

Inquest Guidance

Guideline information

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Summary of document:

This guidance has been prepared to help staff who are asked to prepare a statement in relation to a Coroner's Inquest and/or asked to attend court to give oral evidence

Scope:

This guideline is applicable to all staff

To be read in conjunction with:

[894 – Putting Things Right Policy](#) (opens in a new tab)

[004 - Management of Claims Policy](#) (opens in a new tab)

Patient information:

[Patient Information Library](#)

Owning group:

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- 2 - Updated 15.8.2017
- 3 – Updated September 2023
- 3.1 – Ceredigion Coronor contact details updated 16.7.2025

Keywords

Witness evidence required for a coronial investigation, attending coroner's court, preparing statements for the coroner, preparing for an inquest

Glossary of terms

HB – Health Board

RCA – Root cause analysis

HSE – Health & Safety Executive

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AIM

The aim of this guideline is to explain the role of the Coroner; the purpose of an Inquest, and to give guidance to staff who are witnesses in an inquest.

SCOPE

The guideline is applicable to all staff.

OBJECTIVES

This document provides information about the purpose and process of an Inquest, what to expect if asked to attend court and who to contact for support and further guidance.

ROLE OF THE CORONER

The Coroner is an independent judicial office holder, who is a qualified solicitor, barrister or legal executive with at least 5 years post qualification experience. The Coroner has a statutory duty to investigate deaths where there is reason to suspect they are violent or unnatural, the cause of death is unexplained, the deceased died of a notifiable disease or the deceased died in custody or otherwise in state detention.

The Coroner's role is to establish the answers to 4 questions about the deceased person; who died, where they died, when they died and how they came by their death, that is by what means the person died and if Article 2 of the European Convention on Human Rights (the right to life) is engaged, the scope of the inquest is widened to include by what means and in what circumstances the person came by their death. The Coroner will determine the cause of death with evidence from clinicians and/or a pathologist. The Coroner also has jurisdiction to make inquiries into any treasure which is found in their district.

The inquest process is a fact finding, inquisitorial process rather than adversarial process. The coroner makes findings of fact and reaches a conclusion on how a person died. There are no parties, prosecution witnesses/claimants or defendants, as in the criminal/civil courts. Here the Coroner will make people or organisations "interested persons." There is a list of who is likely to be interested persons at s47 Coroner's and Justice Act 2009 and the one most applicable to deaths occurring in hospital or where medical nursing intervention is ongoing is s47(2)(f).

"S47(2)(f) a person who may by any act or omission have caused or contributed to the death of the deceased, or whose employee or agent may have done so;"

The coroner is not permitted in law to reach any conclusions on civil or criminal liability.

There are two Coronial jurisdictions covering the Hywel Dda area:

HM Coroner for Pembrokeshire and Carmarthenshire: Council Chambers, County Hall, Haverfordwest, Pembrokeshire

Tel 01437 775001, 01437 775134

pembscarmscoroner@pembrokeshire.gov.uk

Inquests take place at either (1) Council Chambers, County Hall, Haverfordwest, Pembrokeshire, SA61 1TP or (2) Town Hall, Church Street, Llanelli, SA15 3AH.

HM Coroner for Ceredigion: Canolfan Rheidol, Aberystwyth, Ceredigion, SY23 3UE

Tele: 01970 633580

coroners@ceredigion.gov.uk

Inquests take place at: Aberystwyth Justice Centre, Y Lanfa, Trefechan, Aberystwyth, Ceredigion, SY23 1AS.

It is possible that some inquests may take place in North West Wales where a patient has been cared for in Bronglais Hospital but lives in North Wales or in Swansea or Cardiff if the patient is transferred and dies in a hospital within those Health Boards. Similarly, if a patient is transferred to and dies in a hospital in England, an inquest may well take place there. In some cases, if most of the witnesses would be in Wales, then the inquest can be transferred but this will be a decision made between the coroner's of the relevant areas prior to the interested persons being formally identified.

REPORTABLE DEATHS

Since 2019 there are regulations which impose a duty on registered medical practitioners to report a death in specific circumstances. Prior to the Regulations coming into force, the reporting of a death by a doctor was discretionary although guidance was available.

Notification of Death Regulations 2019

Circumstances in which the duty to notify arises

3.—(1) The circumstances are—

(a) the registered medical practitioner suspects that that the person's death was due to—

(i) poisoning; including by an otherwise benign substance;

- (ii) exposure to or contact with a toxic substance;
 - (iii) the use of a medicinal product, controlled drug or psychoactive substance;
 - (iv) violence;
 - (v) trauma or injury;
 - (vi) self-harm;
 - (vii) neglect, including self-neglect;
 - (viii) the person undergoing a treatment or procedure of a medical or similar nature; or
 - (ix) an injury or disease attributable to any employment held by the person during the person's lifetime;
- (b) the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);
- (c) the registered medical practitioner—
- (i) is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person; but
 - (ii) despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown;
- (d) the registered medical practitioner suspects that the person died while in custody or otherwise in state detention;
- (e) the registered medical practitioner reasonably believes that there is no attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person;
- (f) the registered medical practitioner reasonably believes that—
- (i) an attending medical practitioner is required to sign a certificate of cause of death in relation to the deceased person; but
 - (ii) the attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death;
- (g) the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.

Where there is any doubt as to how to proceed, advice can be sought from the Medical Director, the relevant Hospital Director, the Pathology Service, the Medical Examiner or the Health Board's Legal Services Team. The Doctor should inform the Medical Director or local Hospital Director if a death is

reported to the Coroner, or in the event concerns are raised regarding the clinical management of a patient. In relation to the latter, an Incident Report Form should also be completed on Datix. This will facilitate an internal investigation and remedial action to manage any patient safety risks at the earliest opportunity.

