



## Coroner's Inquest Advice for GPs

### From Report Writing, to Inquest and Beyond.

Most GPs will be called upon to write a Coroner's report during their career, and some will be called to attend the Coroner's Court as a witness.

Even the most experienced GPs find the call to attend an inquest daunting. It can be difficult to know what to do, where to get help and how to behave. It can also be difficult to know how to support a colleague going through this process.

This guide has been designed to help you understand the process and signpost you to sources of help.

We would like to thank the many local GPs who have contributed their own experiences to help create this guide and the invaluable advice from the Derbyshire Coroner's team.

#### **Which deaths need to be reported to the Coroner?**

As a recap, if death occurs in any of the following circumstances, the doctor should report it to the Coroner:

- after an accident or injury
- following an industrial disease
- during a surgical operation or before recovery from an anaesthetic
- if the cause of death is unknown
- if the death was violent or unnatural - for example, suicide, accident or drug or alcohol overdose
- if the death was sudden and unexplained - for instance, a sudden infant death (cot death).

In addition, if the deceased was not seen by the doctor issuing the medical certificate after he or she died, or during the 14 days before the death, the *death must be reported* to the Coroner.

Anyone who is concerned about the cause of a death can inform a Coroner about it, but in most cases a death will be reported to the Coroner by a doctor or the police.

Once a death has been reported to the Coroner, the registrar cannot go ahead with the registration until the Coroner has decided whether any further investigation into the death is necessary.

In the vast majority of cases, no further investigation is necessary, and the registration can be completed straightforwardly. Where an investigation is required this often is concluded by way of an inquest.

You can find full details on when an Inquest is required [here](#).



## When is an inquest held?

The Coroner must hold an inquest where the death was:

- Violent or unnatural
- Sudden and of unknown cause
- In prison or police custody

Where the medical cause of death is unknown, the Coroner may order a post mortem. If the death is found to be natural and there are no issues regarding care or treatment, an inquest may be unnecessary.

This list demonstrates that, in some cases, you can predict when an inquest will, or might be held, and therefore where you might be called upon to write a report.

## Writing a Report

The MPS gives this useful [advice](#):

'If you are involved in the care of a patient whose death is reported to the Coroner, you might be asked to write a report, or even to give evidence. In these circumstances you will be "a witness of fact" – i.e. *you will only be asked to give the facts as you know them.*

Your report should be straightforward and written in the first person, and you should describe what happened (what you did, what other people did, etc.) without speculating about or commenting on others' motivations. The structure should be simple:

- **First paragraph:** who you are (including your qualifications, experience and post) and where you work.
- **Subsequent paragraphs:** the sequence of events you are being asked to report on, including the names and roles of other people involved. Be as accurate as possible about dates and times and use a separate paragraph for each occasion you saw the patient. Include information about history taking, examination, differential diagnosis, investigations, management plan, etc.
- **End with a signed and dated statement of truth:** "I believe the facts in this report are true."

The Coroner may ask you to comment on the medical cause of death in the context of the clinical history or ask a specific question about the clinical history. Make sure you address these specific queries in your report.

You may wish to include your condolences in the report. This is a personal decision and you may wish to discuss this with your MDO. Remember the report is a public document.



Before submitting it, proofread your report to check that it is complete and accurate and remember to keep a copy.

You can find a guide from the MDU on writing a report for the Coroner [here](#).

**Learning Point:**

Many GPs who have been through this process would recommend you contact your MDO for advice before sending the report on.

Sometimes the Coroner may decide to hold and record a documentary inquest. This is where they may have all the information necessary to make a good judgement on the cause of death for the person. This adds extra weight to the purpose of writing a detailed and full report and may prevent you having to be called.

**Do I need to tell anyone else?**

Later we will discuss who might need to be informed following an inquest. However, prior to this, you may need to contact the CCG. If an incident in primary care results in death and meets [Serious Incident](#) (SI) criteria the CCG must be informed. The CCG would then support the practice in undertaking the investigation pre court case.

These reports are then submitted, with consent of the practice, to the Coroner and can often support individual GPs going forward e.g. learning identified, root cause etc.

The CCG have found, in the past that by being able to evidence what has happened and how it has been managed it can prevent the Coroner applying sanctions after the hearing.

You can find details of Serious Incident reporting on each CCGs website.

As part of this process you should also consider any safeguarding issues and if concerns are raised, escalate these to the local safeguarding board ([Derbyshire Safeguarding Adult Board](#) or [Derbyshire Safeguarding Children Board](#)).

**Significant Event Analysis (SEA)**

Even if the case doesn't meet the SI criteria, you may find it useful to review the case as a Practice and write a formal SEA. Any organisational learning acquired during this SEA can then be submitted to the Coroner along with the report as evidence that any issues have been addressed.

The MPS when asked about this issue said:



*'holding an SEA before an Inquest occurs can be helpful; if an individual or Practice can demonstrate that they have identified areas for improvement and already taken steps to put changes in place the Coroner may be less minded to issue a report for the prevention of future deaths (known as a Regulation 28 letter).*

*If failings are identified or doctors are in any way concerned about their actions/omissions relating to the care of a patient who becomes the subject of an Inquest then we would advise that they seek assistance from their Medical Defence Organisation as soon as possible so that decisions can be made about disclosure of the SEA to the Coroner (if they haven't already requested it) and the timing of such disclosure.'*

### **Inquest**

It is usual to feel apprehensive about the inquest. However, having read the above, you should have written a good report, which has been checked with your MDO and therefore be prepared.

