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A GPs guide to inquests

What is an inquest?

An inquest is a fact-finding inquiry, held by a Coroner. It is not a trial and the Coroner does not seek to apportion blame. The purpose of an inquest is to find the answer to four key questions – *who the deceased was, when they died, where they died and how they died.* As a doctor, you may be asked by the Coroner to provide medical records and a report. During the inquest itself, the Coroner will consider all the relevant evidence before coming to a conclusion. The Coroner may give a short form conclusion, such as natural causes or accident. Alternatively, the Coroner may give a narrative conclusion, which is a short factual statement about how the deceased came about their death. The Coroner has an additional function of considering whether there is a risk of future deaths and if appropriate, the Coroner may issue what is referred to a 'Regulation 28' or 'prevention of future deaths' report

Notification of Deaths Regulations

The Notification of Deaths Regulations 2019 came in to force on 1 October 2019 and brought with them, much needed clarity. These new Regulations place a duty on registered medical practitioners to notify the Coroner of an unnatural death. The full list of circumstances are set out in Regulation 3 and include violence and neglect.

A failure to notify a death under the Regulations, may lead to referral to the GMC or disciplinary action. Therefore, it is important to read and fully understand your obligations under the new Regulations. Guidance from the Ministry of Justice has been published to assist medical practitioners in understanding their obligations under the Regulations. The guidance can be found here.

How to respond to a request from the Coroner

As a doctor, it is possible, that at some point during your career, a Coroner will ask you to provide them with a copy of the notes of a deceased patient, or even a report detailing the patient's medical history and any involvement you may have had in their care. In most circumstances, this is a standard request for information, as part of the Coroner's fact finding obligations. However, in some circumstances, the Coroner may be more interested in your role leading up to the patient's death and you may be asked to give evidence at the inquest. If

the Coroner explores your involvement in a patient's care, there may be a risk of your practice being criticised during an inquest.

If a Coroner asks you to prepare a report, it is important that you reply within the deadline prescribed, or otherwise in a timely manner. Your report should be an accurate, factual account based on your knowledge and the patient's medical records. It is important that your report is detailed in order to assist the Coroner with their investigation in to the patient's death. You should set out the patient's previous medical history and details of relevant consultations. If you use any medical terminology, it is often helpful to provide an explanation. Most Coroners these days are from a legal background and may not have in-depth medical knowledge and experience. Additionally, your report is likely to be shared with the family and other non-medical Interested Persons. An Interested Person is usually someone who is centrally involved in the circumstances leading to the patient's death, for example, family members and treating clinicians. We usually advise against copying and pasting sections of the patient's records into your report as entries in records often lack detail and clarity.

If you are asked to provide a report, it does not necessarily mean that you will be required to attend the inquest. However, if you are asked to attend, you should clarify whether you are an Interested Person or a witness. If you are identified as an Interested Person, you are entitled to receive disclosure and have legal representation at the hearing. In some cases, you may be at risk of criticism during an inquest and therefore, it is essential to obtain legal advice and ensure you are fully prepared.

As a doctor, you are required to assist the Coroner with their investigation and a failure to do so may lead to a referral to the GMC and maybe even a criminal conviction. In 2019, we saw the first ever conviction for failing to provide the Coroner with information requested – indicating that Coroners are willing to use their legal powers to require witnesses to assist them. You cannot escape your obligation by relying on confidentiality, as Good Medical Practice clearly states that one of the circumstances where you must disclose relevant information about a patient who has died is to help a Coroner with an inquest.

It is important to remember that if you do attend an inquest and you are criticised during the hearing, you may be required to report this to the GMC. If you are on the NHS Performer's List in England, you may also be under an obligation to notify NHS England. The Coroner may also consider referring you to the GMC.

If you are concerned that you may be or have been criticised during inquest proceedings, you should obtain legal advice. Contact our experienced health and social care solicitors to discuss how we can help you. Get in touch by calling 01202786161 or emailing online.enquiries@la-law.com.

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