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Coronial and Inquest Procedure

Author & Title	[REDACTED]				
Responsible Dept / director:	[REDACTED]				
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1. INTRODUCTION

- 1.1 Coroners are independent judicial officers responsible for investigating the cause of deaths. Coroners inquire into the causes and circumstance of a death solely to ascertain:
 - who the deceased was;
 - how, when and where the deceased came by his or her death; and,
 - the particulars (if any) required by the Births, Deaths and Registrations Act 1953 to be registered concerning the death.
- 1.2 Inquests are legal inquiries into the cause and circumstances of a death, and are limited, fact-finding inquiries; a Coroner will consider both oral and written evidence during the course of an inquest.
- 1.3 The Health Board has a legal and moral obligation to support the Coroner in their duties, and commits fully to doing all it can to assist the Coroner. This procedure sets out how we will respond to coronial investigations and inquests.
- 1.4 The Health Board also supports the expectation of the Coroners that bereaved families are at the heart of the coronial and inquest process. The Health Board and its staff will be respectful of the bereaved and will engage openly, fully, compassionately and in a timely way with all coronial and inquest requests and requirements.

2. SCOPE

- 2.1 This procedure applies to all clinical and corporate services within the Health Board and all staff. The term 'staff' is used throughout this document and includes employees, bank, agency, locums, students etc.

3. ROLES AND RESPONSIBILITIES

- 3.1 The **Executive Medical Director** is the lead executive officer for healthcare law (including coronial and inquest matters). The Executive Medical Director has delegated authority from the Board and Chief Executive to ensure the Health Board complies with this procedure and all coronial and inquest requirements.
- 3.2 The **Deputy Director for Quality Governance** is the lead officer for healthcare law services (including coronial and inquest matters) and is the head of the Healthcare Law Team and principal advisor to the Board on healthcare law matters. The Deputy Director for Quality Governance has delegated authority from the Executive Medical Director to ensure services comply with this procedure with all coronial and inquest requirements.

- 3.3 The **Regulatory Assurance Group** is the lead management group with responsibility for seeking assurance that systems and processes are in place across the Health Board to comply with this procedure and all coronial and inquest requirements. The Executive Medical Director will also chair an **Inquest Oversight Panel** to seek direct assurance and to provide direction to any clinical and corporate services within the Health Board on coronial and inquest matters; the panel will also be the point of escalation for matters of non-compliance with this procedure.
- 3.4 **IHC/Regional Service Directors and their senior leadership teams** are responsible for ensuring this procedure is implemented in their services.
- 3.5 **Operational Managers and Clinical Leaders** are responsible for ensuring this procedure is implemented in their services with a particular responsibility for ensuring their staff are supported pre, during and post inquest.

4. THE ROLE HM CORONER

- 4.1 Coroners are independent judicial officers, appointed by the local authority, and are either doctors or lawyers responsible for investigating the cause of deaths. Coroners inquire into the causes and circumstance of a death under section 5 of the Coroners and Justice Act 2009; inquiries are directed solely to ascertain:
- who the deceased was;
 - how, when and where the deceased came by his or her death; and,
 - the particulars (if any) required by the Births Deaths and Registrations Act 1953 to be registered concerning the death.
- 4.2 A Coroner will conduct an investigation (legal inquiry) when informed that the body of a person is lying within their district (geographical jurisdiction).
- 4.3 Coroner's Officers work under the direction of Coroners. They 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 the Health Board's Healthcare Law Team.
- 4.4 Within North Wales, there are two coronial districts: North Wales (East and Central) covering Wrexham, Flintshire, Denbighshire and Conwy and North Wales (West) covering Gwynedd and Anglesey. Each district has a Senior Coroner who will be supported by a number of Assistant Coroners. *The term "Coroner" is used throughout this procedure, as both Senior and Assistant Coroners have the same powers and authorities when investigating or holding an inquest. Some matters are specific to Senior Coroners, in which cases the term Senior Coroner is explicitly used to mean that official.*
- 4.5 The Coroner is expected to open an inquest where there is reasonable suspicion that the deceased has died a violent or unnatural death, where the cause of death is unknown or if the deceased died while in custody or state detention as defined by section 1(2) of the Coroners and Justice Act 2009.

