner

Operation deaths etc.

Allegations of negligence

Industrial diseases

Infant deaths

Road Accidents

Abortions

# Coroner's powers upon reporting of a death

Upon reporting of a death the Coroner can do one of four things:

- To certify the death as due to natural causes without a post-mortem
- To certify as due to natural causes after a post-mortem
- To initiate an investigation into the death (under CJA 2009)

# Natural Causes does NOT mean Natural Death

- Pneumonia
  - Pressure sores
  - Issues with care
    - Package not provided earlier enough
    - Involving other services – SALT?

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# Alcohol

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- Grey area. Different coroners treat differently

- Chronic conditions –
  - Cirrhosis, end stage hepatic failure – may be natural causes no inquest required.
  - Acute Intoxication is a poisoning and would be subject to an inquest.

- Fall whilst intoxicated

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# Old Age

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- Now generally not accepted, particularly in care home deaths
- Person must be > 80 years old
- Must be a history of progressive deterioration and decline over a period of time in the absence of acute illness

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# The decision to hold an Investigation

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- The Coroner has a duty to investigate the death where:

  - Death is violent or unnatural (including death due to self harm)
  - The cause is unknown
  - Death in custody or state detention

- Discontinuance of investigation (CJA 2009)

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# Unnatural death

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- "Unnatural death" is wider than "unnatural causes"
- Test is not whether the <u>cause</u> of death is natural, but whether the <u>circumstances</u> of the death are
- A death is unnatural "whenever a wholly unexpected death, albeit from natural causes, results from a culpable human failure" - *R (Touche) v Inner North London Coroner [2001]*

# Touche – the facts



- Dcd gave birth to healthy twins by caesarean section.
- 11pm BP 120/60
- No further monitoring until 1.35am when BP 190/100
- Suffered left sided hemiplegia and cerebral haemorrhage and died.
- Expert evidence described the lack of monitoring as "astonishing" and advised that with monitoring and earlier intervention death would probably have been avoided.
- Hypertension leading to cerebral haemorrhage was a natural medical cause, but the circumstances of the death were unnatural and an inquest should be held.

# DOLS



- Coroners have issued their own specific guidance

- The Chief Coroner's guidance (December 2014) :-
  - any person subject to a DoL is '*in state detention*';
  - the death should therefore be reported to the Coroner
  - Coroner should commence an investigation;
  - the person is not '*in state detention*' until the DoL is authorised;
  - where the authorisation relates to a care home and the person is removed to a hospital and dies there (or in transit), Coroners should err on the side of caution and an investigation must be commenced;
  - the DoL is strictly place-specific, the law of necessity may allow the hospital to 'detain' the person, therefore an inquest would be necessary;
  - the investigation **cannot** be discontinued.
  - there **must** be an inquest

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# The purpose of the Inquest

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- Fact finding Exercise – <u>**not**</u> to apportion blame

- Section 5(1) CJA 2009 - Solely to ascertain

  - **Who** the deceased was
  - **How, when** and **where** the deceased died

- Section 10(2) CJA 2009
  - *"No <u>conclusion</u> shall be framed in such a way as to appear to determine any question of:*
    1. *Criminal liability on the part of a named person, or*
    2. *Civil liability*

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# However…

- Section 10 (2) only applies to Conclusions (verdicts)
- The evidence can deal with issues of fault/failures/negligence so long as the matters investigated are relevant to “how” the service user/ person died
- But the main purpose is to investigate “how”, not to determine civil or criminal liability

# The scope of the Inquest

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- Notwithstanding section 5(1) and Section 10(2), it is now expected that:
  - *"culpable and discreditable conduct is exposed and brought to public notice"* Lord Bingham in Amin (2003)
  - *It is the duty of the Coroner.....to ensure that the relevant facts are fully, fairly and fearlessly investigated. He must ensure that the relevant facts are exposed to public scrutiny particularly if there is evidence of foul play, abuse or inhumanity"* ex p Jamieson (1993)

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# Conclusions / Verdicts

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- Short Form:
  - Natural Causes
  - Accidental death
  - Suicide (NB standard of proof)
  - Unlawful killing
  - Open
  - *Alcohol/Drug Deaths*
  - *Road Traffic Collision*
- Narrative
- The Neglect Rider

# Suicide

- The Coroner must be satisfied beyond reasonable doubt that:

  1. The deceased did the act that resulted in his death **AND**
  2. When he did the act he intended to end his life

- Difficulties of proof with the second limb

- If the Coroner is not satisfied both apply he will consider accidental death / open verdict / narrative verdict

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# Narrative

- Narrative Conclusions are increasingly common
- Must not contravene Section 5(1) or Section 10(2)
- *"… judgmental conclusion of a factual nature, directly relating to the circumstances of the death. It does not identify any individual nor does it address any issue of criminal or civil liability."* Middleton (2004)

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# Middleton (2004)

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- *"The deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so"* (Lord Bingham)

- Does *"appropriate"* contravene Section 10(2)?!

