Inquests: Be Prepared!

WSPIC/SFC Managers Forum
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Welcome – LA Care Team

- CQC registration
- CQC criminal proceedings
- Challenging CQC inspection reports
- Defending enforcement action by CQC
- Advice and representation in Coroner's inquests
- Supported living
- Safeguarding
- Disputes with social services and ICBs
- Contractual matters
- Unpaid fees
- Court of Protection
- Judicial review
- Health & safety
- Employment advice
- Property advice & buying or selling a care service
- Corporate & partnership matters
- Charities & the Third Sector
- Professional disciplinary/fitness to practice proceedings
- Disclosure & Barring Service

Introduction

- What is an inquest?
- The role of the Coroner
- The inquest process
- Before the inquest
- The hearing
- Potential outcomes
- Be prepared!

What is an Inquest?

- An Investigation
- An inquest will only be required in specific circumstances:
  - Sudden or unexpected death
  - Violent or unnatural death
  - The cause of death is unknown
  - The deceased died in custody or other state detention
    - Prison, police custody, under control and responsibility of authorities
  - "*If the death flows from any sort of traumatic event, accidental or deliberate, self-induced or otherwise, the death clearly falls within the meaning of `violent or unnatural'".*

The Role of the Coroner

- The Coroner's first role after the death is to record it and consider whether a post mortem is required.
- The purpose of their investigation/inquest is to establish four key things:
  - *Who* the deceased is?
  - *Where* did they die?
  - *When* did they die?
  - *How* did they die?
- The Coroner's role is not to attribute blame. They cannot establish civil or criminal liability.
- Prevention of future deaths.

The Inquest Process

- Different to other civil or criminal courts
- It is an investigation – a fact-finding process
- Not adversarial
- The Coroner cannot attribute any civil or criminal liability (but can refer to concerns to other agencies)
- A formal process but not as rigid as other court processes

Why Does it Matter?

- Value life
- Opportunities for learning
- Risks to company
  - Reputational
  - Neglect
  - PFD report
  - Civil claims
  - Criminal investigations
- Risks to individuals
  - Professional regulators
  - Criminal investigations

Your role

- To assist the Coroner
- Remember it is not a court of blame
- Be mindful of grief

Before the Inquest

- Coroner will undertake initial investigations, which may include:
  - Post mortem
  - Requesting information or care records
    - Care home records
    - Hospital records
    - Clinician view of cause of death
    - Police
  - Requesting witness statements or reports
    - Care home – typically manager and staff involved
    - GP / Hospital / Paramedics

NB: Schedule 5 notices

Before the Inquest

- There may be a Pre-Inquest Review (“PIR”)
- Likely topics:
    - Scope
    - Interested Persons
    - Article 2
    - Juries
    - Disclosure
    - Witnesses (live or read?)
    - Dates of availability
    - Likely date and time for final hearing

Preparing Witness Statements

- Clear and detailed – ensure chronology of events are clear
- Review all relevant records and speak to staff first
- Don’t just focus on daily notes
- Think what may be missing from the statement
- Use formal terminology, avoid abbreviations – remember the family will need to understand it
- Consistent – e.g. use of names, format of dates/times etc
- Remember the deceased
- Mindful of language

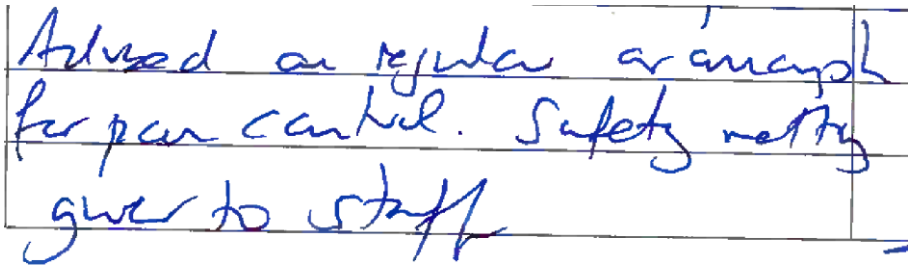
Observation records

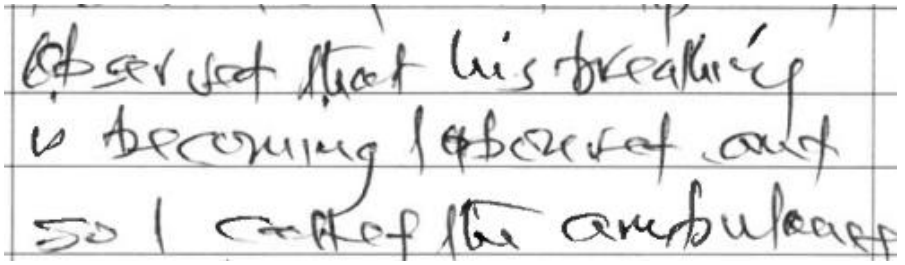
- Think about wording – e.g. dates and record entries – What would a Coroner infer from these overnight notes entries?