- 4.6 In addition, the Coroner will also investigate where the deceased has not been seen by the doctor issuing the medical certificate, or during the 14 days before the death.
- 4.7 Coroners will conduct inquests into a death where the deceased's body is lying in their district. Where a body has been washed ashore, the death will be investigated by the Coroner for that district; where multiple bodies have been washed ashore in different locations, the Coroners for those districts will agree between themselves that a 'grouped inquest' might be the best course of action. Where a death has occurred aboard an aircraft, the Coroner residing within the district where the aircraft lands will hold the inquest, regardless of where the aircraft was located when the death occurred. A body returned from abroad will usually be dealt with by the Coroner in the jurisdiction where the body is to be buried or cremated.

5. INQUESTS

- 5.1 Inquests are legal inquiries into the cause and circumstances of a death, and are limited, fact-finding inquiries; a Coroner will consider both oral and written evidence during the course of an inquest. The Coroner's duty to hold an inquest is contained in section 6 of the Coroners and Justice Act 2009.
- 5.2 An inquest will open to record a death, ensure the deceased is identified and for a body to be released for burial or cremation.
- 5.3 Where suspicion arises that the deceased's death was caused by a criminal act, the Coroner will open an inquest, and then adjourn it until the conclusion of any criminal proceedings has been finalised, *sine die* (without fixed date). It is the Coroner's prerogative to resume an inquest following a criminal trial, but where an inquest does resume, its outcome (conclusion or determination) as to the cause of death, must not be inconsistent with the outcome of the criminal proceedings. Coroners can themselves (without external influence) adjourn inquests pending a public inquiry as set out in paragraph 3 of Schedule 1 of the Coroners and Justice Act 2009 or under Rule 25(4) of the Coroners (Inquest) Rules 2013.
- 5.4 In more complex cases, the Coroner may also hold a Pre-Inquest Hearing(s) (PIH) where the scope of the inquest will be considered, including possible timeframes, witnesses and directions will be set. Pre-inquest hearings will usually be held in public except where it is in the 'interests of justice or national security', under Rule 11(5) of the Coroners (Inquests) Rules 2013. The Coroner will invite 'properly interested parties' to these hearings for the opportunity to make representations to the Coroner, where required.
- 5.5 The Coroner will mostly sit alone to hear an inquest, but there are certain circumstances (as defined by section 7 of the Coroners and Justice Act 2009) which place a requirement upon the Coroner to summon a jury to hear an inquest case.

- 5.6 The designation of “Interested Person” (IP) is determined by the Coroner. Being given the status of interested person gives a person or entity the right (if they wish) to participate, and to play an active part in the inquest hearing or any pre-inquest hearing. In most cases where the Health Board or its staff will need to play an active role in an inquest or where its actions may have contributed to the death, this status would be given to the Health Board by the Coroner.
- 5.7 There are two types of inquest; a traditional inquest (also known as a “Jamieson Inquest”) which requires the Coroner to consider by what means the deceased came to his death (as detailed in section 5.9 below) or an Article 2 inquest (also known as a “Middleton Inquest”) in which there is a wider reaching enquiry into not only by what means the deceased died but also the circumstances surrounding the death.
- 5.8 Article 2 inquests are enhanced inquests held in cases where the State or 'its agents' have 'failed to protect the deceased against a human threat or other risk' or where there has been a death in custody. Cases where the deceased has been under the care or responsibility of social services or healthcare professionals are sometimes included in this category of inquest.
- 5.9 An inquest produces a conclusion (previously referred to as a verdict, although as mentioned elsewhere it is not a trial). There is no definitive list of conclusions available to a Coroner. The following are those most commonly used:
- natural causes (including fatal medical conditions);
 - accident or misadventure;
 - industrial disease;
 - dependence on drugs/non-dependent abuse of drugs;
 - attempted/self-induced abortion;
 - disasters subject to public inquiry;
 - lawful killing (such as deaths caused during acts of war, or self-defence);
 - unlawful killing;
 - suicide;
 - alcohol/drug related death, and
 - road traffic collision.
 - open verdict (where there is insufficient evidence for any other verdict)
- The conclusion of unlawful killing is restricted to the criminal offences of murder, manslaughter (including corporate manslaughter), and infanticide.
 - Coroners or a jury may also deliver a 'narrative' conclusion which sets out the facts surrounding the death in more detail. This longer explanation will include the Coroner's or jury's conclusions on the main issues arising in the surrounding circumstances of the death.
 - The Coroner is also not bound by the list of suggested conclusions above; this means that as long as the Coroner can form a conclusion which is

