

Inquests into deaths following medical treatment

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0845 123 2352 (Mon to Fri 10am - 5pm)

www.avma.org.uk

Although inquests can be held in many circumstances this leaflet provides information about inquests following medical treatment here we refer to this as a 'medical inquest'. This leaflet will explain the inquest process, the role of the coroner, your involvement and possible verdicts. You may also obtain more detailed information on inquests in general from the Ministry of Justice's Guide to Coroners and Inquests.

The Inquest

An inquest is usually opened soon after a death to record that the death has occurred and to identify the deceased, it is then usually adjourned and a date set for a full hearing. This generally enables burial or cremation to take place without any delay. The time before the inquest is resumed enables the coroner to make enquiries. The enquiries may take about 3-4 months, sometimes over a year. When evidence needs to be collected from hospitals and doctors, as is usual in a medical inquest, enquiries may take longer. But this also gives time for the families to take advice and submit questions or evidence to the coroner.

An inquest is a fact finding enquiry. Its purpose is to answer the following questions on behalf of the State:

- The name of the deceased;
- When they died;
- Where they died;
- How they came to their death

The coroner for the district where the person died is in charge of the inquest. So, if the deceased lived in Sheffield but died in North Devon the coroner will be the coroner for North Devon. A coroner must be either a lawyer or a doctor and may be both. Each coroner has a deputy and one or more assistant deputies who may hold the inquest on the coroner's behalf. The coroner is often assisted in making enquiries by his or her officer (although some coroners do not employ an officer to carry out investigations, handling this themselves).

The coroner's officer will liaise between you and

the coroner during the investigation period before the actual hearing, passing on your questions and requests for information.

When is an inquest held and who is involved in making it happen?

If there is uncertainty when a person dies following medical treatment it may be referred to the Coroner. It is the coroner who decides on whether or not an inquest takes place. This may be because the death is connected with an operation or occurs following the administration of an anaesthetic. If the death is sudden and there has been no medical attention for a period of time, or doctors cannot confirm the cause of death, or there has been a violent or unnatural death occurring within the jurisdiction of the coroner, they will refer the case to the coroner. If you have concerns about the cause of death or wish there to be an inquest you or a representative should tell the coroner as soon as possible after the death. If you are unsatisfied with any aspect of the medical treatment of a friend or relative, you can make a formal complaint against the healthcare provider even whilst the inquest process is ongoing. There is a 6 month time limit for making a complaint so it is usually best to make the complaint even if there is an inquest. AVMA may help you with this.

What investigations are needed to prepare for a medical Inquest?

An inquest may be the only chance to find out about the circumstances of your relative's death. If you are unhappy with the inquest findings, or perhaps that a particular witness was not called, you are unlikely to be able to get the inquest re-opened. Therefore it is important that the coroner is aware of all your concerns as early in the investigation as possible. It is also helpful to have a realistic understanding of the limitations of the inquest process, this will help set realistic targets for you about what might be achieved, and avoid some of the frustration you may feel that the inquest is not able to answer all your questions. An inquest is not permitted to state whether someone has criminal or civil liability for the death, it is about what happened, not who was responsible for what happened.

To find your local coroner you can go to www.coronersociety.org.uk/ and on their front page is a search facility to look for your local coroner.

You can contact the coroner's court by post or by ringing the court and talking to the coroner's officer. We would also recommend that you either get legal advice or contact our **Medico Legal Advice Service Helpline on 08451 232352** as soon as possible for immediate advice about how to deal with the inquest.

Putting together all this evidence for the coroner in a short space of time, in order to support your concerns, can be complex and difficult. AVMA can assist in many cases. We may also be able to refer you to one of our panel of solicitors, who are specialists in clinical negligence litigation and understand the medical terms and issues involved in these cases.

Key information that should be made available to the coroner is as follows:

- **The deceased's medical notes and records.** These are available to the next of kin or personal representatives of the deceased's estate under the Access to Medical Records Act 1990. The coroner should also have access to the records. If you have legal representation your advisor will most likely sort the records into a file with clearly marked page numbers. This saves time for everyone in the inquest, and makes it much easier to ask questions.
- **Statements from family members about the facts surrounding the death.** A legal representative or AvMA can advise on whether the statement contains all the information a coroner needs. The coroner will obtain statements from those involved in the deceased's treatment.
- **The post mortem report.** You may request a copy from the coroner and any statements that have been provided to him or her.
- **Evidence the family believes is relevant to the cause of death.** Requests can be made to the coroner to call this evidence although ultimately he or she will decide on what evidence he will hear. You can identify possible witnesses from the medical records and statements. Witnesses may be doctors, nurses, pathologists, hospital managers or even another patient from the same ward if able to give evidence on what he or she saw of the deceased's care.
- **Expert evidence.** A coroner may call for expert evidence but you may also instruct an independent medical expert.. For instance, if the deceased died following heart surgery, you may wish to instruct a heart surgeon to advise the coroner on the surgical technique used

The Coroners Court

Most inquests are conducted by the coroner alone with his or her officer present for assistance. Occasionally the inquest may be held with a jury. In a jury inquest, the coroner decides matters of law and procedure and the jury decides the facts of the case and reaches a verdict. Neither the coroner nor a Jury are allowed to blame any individual or institution for the death. A jury is usually only called where the death occurred in custody or at work but may (very rarely) be called in cases of deaths in a health care setting.