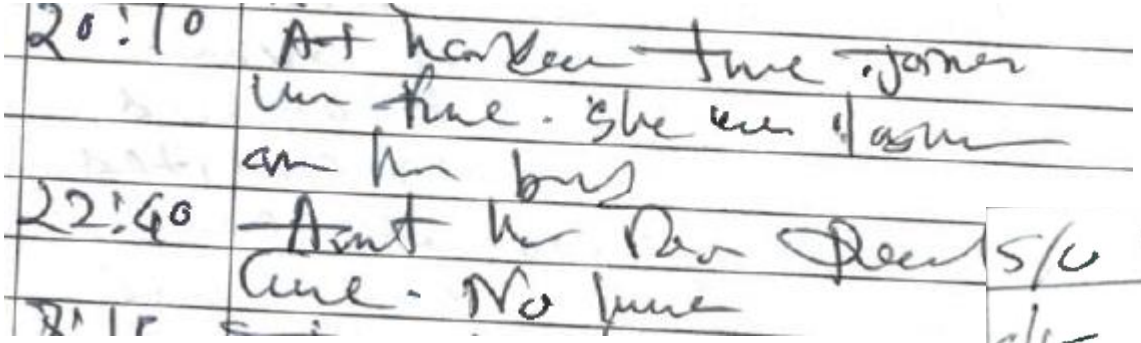
Time	Comment on Observations and Interactions with t person and any concerns during the night
8pm	[redacted] was in lounge Lounge watching TV.
10pm	[redacted] in the lounge. watch
12am	[redacted] in his room
2am	[redacted] in his room
4am	[redacted] in his room
6am	[redacted] in his room
8am	[redacted] in his room

Healthcare

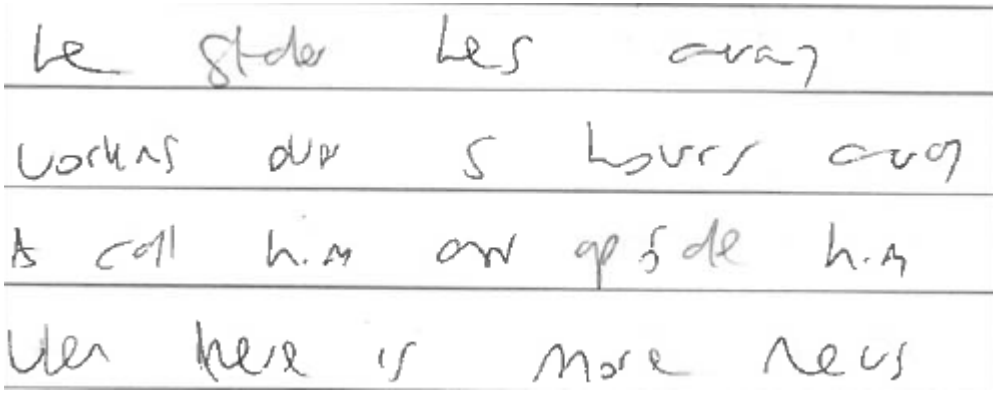
Handwritten care records

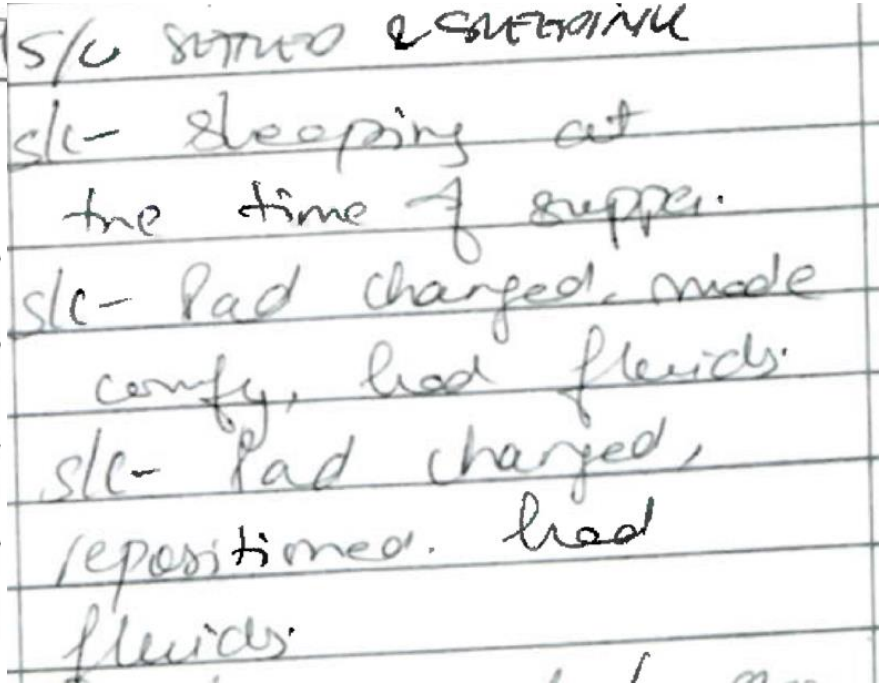

Advised on regular arrangements for pain control. Safety netting given to staff


Observed that his breathing is becoming laboured and so I called the ambulance


20:10 Arrived home time. Joined in time. She was asleep on her bed
22:40 Asked her Pain Score. Nine. No time