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# Narrative Conclusions

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- *"Mrs H died of bronchopneumonia resulting from dementia. Her death was probably accelerated by a short time by the effect on her pneumonia of injuries sustained when she fell through an unattended open window, which lacked an opening restrictor"* Longfield Care Homes (2004)

# The “Neglect” Rider

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- Not a conclusion in its own right - rider to the main conclusion
- Not to be confused with negligence
- Neglect is defined as *“a gross failure to provide adequate nourishment or liquid, or to procure basic medical attention for someone in a dependant position”*… ex p Jamieson (1994)
- Failure must be “gross” - beyond “ordinary” negligence

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# What amounts to Neglect?

- Not every incorrect judgment amounts to neglect
- If a social worker considers all of the issues and asks himself the right questions an erroneous decision would not normally amount to neglect
- Failure to follow proper and routine procedures can amount to neglect

# Neglect and causation

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- There must be a casual link between the gross failure and the death
- Sufficient to show neglect was a "significant contributory factor"

# Preventing Future Death Reports

- Coroner MUST issue a report where the evidence *gives rise to a concern that circumstances exist which create a risk that other deaths will occur in the future*, and

- In the Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk

- Can be issued at inquest or during investigation

- Recipient must respond within 56 days and must include an action plan and timetable for implementation or reasons why no action proposed

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# Publication of reports

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- Reports and responses sent to:
  - Chief Coroner
  - All interested persons
  - Anyone who Coroner believes may find it useful or interesting – CQC
- Chief Coroner reports as follows:
  - Website
  - Annual report to Parliament

# Example PFD Reports

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- To consider reviewing the system for communication between the Mental Health Trust and the LA
- To consider whether all referrals should be reviewed by a specialist practitioner
- To consider a review of how Social Services are invited to/involved in MDT meetings
- To review the system for annual leave cover to ensure consistency and record keeping

# Avoiding PFD Reports

- The need for a thorough investigation at an early stage
- Disclosure of the investigation report to Coroner
- Specific Organisational Learning evidence from a senior manager explaining the investigation and what processes have changed

# Writing reports for the coroner

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# Accuracy

- Never write from memory – review records
- Cross refer to those records/assessments
- Once committed to paper incorrect or misleading details will take a lot of explaining in witness box. Review and review again and
- Ask a senior colleague to proof read and double check

# Relevant documents

- Consider all relevant documents e.g.

  - Policies **in place at the relevant time**
  - Guidelines **in place at the relevant time**
  - Investigation Report/Serious Case Review  and any statements prepared for that

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# Structure

- Qualifications and experience
- Use numbered paragraphs
- Factual chronology/overview - events in order they occurred giving <u>times</u> and dates
- Summary and Conclusions
- Express condolences - public document
- Date and signature

# Content

- Chronology of Events
- Include **times** and dates
- Use unambiguous language:
  - Explain acronyms, conditions and procedures in layman's terms
  - Get the terminology right

# Content

- Be sensitive and refer to service user by name
  - Not "*the service user*" or deceased
  - Correct DOB, DOD, title, address…
  - Public document sent to the family
  - May also be read out in court in front of the family and press

- When referring to colleagues use full name and title. e.g. Mrs Smith, The Senior Social Worker

- Stay within your area of expertise

# Fact NOT Opinion

- Avoid Jargon/acronyms
- Not airtime for your personal grievances
- Unbiased and neutral facts:
  - NOT speculation
  - NOT opinion

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# Concerns

- Raise these with Management
- Consider whether there any organisational learning
- If you have concerns about the case or are aware that the family have concerns contact Management separately

# Coroners, Investigations, Serious Case Reviews and Inquests

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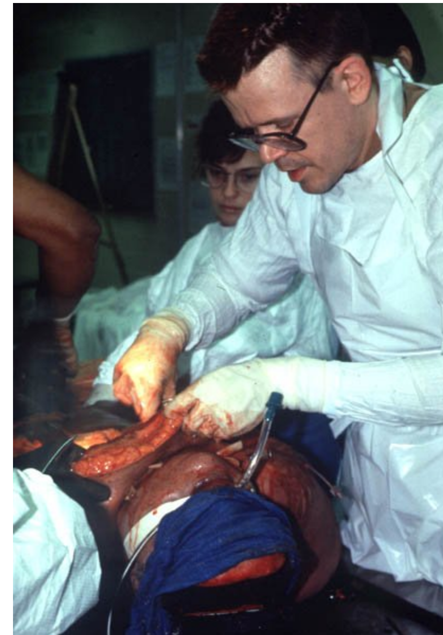
# This is NOT a Coroner