concise and indicates how the deceased came by their death, a narrative verdict is acceptable.

- 5.10 The inquest does not set out who is responsible for a death. It is not the Coroner's role to determine whether any civil or criminal liability attaches to any named person or to apportion blame. The Coroner is unable to apportion any blame or civil or criminal liability of another individual as defined by section 10(2) of the Coroners and Justice Act 2009.
- 5.11 The Coroner can add a rider of "neglect" to the conclusion where they feel that there was a missed opportunity or gross failure to provide medical attention. There must be a clear connection between this neglect and the cause of death on "the balance of probabilities". In the Coroner's court, neglect does not imply negligence
- 5.12 All inquests are held in public (except in the 'interests of justice or national security'), allowing members of the public and journalists the right to attend. Coroners are permitted to hold sections of inquests privately (Rule 11 of the Coroners (Inquest) Rules 2013), although this will only apply to a specific part of the hearing (usually evidence that may prejudice or compromise national security if disclosed into the public domain).
- 5.13 Most inquests are heard by the Coroner sitting alone. However in certain circumstances a Jury may be called. 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.
- 5.14 Under Rule 8 of the Coroners (Inquest) Rules 2013, Coroners are required to complete an inquest within 6 months of the date on which the Coroner is made aware of the death, or as soon as is reasonably practicable.
- 5.15 Coroners can impose reporting restrictions to ensure risks to prejudicing the administration of justice are avoided; these include specific powers to prohibit the publication of personal details of any children or young people who appear as a witness.
- 5.16 As mentioned above, criminal proceedings will usually be heard and finalised before an inquest is fully heard. Any civil proceedings (for example for claims) will normally follow an inquest, as facts about the cause of death will then be known.
- 5.17 There is no right of appeal of the conclusion of a Coroner. It is inevitable that some parties may be aggrieved by the conclusion and seek to have this overturned. This is effected by way of a judicial review. This is not a re-hearing of the facts; the review hears the specific application that the matter was dealt with in a manner that was unlawful, procedurally unfair and/or irrational. A successful review may result in a re-hearing but would not substitute a

conclusion. The decision to bring forward a judicial review is significant and is a reserved matter for the Board, which would be on the basis of a recommendation from the Executive Medical Director and Deputy Director of Quality Governance informed by legal advice.

