Coroner's Inquests: Be Prepared

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We spend a lot of time representing care providers in Coroner's investigations and inquest hearings around the country. However, when lockdown began last March, the courts closed and all of our pending hearings were removed from the diary. For many months, we heard very little from Coroner's offices – but now we are seeing a definite push from Coroners to get back to normal and clear their backlog.

The COVID-19 pandemic has caused the adjournment of many scheduled inquest hearings, posing significant problems, delays and administrative backlogs for Coroner's Courts up and down the country. The pandemic has, therefore, forced Coroner's Courts to consider how they can circumvent the problems associated with the current social distancing restrictions and introduce partially remote court hearing participation via video or audio wherever possible.

In August 2020, Chief Coroner published guidance on remote participation in coronial proceedings via video and audio broadcast.

Coroners remain under an obligation to hold an inquest in public and a Coroner must physically be in court to hold an inquest hearing. The guidance states that partially remote inquest hearings should not prevent Coroner's Courts from being used in line with the social distancing guidelines. The Coroner should be physically present for all hearings and the courtroom should, as far as possible, remain accessible to professional participants, interested persons, witnesses and must be open for the public and the press, even where remote court participation is taking place.

However, in practice, we are now seeing a number of hearings being listed (after some considerable delay) to be held via Microsoft Teams. This means that whilst the Coroner is physically in court, witnesses and legal representatives will join remotely, subject to strict rules.

We have already taken part in a number of remote pre-inquest reviews and full inquest hearings, with mixed success on the technology front. However, it is evident that Coroners are embracing this change and keen to progress investigations and hearings.

We are aware that a lot of Coroners services are currently overwhelmed by the backlog, and additional referrals, resulting from the pandemic. Legislation provides that inquests should take place within six months of the death,

which has inevitably been unavoidably exceeded in many cases, but Coroners are under pressure to progress cases. We have received a notable increase recently in requests for witness statements from Coroners and have had a number of hearings which have now been listed over the coming months.

Evidence

Usually, the Coroner will commence an investigation by obtaining a post mortem or proposed medical cause of death from a doctor and will then request witness statements. Typically, the standard initial letter from a Coroner's Office will request an overview report, and may also request copies of certain care records or for particular points to be addressed in the report. We regularly prepare such witness statements for providers, usually from a care home manager or service manager, providing an overview of the individual's care needs and the circumstances leading to death. The information which is most relevant will depend on the cause of death. It is often necessary to obtain witness statements from members of staff also, for example, care home staff who provided immediate care following a fall or who witnessed a choking incident. It is important to ensure that such statements are factually correct and contain all relevant information, to hopefully avoid the need for the witness to have to attend a hearing and provide live evidence in due course.

Of course, given the delays in many of these investigations, it may well be the case that staff members no longer work for the business by the time the Coroner requests a witness statement from them or asks them to attend court. Generally, though, it is beneficial to make contact with the former staff member to obtain their statement and/or support them to prepare for the inquest hearing, to avoid any unnecessary surprises at the hearing and to ensure staff/former staff feel supported and represent the business in the best possible light. The exception to this will be if there is any conflict of interest with the former employee or concerns have been raised about their conduct.

It is also important to establish whether any concerns have been raised (by the family, GP, safeguarding, CQC etc) and consideration should always be given to applying to the Coroner for interested person status and for disclosure of the evidence. This is to ensure that you and your staff are adequately prepared for the hearing and what may be asked.

You should also make sure that you prepare thoroughly for any hearing by reviewing the relevant care records and proactively identifying (internally) and rectifying any gaps. Commonly we see examples of care plans or risk assessments not being updated after a fall, for example.

It is also often prudent to volunteer additional witness statements to the Coroner, which have not been requested, particularly where any concerns have been identified. This is to avoid any Prevention of Future Deaths Reports and the associated potential adverse publicity.

Witness statements present an opportunity for you to have some control over how the evidence emerges and how matters are presented to the Court so play an important role in protecting your interests and minimising any risks posed by the inquest process.

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CQC

It is worth being particularly cautious where CQC is taking an interest in the inquest process or is an interested person, especially where any concerns have been raised. We are seeing CQC taking an increasing interest in inquest hearings and then using any shortfalls identified by a Coroner as a ground for commencing a criminal investigation in respect of a potential breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In such cases, it is even more important to ensure you and your staff are prepared for the inquest hearing and that you have presented the evidence in a way that best protects your business and reputation. Legal advice and representation should always be obtained where concerns are being raised over the care provided and whether actions of staff caused or contributed to a death, to give the best prospects of avoiding any adverse finding by the Coroner, Prevention of Future Deaths Report, civil claim or CQC action.

If you require any further advice in respect of an inquest process, have received a request to provide witness statements or notification of a hearing, we can assist you. Please do not hesitate to contact us on 01202 786187 or email laura.guntrip@la-law.com and our specialist inquest solicitors will be happy to support you.

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