Many coroners do not have specific courts and waiting rooms are very limited. When you arrive at the inquest, you may have to share your waiting area with other witnesses, including people you may hold responsible for the deceased's death. It is important to be aware of this likelihood in advance, also to recognise that this is a public hearing, any evidence given at the inquest can be reported

The Hearing

You may be attending the inquest with a legal representative, who will ask questions and analyse the evidence objectively. The legal representative may persuade the coroner to allow questions exploring broader issues than the immediate events surrounding the death. AvMA or the solicitor who advises you in the run up to the inquest may be able to assist in finding you a barrister to act for you at the hearing. You will be able to give evidence at the inquest if the coroner considers you are a properly interested person. Generally, parents and siblings of the deceased are properly interested parties, as are husbands, wives, children, fiancés and common law partners.

The coroner will begin the inquest by confirming its purpose (see box 1 above). The coroner will then call the witnesses including expert witnesses if there are any. She or he will usually begin by taking the witness through their statements or reports then ask questions. In a medical inquest, it is essential that the medical records are available to everyone involved (coroner, witnesses and legal representatives)

Once the coroner has finished questioning the witness the legal representatives for all the interested parties may ask questions, this may include the healthcare provider. If you do not have legal representation you may ask the witness questions yourself. The coroner may intervene when the witnesses are being questioned if he or she thinks the question inappropriate. Repeated attempts to get a witness to answer questions in an incriminating way may lead to a coroner refusing to let the questioner ask any more questions. The coroner has ultimate authority in his court. Once all the evidence has been heard, legal representatives may request the opportunity to suggest a possible verdict. This is called legal submissions.

The Verdict

At the end of the inquest the coroner will sum up the evidence, if there is a jury, and declare his/her verdict. The coroner may decide to take time to consider his or her verdict and provide it in writing or orally (or both) at a later date. Because the inquest is purely a fact finding mission the verdict may seem unnecessarily restrictive to you.

The verdicts most commonly used at medical inquests are natural causes, open verdict, want of attention at birth, accident/misadventure.

Whilst the coroner might arrive at a verdict of misadventure or natural causes, it is the summing up or "narrative verdict" that will be more important. The coroner may not blame any named individual for the death, nor suggest criminal or civil liability in his or her verdict. However, while the verdict may be that the death was by natural causes, the analysis may conclude that recent surgery also played a part. That may be important evidence to help understand whether or not the medical care provided to the deceased was of a satisfactory standard and whether the death was avoidable.

The verdicts explained

- **Open verdict:** This cause of death cannot be established and doubt remains as to how the deceased died.
- **Contributed to by neglect:** This phrase (or systemic neglect) can also be considered in circumstances where the evidence shows that insufficient actions were taken to prevent a death. This is a verdict that sometimes is being returned where there is clear evidence before the coroner that a medical condition should have been recognised and was not treated or that a person was denied the basic needs of food or water.
- **Accident death/misadventure:** This means that the person died as a result of actions by themselves or others that went wrong or had unintended consequences.
- **Suicide:** for such a finding the Coroner must be satisfied beyond all reasonable doubt that the deceased meant to kill themselves. Likewise to reach a verdict of unlawful killing the coroner must be sure beyond all reasonable doubt that cause of death was unlawful.
- It is very rare for coroner to find that a hospital has neglected the deceased and that caused the death and even if such a verdict is returned it will not blame any individual or institution.

| Organisation | How it can assist | Contact details |
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| AvMA | Medico-legal advice, list of specialist lawyers, advocacy service | 0845 123 2352 www.avma.org.uk |
| HMSO for the leaflet | Detailed information leaflet about Inquests | www.coronersociety.org.uk/wfPublicAnnDet.aspx?id=54 |
| Inquest | Helps with Inquests arising out of deaths in Custody | 020 7263 1111 www.inquest.gn.apc.org/ |
| Liberty | Has information about Inquests | 0845 123 2307 www.liberty-human-rights.org.uk |
| The Coroners' society of England and Wales | Shows addresses for all Coroners | www.coronersociety.org.uk |
| SANDS | Helpline for anyone who has been affected by the death of a baby and wants to talk to someone about their experience | 020 7436 5881 |
| Cruse | Promotes the well-being of bereaved people and enables anyone bereaved by death to understand their grief and cope with their loss | 0844 477 9400 www.crusebereavementcare.org.uk/ |
| Coroners Courts Users Services | Emotional and practical support to families and other witnesses attending Inquests | 0207 802 4763 www.coronerscourtsupportservice.org.uk/ |
| Direct Gov | For information about Coroners, post-mortems and inquests | www.direct.gov.uk/en/GovernmentCitizensandRights/Death/WhatToDoAfterADeath/DG_066713 |

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