# This is NOT a Coroner

# Common Law Duty

Common law duty upon all citizens to give information which may lead to the coroner having notice of circumstances requiring the holding of an inquest

# Common Law & Statutory Offences

- Common law offence of obstructing the Coroner – disposing of a body before the Coroner can inquire, or otherwise acting to frustrate or prevent an inquest.
- Common law offence of perverting the course of justice.
- Common law offence of contempt of court and statutory offences under the Contempt of Court Act.

# New Statutory Offences - CJA 2009

Schedule 6 (7)(1)- It is an offence to do anything that is:

(a) Intended to have the effect of distorting or otherwise altering any evidence, document or other thing that is given, produced or provided for the purposes of an investigation/inquest.

(b) Preventing any evidence, document or other thing from being given, produced or provided for the purpose of such an investigation.

Or to do anything that a person knows or believes is likely to have that effect.

Schedule 6 (7)(2) – It is an offence for a person:

(a) Intentionally to suppress or conceal a document that is and that the person knows or believes to be a relevant document or

(b) Intentionally to alter or destroy such a document

# Timing of Inquest

- Rule 8 Coroner's Inquest Rules 2013- where practical all inquests must be concluded within 6 months of Coroner being informed of the death

- Rule 5 Coroner's Inquest Rules 2013 – hearing date will be set at the inquest opening

- Implications :
  - More timely completion of reports
  - Powers to compel production and penalties
  - Less notice of inquest hearings

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# LSCBs & SCRs

- The Coroner ***must***
  - notify the appropriate Local Safeguarding Children Board within 3 days
  - provide all information that is held by the coroner for the purposes of an investigation
- The LSCB will have started a serious case review
- Every Agency involved with the child or family prior to death asked to contribute by providing an Agency report
- Likely that your employer will disclose a copy of their Agency report prepared for the purpose of the Serious Case Review and
  - a copy of your interview/statement obtained during their investigation.
- Whilst your statements do not need to be identical, you do need to ensure the facts contained within them are consistent.
- The Serious Case Review will **not be published** until the Coroner's inquest has concluded

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# LSB

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- The requirement to conduct a Serious Case Review is **not mandatory**
- Where a vulnerable adult has died following a serious incident and/or abuse or neglect is suspected, the Coroner **will**
  - be notified at the earliest opportunity
  - co-ordinated by the Adult Social Care Manager
  - area team is likely to have its own protocol; but deaths arising in the following situations should be reported:-
    - deaths where contributory abuse or neglect is suspected particularly domestic violence or services in the statutory, independent or voluntary sector;
    - deaths that occur during a Safeguarding Adults process;
    - deaths that occur immediately after a Safeguarding Adults Process has been completed within the last 30 days

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# LSABs

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- Coroners *may* also be notified when
  - a Large Scale Investigation is started
  - services where it is identified there appears to be a high death rate
- The Coroner *may* have specific questions arising from the death of an adult at risk where
  - serious failing by one or more organisations;
  - no obvious failings but the action taken by organisations requires further exploration/explanation;
  - a death has occurred and there are concerns for others in the same household/ setting (such as a care home)
- The Safeguarding Adults Board will give ***serious consideration*** to instigating a serious case review

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# The Inquest Hearing

- A fact finding Inquiry
- Not intended to apportion blame
- A conclusion can not determine criminal liability on a named person or civil liability

- N.B. Issues bearing on criminal or civil liability may be explored during the course of the inquest

# What should the Inquest achieve?

- Independent scrutiny of events surrounding a violent / unnatural death
- Establish the facts
- Allow properly interested persons an opportunity to question witnesses
- Draw attention to circumstances which might lead to further deaths

# The Inquest

- Must sit with a jury in any death where in custody or detained by the state, including DoLS, police, MH, immigration
- Death related to act or omission of police
- Statutory requirement to notify the death – HSE, ? CQC
- In all other cases it is at the Coroner's discretion

# The Inquest

- Coroner questions witness
- Legal representatives question witness
- Any interested party question witness
- N.B. if sitting with a jury any jury member may ask questions of the witness