6. NOTIFICATION OF DEATHS

- 6.1 The majority of deaths are not reported to the Coroner and in most cases the deceased's doctor will issue a medical certificate with the cause of death without reference to a Coroner, especially if they have been treated for an illness which caused the death. There are strict rules governing when a doctor may do this. They must know what illness caused the patient's death and must have seen and treated them for that illness within the 28 days before they died (this can include face to face or video). These rules are in place to safeguard patients and ensure that death reporting and registration is accurate. Doctors must be familiar with the requirements for completing medical certificates of the cause of death (MCCD) and only sign statements they believe to be true.
- 6.2 The Notification of Deaths Regulations 2019 require a doctor (who is registered with the GMC and has a licence to practise) to make a notification to the Senior Coroner in the area where the deceased's body lies, under certain circumstances. These are:
- poisoning, including by an otherwise benign substance (such as salt/sodium) and refers to either deliberate or accidental intake of poison;
 - the use of a medical product, controlled drug or psychoactive substance;
 - violence, trauma or injury (including those that are self-inflicted as well as assaults and accidents);
 - self-harm;
 - neglect, including self-neglect;
 - death due to a person undergoing a treatment or procedure of a medical or similar nature;
 - an injury or disease attributable to a person's employment;
 - where the practitioner suspects the person's death was unnatural;
 - deaths in custody or state detention;
 - cause of death or identity of the deceased is unknown.
- 6.3 If there is no doctor available who can issue this certificate, the death must be reported to the Senior Coroner.
- 6.4 Where the death is suspicious, it is important to inform the police straight away. For deaths that are not suspicious, but need to be reported to the Coroner, the expectation is that this will be done as soon as reasonably practicable.

- 6.5 There is a common duty upon all citizens to give information which will inform a Coroner of circumstances for when an inquest should be held. It is a common law offence to obstruct a Coroner, whether by disposing of a body before a Coroner can openly inquire into the circumstances of a death or acting to prevent an inquest.
- 6.6 The Coroner may request a post mortem to assist with investigations into the cause of death. All post mortem reports requested by the Coroner are therefore the possession of the Coroner. The Health Board may request a copy of the Coroner's post mortem report for the purposes of an internal patient safety investigation. All requests are made through the Healthcare Law Team and are solely at the Coroners discretion.
- 6.7 When referring a death to the Coroner, doctors or other staff should inform the family that they are referring the death to the Coroner including an explanation of the reason for the referral and they must advise the family that they will receive a telephone call from the Coroner or their Officer.

7. INTERFACE WITH HM CORONER

- 7.1 The notification of a death is made direct to the Senior Coroner by the doctor, or other person if appropriate (see above).
- 7.2 The Executive Medical Director and Deputy Director of Quality Governance will meet with the Senior Coroners on a regular basis to maintain effective working relationships and to resolve any issues.
- 7.3 The Coroners, and their Officers, will liaise with the Healthcare Law Team once an investigation or inquest is opened. The Healthcare Law Team act as the single point of contact for the Coroner and their Officers and this centralised process has been agreed between the Health Board and the Senior Coroners. Staff should not send statements or evidence direct.

8. COORDINATION OF AN INQUEST

- 8.1 The Healthcare Law Team will coordinate all requests from the Coroner and all matters relating to inquests including submission of statements and evidence and coordination of witness availability for the inquest.
- 8.2 When notified by the Coroner of an investigation or inquest, the Healthcare Law Team will open a file on the Datix quality management system and complete an initial case review including a risk assessment tool.
- 8.3 The initial case review will include searching for any investigation report (incident, complaint, mortality or claim). Where a death appears serious but no investigation can be located, the Patient Safety Team will be notified to determine if a review is needed. Equally, where an inquest file has already been opened but a subsequent incident, complaint, mortality review or claim

is completed which identified failures contributing to a death, the respective corporate team must proactively alert the Healthcare Law Team to this new information.

- 8.4 The risk assessment tool will determine the level of case handling, as below:
- Level 1 – lower risk cases will be managed by the Healthcare Law Manager aligned to each Integrated Health Community;
 - Level 2 – medium risk cases will be managed by the Lead Healthcare Law Manager (or another specialist member of the team designated by them) who acts as case manager;
 - Level 3 – high risk cases will be managed by a healthcare lawyer (which could be an in-house lawyer, or a lawyer from NHS Wales Legal and Risk Services or legal firm instructed to act on behalf of the Health Board).
- 8.5 The Deputy Director of Quality Governance has the delegated authority to instruct legal representation for inquests and to authorise legal submissions.
- 8.6 In certain extreme cases, the Health Board may determine that current or former staff will not be subject to its support or representation. In these cases, any person affected will be advised to seek their own legal representation. These cases are extremely rare and in all cases require the approval of the Deputy Director of Quality Governance or Executive Medical Director.