BP 170/97


He stole Les away
Works dur s Lours away
& call h.m on upside h.m
Uer here is more news


s/c sitting & sleeping
s/c - sleeping at the time of supper.
s/c - Pad changed, made comfy, had fluids.
s/c - Pad changed, repositioned. Had fluids.

Digital call bell records

[redacted] rang the call bell. *Communication Verified by Integration GenericAPI:*	GenericAPI Integration	18:34
[redacted] rang the call bell. *Communication Verified by Integration GenericAPI:*	GenericAPI Integration	18:34
[redacted] rang the call bell. *Communication Verified by Integration GenericAPI:*	GenericAPI Integration	18:34
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Interested Persons ("IP")

- There is a list of the classes of people who would be deemed to be an IP, including:
  - immediate family;
  - personal representative or beneficiary under policy of insurance;
  - a person who may have caused or contributed to the death of the deceased; and
  - anyone else the Coroner thinks has sufficient interest – Coroner's discretion.
- Staff members may be IPs in their own right
- An Interested Person has the right to actively participate in the Inquest

The Inquest Hearing

- Evidence under oath or affirmation
- The Coroner will ask questions of witnesses based around the statement they have provided.
- All parties with interested person status can ask questions of the witnesses.
- Family members usually attend on the day and are often unrepresented. They are likely to have interested person status and will be able to ask questions of the witnesses.
- Inquests are held in open court, so there may be members of the public or the press present on the day.
- There may be a jury present.

The Inquest Hearing – remote witness

- Witnesses *may* be given permission to attend remotely
- Virtual extension of the Courtroom
- Conduct – how are you presenting yourself?
  - Where are you?
  - Are you alone?
  - Are you dressed appropriately?
  - Are you ready?

Conclusions

- Short form conclusions – preferable - natural causes; accident or misadventure; unlawful killing; lawful killing; suicide; and open verdict.
- Burden of proof – balance of probabilities
- Narrative conclusions – short factual statement.
- Neglect Riders – this may be added to the main conclusion if, on the balance of probabilities, there has been a gross failure to provide food, drink or medicine to a person in a dependent position. There must also be a causal link between the failure and the subsequent death. A Coroner may also attribute a rider of Self-Neglect.

Neglect

- Underestimation of dependant person's condition
- Question is whether carer *should* have realised need for action in all circumstances
- Does not extend to saying every incorrect clinical judgment amounts to neglect – if consider all issues and ask right question
- Not the role of the inquest to criticise every aspect of treatment – not concerned with correctness of complex and sophisticated procedures – but consequences of (for example) failing to make simple checks

Prevention of Future Deaths

- Prevention of Future Deaths ("PFD"):
  - where a Coroner considers that the investigation has uncovered a concern which might give rise to a risk of future deaths, the Coroner is under a duty to make a report to prevent future deaths from occurring.
- The report is sent to whoever the Coroner deems to have the power to take action on the concern raised.
  - The Coroner may also require them to respond to their report and the response may be published, sent to the relevant governing body and/or the family of the deceased.
  - This can be a reputational concern.

Prevention of Future Deaths

- These can provide powerful leverage for change.
- PFDs are also an opportunity for the industry to learn from mistakes or make changes in practice.
- 56 days to respond.
- Can be published
- Risk adverse publicity
- CQC usually sent a copy – can prompt an inspection
- Can invoke funding penalties

Be Prepared!

- Ensure thorough review of care records in good time.
- Ensure relevant evidence is presented.
- Consider potential criticisms.
- Consider need for any further evidence to avoid neglect or PFD report and who best to provide.
- Consider any PR risks.
- Consider need for legal advice – especially if shortfalls have been identified or risk of criticism.
- Ensure witnesses are properly prepared.

When to call legal support?

- Consideration risk of the case at the earliest opportunity
- Keep this risk under review for the duration
- Examples of risks suggesting legal representation:
  - The provider is given IP status.
  - The family have expressed concerns about the care.
  - The family or other IPs are legally represented.
  - Press interest.
  - Ongoing investigation by the police, HSE, Local Authority and/or CQC.
  - A coroner raised concerns about the provider previously.
  - Conflicts between staff / of evidence/ gaps.
  - Investigations identify shortfalls in the care provided.
  - An inquest involving a Jury.

Any questions?