# The Professional Social Worker as a Witness

- All evidence must be taken under oath or affirmation
- Witnesses are Competent and Compellable
- Competent- legally competent and has the capacity to understand questions and legal process
- Compellable – Witness can not refuse to answer questions put to him (subject to 4 exceptions)

# The four exceptions to Witness Compellability

- A witness does not have to answer any question that may tend to incriminate him. (Must be cautioned by the Coroner)
- Legal professional privilege
- Protection of a journalist's Source
- Public Interest Immunity (PPI certificate must be issued by the respective Secretary of State seeking the immunity)

# Penalty for Refusing to Answer Questions

- The Coroner there and then can find the witness in contempt of court and remand to prison for a maximum of 28 days or impose a fine of up to £2,500

- Alternatively the Coroner can refer the witness to the High Court where a longer term of imprisonment may be imposed

# Preparing to give evidence

- Arrive early and notify the court of your arrival
- Wear suitable attire
- Familiarise yourself with your statement/report prior to inquest
- Anticipate any questions you think you may be asked and formulate a coherent and logical response
- Tell the your legal representative if you anticipate any problems with your evidence

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# Giving evidence

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- Address the coroner as Sir / Mam, not your worship, your honour or M'Lud and definitely not "mate"
- Address your answers to the coroner or the jury
- Speak clearly and slowly, the coroner / jury / advocates will be taking notes

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# Giving evidence

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- Do not express opinions outside your area of expertise
- If you don't know something, say so
- Use short simple sentences and explain medical terminology
- Do not be rushed

# Answering questions

- Listen to the question and ask for clarification if required

- If you have been giving evidence for a long time and feel you require a break - ASK

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# Giving evidence

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- Do not get rattled or angry
- Do not get into an argument with the coroner, counsel or the family
- Be sensitive
- Refer to the deceased as Mr / Mrs / Miss and their surname
- Be cautious on using the deceased's first name, gauge the mood of the court

# The Importance of records

- Essential part of the evidence

*"You may have done nothing wrong, but unless the medical records prove this, it can be difficult to defend a claim. Courts have a tendency to believe the memory of a patient, for whom it is a once in a life time experience, rather than the memory of a doctor, recalling many years later one of many similar procedures"*

*Medical Protection Society*

# The Press

- Likely to be present at the Inquest
- Will report matters critical
- May well name individuals
- Press statement should be prepared in advance by the Local Authority
- DO NOT speak to the press yourself

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http://www.telegraph.co.uk/news/uknews/law-and-order/11420881/Social-services-i
HCPC - Health and Care P... hpc-uk.org Social services ignored ...
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# Social services ignored 18 warnings about boy, 7, who died after suffering years of abuse

Damning report reveals social services in Southampton repeatedly ignored warnings that Blake Fowler, seven, was in danger before he died

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Teachers, health workers, police and social workers failed to act swiftly enough to save schoolboy Blake Fowler Photo: Daily Echo/Solent

By Agency
4:59PM GMT 18 Feb 2015

A seven-year-old boy who died from a severe head injury tried to tell the authorities about abuse he was suffering at home - but his pleas were repeatedly ignored, a damning report has revealed.

Teachers, health workers, police and social workers have all apologised after failing to act swiftly enough to save schoolboy Blake Fowler.

No one has ever faced any criminal proceedings over his death, despite traces of the ceiling material Artex found in Blake's hair by forensic experts following his catastrophic head injury.

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# Zoe Black inquest: 'Refusal' to visit killer mother 'unjustifiable'

27 February 2015 | Nottingham

Amy Black was sent to a secure hospital after pleading guilty to infanticide

**A "refusal" of a request for a weekend social care visit for a woman who went on to kill her baby daughter could not be justified, a coroner has said.**

Seven-month-old Zoe Black was killed by her mother Amy Black in Nottingham in September 2013.

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China decides to end its decades-long policy of allowing couples to have only one child, China's state-run Xinhua news agency reports.
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Features

CORONERS
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# The scenario

- Death of a child – infanticide
- Criminal proceedings and family proceedings had already taken place
- Multi agency involvement at inquest
- Mental Health issues
- Key issue for the LA and duty social worker at inquest
  - Urgent visit by the EDT required?
  - Discussion with Mental Health Practitioner
  - Communication and inter relationship between the police and social services – whose duty?

- THE GOOD
- THE BAD
- THE UGLY

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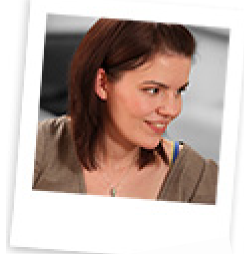

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