9. PROVISION OF STATEMENTS

- 9.1 The Coroner and their Officers will give instructions to the Healthcare Law Team on the statements they require. This could be requesting statements from specific staff, or specific specialities or services. The Healthcare Law Team will liaise with those members of staff, and where possible their line manager, to facilitate statements.
- 9.2 Statements should be submitted to the Coroner within 4 weeks. The statement must be submitted on the standard template and signed.
- 9.3 In cases where specific statements are not requested, the Healthcare Law Team will seek to provide a single overview statement covering the care provided to the patient. The Coroner and their Officers may then request further specific statements if they feel it necessary.
- 9.4 Where clarity is needed on who should provide a statement, the Healthcare Law Team will liaise with the IHC Medical Director or Regional Service Director to confirm.
- 9.5 Staff required to provide a statement should do so within 10 working days. Where this is not possible, such as due to sickness or annual leave, a revised date must be agreed between the staff member and Healthcare Law Team within the overall 4 week deadline.

- 9.6 Where a statement is overdue the Healthcare Law Team will issue a reminder to the staff member.
- 9.7 Where a statement is overdue for more than 5 working days, the Healthcare Law Team will escalate the matter to the relevant IHC/Regional Service Director (relevant to the professional role of the staff member).
- 9.8 Where a statement is overdue for more than 10 working days, the Healthcare Law Team will escalate the matter to the Executive Medical Director.
- 9.9 Operational managers and clinical leaders must ensure their staff have protected time to complete a statement when one is requested, and that staff are properly supported throughout the process.
- 9.10 When providing a statement, it is essential to have read the appropriate clinical records and/or other relevant documentation. In the unlikely event that records are not available, it is essential that this is clearly stated within the statement that the information contained is from memory only.
- 9.11 Staff should always retain a copy of their statement to refer to in the event of being called to the inquest as a witness (the Healthcare Law Team can provide a copy if it is misplaced).
- 9.12 The Healthcare Law Team (or instructed lawyer) will support staff with preparing statements by providing expert advice and guidance. The Healthcare Law Team (or instructed lawyer) will also undertake a quality check on the final statement before issue to the Coroner. However, for clarity, the statement is a formal legal submission by that member of staff and must be their own statement. No person shall interfere with a statement or provide pressure for any information to be included or excluded.
- 9.13 As detailed below, staff are reminded that failure to submit a statement or failure to submit within the agreed timeframe without a reasonable excuse and agreed extension is both a professional matter and could lead to sanctions from the Coroner.

10. PROVISION OF EVIDENCE

- 10.1 The Coroner and their Officers may give instructions on the specific evidence they require. This could be specific documentation such as clinical records or investigation reports and action plans (with supporting evidence where actions are complete).
- 10.2 Evidence should be submitted to the Coroner within 4 weeks of their request or at least 4 weeks prior to the inquest. The Healthcare Law Team will establish an internal deadline for the submission.

- 10.3 As a matter of routine, where an investigation has been undertaken (incident, complaint, mortality or claim) then the report and action plan will be submitted. The approved report and action plan uploaded to the Datix quality management system will be submitted. Where an investigation has not been completed, the Healthcare Law Team will submit once it is finalised and approved. However for clarity, the Healthcare Law Team do not monitor the timeliness or quality of investigations as this is the responsibility of the Patient Safety Team (please refer to the Incident Procedure).
- 10.4 As a matter of routine, where an investigation has been undertaken (incident, complaint, mortality or claim) then the service will be asked to submit a learning statement. This statement will be from an operational manager or clinical leader and will set out the learning and improvements made as a result of the investigation. Evidence shall be attached to the statement as appendices. The learning statement will be provided within 4 weeks of the request from the Coroner or at least 4 weeks prior to the inquest. The Healthcare Law Team will establish an internal deadline for the submission. Where clarity is needed on who should provide a learning statement, the Healthcare Law Team (and any instructed lawyer) will liaise with the IHC Medical Director or Regional Service Director to confirm.
- 10.5 Where evidence is overdue the Healthcare Law Team will issue a reminder to the staff member.
- 10.6 Where evidence is overdue for more than 5 working days, the Healthcare Law Team will escalate the matter to the relevant IHC/Regional Service Director (relevant to the professional role of the staff member).
- 10.7 Where evidence is overdue for more than 10 working days, the Healthcare Law Team will escalate the matter to the Executive Medical Director.
- 10.8 The Healthcare Law Team (or instructed lawyer) will undertake a quality check on evidence to identify any gaps however the collection of evidence is a core part of the Incident Procedure and should be conducted for the purposes of learning and improvement, not solely for the purposes of the Coroner. For clarity, the evidence cannot be altered or manipulated for submission to the Coroner. No person shall interfere with evidence or provide pressure for any evidence to be excluded.

