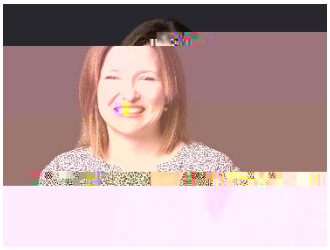
The session was chaired by Nicola Evans, Partner at Browne Jacobson. We were delighted to be joined by a panel of extremely experienced Coroners who shared their insights with over 150 senior leaders and professionals drawn from the health and care sector across England and Wales.

We covered a range of topics including a back to basics reminder of when and why a death is referred to the Coroner and the processes followed by the Coroner when a death is referred, including what happens at inquest.



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All inquests have to be formally opened in Court. The Coroner will set directions for future management of the inquest outlining factors such as interested persons, whether a jury is needed, the scope of the inquest and what evidence is required. This can also be done at a Pre Inquest Review Hearing.

Once all the evidence is available it is reviewed and a decision is made whether more evidence is required or to go to a final inquest hearing.

The purpose of the inquest hearing is set out in Section 5 (1) of the Coroners and Justice Act 2009, which states that the Coroner must ascertain **who** the deceased was, **how**, **when** and **where** the deceased came by his or her death. This means that at the final hearing of the inquest, irrespective of the complexities of the case, the Coroner makes the same determinations on the four statutory questions about the death – **who, when, where, how**.

The question of "how" might change depending of the scope and whether Article 2 of Human Rights Act is engaged.

Question What length of delay in treatment merits investigation?

This is addressed on a case by case basis. The question for the Coroner will be whether there is reasonable cause to suspect that the delay has more than minimally contributed to the death. If so, the duty to investigate will be triggered on the basis that there is reasonable cause to suspect that the deceased died an unnatural death. This will be the case even if the cause of death was natural causes – if delay in treatment has contributed to the death then this becomes an unnatural death.

Timings that would merit investigation depend entirely on the case e.g. in an obstetric case it might be a few minutes or with delays in scanning or diagnosis it might be months that would have an impact on the outcome.

Hospitals have got better at highlighting to the Coroner at an early stage where there might have been some delay or missed opportunity in the treatment.

Medical Examiners often refer these types of cases to the Coroner. Our note of a previous Shared Insights session here sets out the Medical Examiner perspective on notification of deaths.

Question Do all unexpected child deaths automatically trigger an inquest?

No. There are no special rules for neonatal or child deaths. The Notification of Death Regulations 2019 apply to all deaths and do not differentiate between children/neonates and adults. The Coroner's statutory duty to investigate remains as set out in Section 1 of the Coroners and Justice Act 2009. If a child has died a violent or unnatural death, the cause of death is unknown or the deceased died in custody or state detention then there will be an inquest just as there would if the deceased is an adult.

Question What happens if no cause of death is found at post-mortem?

This does sometimes occur but is case specific – just because there is no medical cause of death does not necessarily mean the Coroner is unable to make determinations about whether the death is natural or unnatural. E.g. there might be a case where the body is decomposed and the pathologist is able to determine that there was no unnatural element to the death but they are not able to determine specifically on the balance of probabilities what the medical cause of death was.

Interested Person (IP) status

Individuals and organisations can be awarded IP status by the Coroner, despite the "person" terminology. An IP is defined by Section 47(2) of the Coroners and Justice Act 2009. Organisations and individuals will usually be offered IP status at an inquest under Section (f) or Section (m) of the Act:

"Interested person" in relation to a deceased person or an investigation or inquest under this Part into a person's death, means—

(f)A person who may by any act or omission have

Regulation 28 of the Coroners (Investigations) Regulations 2013 sets out the steps a Coroner must

Tips for assisting the Coroner when considering organisational learning

Mrs Debbie Rookes
Assistant Coroner in the County of Dorset,
Assistant Coroner for Avon

Tips for assisting the Coroner's consideration of organisational learning

Where your organisation may be at risk of a PFD, providing evidence of organisational learning at an inquest is important.

In complex cases where there have been shortcomings in care an organisation will often disclose written evidence in advance of the inquest to provide the Coroner with assurance that their statutory duty to issue a PFD is not triggered. This may take the form of an internal investigation report or an organisational learning report from someone senior, setting out relevant changes made since the death or plans to implement such changes.

Often the family wants to see lessons learned from a death and things changed for the future. That links into the organisation's investigation after the death. Internal investigations need to be robust, consider the right issues, involve staff and make relevant and appropriate recommendations.

It will be important for organisations to ensure that the right people have been involved in the investigation. Often, this will include the witnesses at the inquest as well as the family.

It is important that witnesses are reflective and can talk about recommendations made and actions taken as a result of the internal investigation.

The organisation should also be able to demonstrate how actions are being monitored and audited to ensure changes have been effectively embedded and are driving meaningful change.

The panel agreed that the quality of internal investigations is not always where it needs to be and some PFD Reports have related to the processes in place for investigating patient safety incidents within organisations.

Communication with the family is also so important. Some clinical witnesses give evidence really well, offer condolences and are really good at listening to questions and giving thoughtful responses. This makes a real difference in terms of how those questions are answered, and to the family feeling heard during the inquest hearing.

To read more about PFD Reports, see the note of our previous Shared Insights session on preparing and delivering organisational learning evidence in the Coroner's Court

Questions from the chat

This was a packed session and there were a handful of questions we were unable to cover, so we have set these out below:

Question – What are the Coroners' experiences of PSIRF in the inquest process?

The panel have not seen many PSII reports yet and so it is too early to comment on what impact these are having at inquest but generally the Coroner's Duty to make a PFD Report under Regulation 28 Duty is as set out in the legislation and the format of the investigation does not change this duty. The Trust will need to provide evidence to assure the Coroner that the statutory duty is not triggered. As set out above, that means ensuring the investigation covers the relevant issues and that the clinicians and family are involved in the investigation so that it addresses key learning and is robust and fit for purpose.

See our note from a previous Shared Insights session on organisational learning evidence and Browne Jacobson's Guide on the same topic.

Question There were some questions about organisations engaging with families during the inquest process.

See our note of the previous Shared Insights session we delivered with the Chief Coroner, Irwin Mitchell and NHS Resolution.

Question Have you noticed

Question – The Child Death Review Process, suggests the Child Death Review Meeting (CDRM) should take place prior to the inquest, and then the outcome/feedback of the Child Death Review Meeting should be shared with the Coroner to feed into the inquest (if this is to take place). Once the inquest has taken place, the case can then be referred into Child Death Overview Panel for a final review. As CDOP are not an IP, we would not be entitled to further information about the inquest, therefore we are finding it difficult to time the CDRM prior to inquest. We have been told the CDRM may not reflect the items under consideration by the Coroner.

Any advice on this? Do other areas have a

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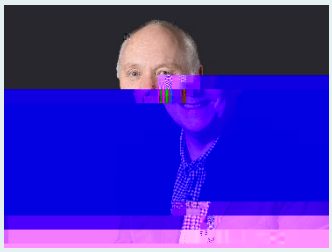

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