Chat to your colleagues, if you feel comfortable to do this, otherwise please contact the LMC for support.

**If you haven't contacted your MDO by this point you may wish to do so.**

#### **Learning Point:**

The inquest is simply a fact-finding process; *the purpose is to find out who died – when, where and how*

There is a lot of advice out there and you may find the following weblinks from the main Medical Defence Organisations useful:

[\*\*MPS\*\*](#)   [\*\*MDU\*\*](#)   [\*\*MDDUS – Part 1 and Part 2 of a series\*\*](#)

and additional information on taking the stand

<https://www.mddus.com/resources/publications-library/gpst/gpst-issue-06/taking-the-stand>

### **Local Advice**

The hyperlinks above have a wealth of information, but personal advice can also be very informative. We have asked many local GPs who have been through this process on what advice they would offer colleagues. The advice offered is summarised below:

#### **Before the Inquest**

- **Tell your MDO:** Your MDO will help you prepare. This may involve a lengthy discussion about the case at their offices with appointed legal counsel. Although



daunting this is a thoroughly useful exercise. It can prepare you on what to expect, who is going to be present and how to act.

- **Inform your Practice Manager:** The inquest may take several days, although you may be only required for a proportion of that time. Informing your Practice Manager will help ensure arrangements are made to cover any sessions you miss. The Coroner's office team may be able to guide you on the anticipated time you will be required for.
- **Review the documents:** You are likely to receive a large pack including the witness statements and post mortem report and any relevant correspondence. Review this prior to the Inquest with your MDO. It may help gain a bigger picture of the events that occurred and prepare you for likely questions.
- **The Practicalities:** Make sure you know where the Coroner's Court is and if there is parking. Allow plenty of travel time.

### **On the day**

- **Be Smart:** This is HM Court so suits/smart office wear are the norm.
- **Turn off your mobile phone.** Not just on silent. Off.
- **Take support:** This may be in the form of a family member, friend or colleague. It is a disconcerting process, so a familiar face will help. If you have no-one who will attend with you *please contact the LMC*.
- **Family members:** There are often family members present and they are able to question witnesses. This can be difficult and emotive. Your MDO will guide you on how to manage these questions.
- **Addressing the Coroner:** The Coroner should be addressed as 'Sir' or 'Ma'am'.
- **Oath or Affirmation:** Evidence is given on oath. You will be asked to swear on a holy book or affirm that you will tell the truth and you can choose either option. If you have a priority, it is sensible to let the Coroner's Office know in advance.
- **Lawyers:** Various other agencies may be represented eg local trust, local Nursing Homes, Mental health services. It is likely that they will all have legal representation who can ask you questions. The family may also have a legal team appointed. It can feel lonely if you are present alone or just with the MDO legal representative.
- **Don't speculate:** Be familiar with your statement and answer facts clearly and concisely don't offer opinions or speculate. Don't stray outside your area of expertise. Try to provide an answer in plain English and if you need to use



medical terms, explain them. This is why early discussion with your MDO on writing a report can help.

- **Press:** Some cases will inevitably attract press attention. This can add to an already pressured situation. Discuss the likelihood of this with the MDO in advance. Their team will help guide you on how to behave what to say and what not to say.

### **Fees for attending Coroner's Court**

Doctors called to give evidence at an inquest may be able to claim fees and allowances. You can find further details [here](#). We would suggest you discuss this with your [local Coroner's office](#)

### **What's next?**

After the inquest is over, for many GPs this process will be too.

However in some cases you need to be aware that there will be dealings with other professional bodies.

The Coroner may make what's called a **Regulation 28 report** following an Inquest, if anything revealed during an investigation gives rise to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future. The Coroner will announce this in court usually at the conclusion of the Inquest.

#### **1) GMC**

If the Coroner has criticised your actions as per the [GMC guidance](#) below, you must inform the GMC:

**75. You must tell us without delay if, anywhere in the world:**

**a. you have accepted a caution from the police or been criticised by an official inquiry**

As a consequence of this you will be referred to the local NHSE Performance Advisory Group (PAG). The normal process is that you will be asked to provide your reflection in relation to this incident. PAG will then consider the concern and your reflection together with any other information NHS England holds about you in order to determine if any further assurance is required in relation to your Fitness for Practice.

You will receive information about sources of support (such as GP-S, see below) at this time, but you may wish to contact them earlier.



## **2) Appraisal and Revalidation**

Any involvement of GMC / PAG will automatically involve the Responsible Officer for Appraisal and Revalidation. Your own appraiser may, however, not be aware, but be prepared to discuss the inquest and its outcomes at your appraisal.

### **Where can I get support?**

#### **1) MDO**

As discussed previously, the MDOs can be a wealth of support and information throughout this process. You pay them lots of money for precisely this set of circumstances, use them.

#### **2) Your LMC**

DDLMC can help throughout this procedure. From signposting to mentorship, we have experience in helping GPs going through inquests. Please [contact us](#) if you need support.

#### **3) GP-S**

[GP-S mentoring](#) is free peer mentoring service for general practice. We have been working with colleagues throughout this process to ensure there is support available to help colleagues going through inquests, PAG etc.

#### **4) GP Health**

The [NHS GP Health Service](#) is a confidential NHS service for GPs and GP trainees in England. The GP Health Service can help with issues relating to a mental health concern, including stress or depression, in particular where these might affect work.

### **In Summary**

Being called to give evidence at an Inquest is difficult for any GP. However, by familiarising yourself with the advice above and seeking help at an early stage you can be ensure you are prepared for the experience.