11. SUBMISSION OF STATEMENTS AND EVIDENCE

- 11.1 The above sections highlight the deadlines and escalation process for statements and evidence. The deadlines are those agreed with the Senior Coroners and non-compliance is a reputational issue for the Health Board and a professional issue for staff. Not only does lateness demonstrate disrespect to the Coroners as judicial officers, delays can cause significant

distress for bereaves families. The Health Board and all its staff will ensure these deadlines are met.

- 11.2 In some cases, Coroners may issue Directions. These require the submission of statements or evidence by a fixed deadline. Such deadlines must be met.
- 11.3 A Coroner may also issue a formal notice requiring submissions. Schedule 5 of the Coroners and Justice Act 2009 gives Coroners the power to require evidence to be given or produced. Intentional suppression or concealment of a document believed to be relevant, or its alteration or destruction, can result in criminal sanctions including a fine of up to £1,000 or up to 51 weeks in prison.
- 11.4 As above, the Healthcare Law Team (supported by any instructed lawyer) coordinate all coronial investigations and inquests. Adhering to the deadlines set will ensure staff are not subject to the risks outlined above.

12. PRE-INQUEST SUPPORT

- 12.1 The Healthcare Law Team coordinate all coronial investigations and inquests and act as the interface between the Coroner and the Health Board. This includes local Coroners and out of area Coroners. The team (supported by any instructed lawyer) will provide support to any staff throughout the process.
- 12.2 This support will include expert support and guidance on the coronial and inquest process, support with drafting statements, quality checking draft statements and any other reasonable support possible. All witnesses will be offered 1:1 pre-inquest support and in most cases, a pre-inquest session will be held with all witnesses to offer support. Confidential support can also be provided to staff by contacting the Lead Healthcare Law Manager.
- 12.3 The Healthcare Law Team cannot tell staff what to say as evidence should be a factual account and cannot be influenced. Evidence is the staff members own evidence, which is given under oath or affirmation 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 to be concerned about.
- 12.4 All operational management and clinical leaders should ensure staff are supported through the coronial and inquest process.
- 12.5 The Healthcare Law Team have a list of “inquest buddies” who are front line staff with experience of inquests, who are able to provide buddy support to staff on their request, in addition to any support from their managers or the Healthcare Law Team.

13. ATTENDANCE AT INQUESTS

- 13.1 Coroners have the power to call witnesses to appear at an inquest, and to determine the evidence to be heard. It is the general duty of every citizen (under common law) to attend an inquest if they are in possession of any information or evidence that details how a person came to their death.
- 13.2 Notification to appear as a witness will generally be informal via the Healthcare Law Team, but a Coroner can issue a summons (these will also be via the Healthcare Law Team). Summonses are issued under the Coroner's common law powers and are governed by the directions set out in the Civil Procedure Rules. Where a summons is issued, and the witness cannot attend, valid proof must be provided to seek an exemption (such as a GP note for sickness or proof of pre-booked foreign travel, etc) and this is at the sole discretion of the Coroner.
- 13.3 Coroners can issue two types of summonses: requiring attendance to give oral evidence, and requiring attendance to produce documents. Oral evidence could be in-person at the Coroner's Court or sometimes conducted virtually (at the discretion of the Coroner). All witnesses can be compelled to attend a Coroner's Court; a person cannot refuse to be a witness because they fear their evidence may lead to them being charged with an offence connected with the death of the deceased. Once sworn in, a witness may refuse to answer any questions put to them on the grounds of self-incrimination (Rule 22 of the Coroners (Inquests) Rules 2013).
- 13.4 The order in which witnesses are called is determined by the Coroner. The Coroner usually calls the Pathologist first (if applicable), 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.
- 13.5 The Health Board recognises that giving evidence at an inquest can be a very stressful and daunting experience and the Healthcare Law Team (or instructed lawyer) will provide advice and support throughout the process.
- 13.6 A member of the Healthcare Law Team (or instructed lawyer) will be present at every inquest to represent the Health Board and support witnesses. However, only legally qualified professionals have a right of audience to advocate for the Health Board at the inquest.
- 13.7 Staff must be punctual and smartly dressed. Not only does this help to convey a professional image, but will also demonstrate respect for the family of the deceased. Unless instructed otherwise, staff should arrive at court at least 30 minutes before the start of an inquest (or be present virtually in advance if an online hearing). 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.

Staff must ensure that mobile devices are switched off before entering the court.

- 13.8 The degree of formality in the court depends largely on the individual Coroner, although all evidence will be given under oath or affirmation. Witnesses may 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 Health Board. When responding, staff should address their answers to the Coroner. When addressing the Coroner, address him or her as Sir or Ma'am.
- 13.9 The media will often be present at an inquest. Staff should not make any statements to the media, and journalists must be directed to the Health Board's Communications Team.
- 13.10 Bereaved families or friends may often attend an inquest. Staff may wish to speak to families and friends, particularly if a prior relationship exists through clinical contact or an investigation. The Health Board supports this but reminds staff that care must be taken to avoid discussing sensitive information in a public place, and that on occasion families or friends may find an inquest upsetting. If families or friends have concerns they wish to explore further, the Healthcare Law Team can ensure these are directed to the best team such as the Complaints Team or Patient Advice and Liaison Service (PALS).
- 13.11 Whilst inquests are generally public hearings, the Health Board is mindful of showing respect to the Coroner and bereaved families. Therefore only those with a role at the inquest should attend. This will include the Healthcare Law Team coordinating the case, any legal representative, any witnesses and staff supporting those witnesses (to be kept to a sensible minimum), and if appropriate a member of the Communications Team.

14. POST-INQUEST SUPPORT

- 14.1 The Healthcare Law Team will provide support to witnesses post-inquest. This will include an offer of confidential support, 1:1 support, a debrief meeting, and/or signposting to staff support services.
- 14.2 In addition, all operational managers and clinical leaders should ensure staff are supported.
- 14.3 The Healthcare Law Team will collect feedback from staff involved in the inquest process through an anonymous survey, which will be used to inform improvements in the coordination of inquests and the support provided to staff.

15. POST-INQUEST ACTIONS INCLUDING REGULATION 28 NOTICES

- 15.1 Following an inquest the Coroner may make requests for further assurances and give a deadline for these to be provided. This is often to support their decision making in regards to any potential Prevention of Future Deaths Report as outlined below. The Lead Healthcare Law Manager will receive all such requests and will liaise with the Deputy Director of Quality Governance to ensure these are reviewed, considered and responded to accordingly. The response will be signed by either the Deputy Director of Quality Governance or the Executive Medical Director as appropriate based upon the seriousness.
- 15.2 Following an inquest the Coroner can make recommendations to prevent future deaths from occurring, previously known as a 'Rule 43 Report' but now known as a Prevention of Future Deaths Report (also known as a Regulation 28 Report or PFD) as set out in paragraphs 28 and 29 of the Coroners (Investigations) Regulations 2013.
- 15.3 The respondent of a Regulation 28 Notice is given 56 days to reply in writing, giving details of actions that have been taken or proposed to be taken, or an explanation as to why no action will be taken to prevent future similar deaths. Copies of all responses will be sent to the Chief Coroner, who may publish the response or a summary of it, unless the Coroner has exercised his/her power to request a restriction to the publication to the Chief Coroner (under paragraph 29(10) of the Coroners (Investigations) Regulations 2013).
- 15.4 The Deputy Director of Quality Governance will receive all Regulation 28 Notices for the Health Board and will liaise with the Executive Medical Director to ensure these are reviewed, considered and responded to accordingly. The response will be signed by the Executive Medical Director.
- 15.5 An inquest may identify further learning for the Health Board. Following each inquest, an outcome summary will be shared with the services involved. The Lead Healthcare Law Manager will keep a log of any additional learning and will report this into the Organisational Learning Forum.

16. TRAINING AND GUIDANCE

- 16.1 The Healthcare Law Team will provide a rolling programme of training for staff covering statement writing and inquest preparation. The Senior Coroners routinely support the team with training. In addition, guidance resources will be available on the Healthcare Law Intranet.

- 16.2 In addition, as detailed above, individual and group support will be available at all stages of an inquest.

17. RECORD KEEPING

- 17.1 ALL CORONIAL INVESTIGATION and inquest records will be held on the inquest module of the Datix quality management system.

18. ASSURANCE AND MONITORING ARRANGEMENTS

- 18.1 The Regulatory Assurance Group (RAG) is the lead management group with responsibility for seeking assurance that systems and processes are in place across the Health Board to comply with this procedure with all coronial and inquest requirements. The group reports to the Quality Delivery Group (QDG) and onwards to the Quality, Safety and Experience (QSE) Committee as the lead assurance committee of the Board for healthcare law.
- 18.2 The Executive Medical Director will chair an Inquest Oversight Panel to seek direct assurance and to provide direction to any clinical and corporate services within the Health Board on coronial and inquest matters; the panel will also be the point of escalation for matters of non-compliance with this procedure.
- 18.3 All Integrated Health Communities and Regional Services are required to establish a forum for the oversight and monitoring of coronial and inquest matters. In most cases this will be an existing forum such as the local quality group or local Putting Things Right (PTR) Meeting and/or a dedicated Inquest Board Round.
- 18.4 The Deputy Director of Quality Governance will seek assurance from IHC and Regional Services on their compliance with this procedure, and the implementation of any actions arising from an inquest including Regulation 28 Notices.
- 18.5 The Deputy Director of Quality Governance will scrutinise the performance of the Healthcare Law Team through the Quality Governance Directorate Management Team Meeting.
- 18.6 A dashboard of key performance indicators will be developed and maintained; this will include submission performance and feedback from staff involved in the process.

19. EQUALITY INCLUDING WELSH LANGUAGE

- 19.1 The Healthcare Law Team will support all staff with reasonable adjustments.

19.2 The Healthcare Law Team will work with staff and Coroners with regards to a preferred language. The Chief Coroners Guidance Note (No. 21) is clear that for inquests held in Wales, the Welsh language may be spoken by any person, not just a witness. Any interpreter used must sign an oath or affirmation.

20. REVIEW

20.1 This procedure will be reviewed in 1 year or sooner in the light of changes to legislation or organisational arrangements, or in light of findings from assurance and monitoring activity.

21. REFERENCES

- Coroners and Justice Act 2009 ([Link](#))
- Coroners (Investigations) Regulations 2013 ([Link](#))
- Notification of Deaths Regulations 2019 ([Link](#))
- Notification of Deaths Regulations 2019 Guidance ([Link](#))
- Guidance for Doctors completing Medical Certificates of Cause of Death in England and Wales ([Link](#))
- National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (aka the Putting Things Right Regulations) ([Link](#))
- Births, Deaths and Registrations Act 1953 ([Link](#))