POST MORTEM

Where a death is reported to the Coroner, a post-mortem (autopsy) may be carried out. This is an examination of a body after death to determine the cause of death. The Coroner may decide that a post mortem is not required if the doctor treating the patient in hospital/community is able to provide a cause of death. After a death has been reported to the coroner he/she takes responsibility for the body (but does not “own” it) and it is the Coroner who decides whether or not a post mortem examination is required.

If a post mortem is ordered by a Coroner, it must take place, whether the deceased’s next of kin has agreed to it going ahead or not. In the event of disagreement, the coroner’s office will deal with that and the coroner will make the final decision on how to proceed. The post mortem will be carried out by a pathologist (if there are suspicions of criminal activity, the autopsy will be carried out by a home office pathologist). Findings at post mortem can only be released to clinicians or third parties with permission from the Coroner.

REQUESTS FOR STATEMENTS AND DISCLOSURE

If an Inquest is to be held, the Coroner’s office will contact the HB’s Legal Services Team to request copies of medical records and statements from relevant staff involved in the patient’s care and treatment.

The Coroner will request disclosure by the Health Board. This may be for a specific period, but often will be all records relating to that patient. This includes medical records, as well as any other information held concerning the patient, including text messages, emails, memo and telephone notes, answer machine messages, ward CCTV, MS TEAMS recordings, documents on WCP and WPAS, MDT notes, handwritten notes, papers gathered and produced as a result of any internal investigation and any assessments. It is important that a thorough search is undertaken to ensure all documents are made available to the Coroner. It is important that retention policies are such as to facilitate such requests. In the event that there is query as to whether a document or item is disclosable, please consult the Legal Services Team.

The Health Board should also disclose all policies and procedures relevant to the case. The documents to be produced are the documents in force at the time and the document currently in force if different.

The Legal Services Team will liaise with the staff identified via the General Manager/Director or Head of Department. Staff should obtain advice from the Legal Services Team before making a statement. Staff should contact their line manager/senior manager upon receipt of a request for a statement. **Witnesses should not discuss their evidence with anyone other than the legal services team prior to the statement being prepared.** It is important that they make their statement based on their own knowledge of the matter and any discussion could distort their memory.

Assistance with statement writing is available from the solicitor with conduct of the matter.

Statements should contain details of the facts as the witness recalls them. The witnesses will need to have access to the entries they made in the person's medical records to assist them with the accuracy of the statement.

Once filed at court, the statement will be considered by the coroner and disclosed to the interested persons (which will include family members). The coroner will decide whether the witness needs to be called to the inquest to give oral evidence or whether their statement can be read out in court.

Occasionally, the coroner may ask for an "overview statement" if there are a number of witnesses all given evidence about the same issue for example where a number of different nurses have dressed a wound, the Coroner may ask for an overview from a nurse manager about how the wound was managed rather than ask for 6 statements from 6 individual nursing staff about their input. In such circumstances, the statement should be a factual account of what the patient was being treated for, the needs of the patient, the care and treatment provided and any difficulties in providing treatment. The statement should not stray into opinion, the coroner will instruct a clinician independently of the health board to provide an opinion on the standard of care provided if he/she believes that is required.

The statements should be forwarded to the Coroner within 28 days of receipt of the request unless there are extenuating circumstances.

Information on the format and content required for witness statements can be found at [Appendix 1](#).

ATTENDANCE

The Coroner will make directions regarding which witnesses he requires to attend court and may or may not issue a summons. Failure to attend court where a summons has been issued is a contempt of court punishable by a fine or imprisonment if good reason is not given. If a summons has been served and the witness fails to attend, the Coroner has the power to obtain a warrant for that person's arrest. If a witness has been directed to attend court by the Coroner or received a summons and cannot attend due to illness or another good reason, it is imperative that the witness notifies the court and the HB legal team at the earliest opportunity. In the event of illness, it is likely that a medical certificate will be required.

Staff will be spared from their duties to attend court and will not be expected to attend in their own time if it is avoidable. In the event they are on annual leave (and are in the UK) they can be given time in lieu.

Attendance can be in person or remote and this is at the discretion of the coroner. If attending remotely, the room from which the person attends becomes an extension of the Court Room. It is governed by the same rules as the Court Room. Only those attending the Inquest should be present in the room, there should be no disturbances during the hearing (e.g. no pets wandering into view, phones ringing etc), and the same rules of dress apply. The Coroner may require the person to have cameras switched on throughout the hearing without a background to enable him or her to observe the remote room. A reliable internet connection will be required to ensure the remote hearing is conducted without issue.

If the witness wishes to swear an oath on a holy book, the witness will need to produce the holy book to the virtual court room. In the alternative an affirmation can be given.

The hearing must not be recorded. The coroner will give a warning about this at the beginning of the inquest. It is a contempt of court to record an inquest punishable by a fine or imprisonment.

An inquest is a public hearing and Managers and/or Consultants are encouraged to attend to support staff. In addition, junior members of staff can be invited to attend for learning (whether remote or in person). They will have to give their name to the court and state their purpose for being there.

PREPARING FOR THE INQUEST

The Coroner's office will contact the HB's Legal Services Team when an inquest has been opened and the Health Board has been given Interested Person status. If a member of staff receives formal communication from the Coroner's officer directly they should immediately inform their line manager/senior manager who will then inform the Legal Services Team.

Please note the Local Authority hosts the coronial service and the administration staff are employees of the Local Authority. The coroner is not an employee and retains independence as a judicial officer. The coroner's officers, as distinct from the admin staff, are employed by the police. Therefore, the staff may be contacted directly by the police on behalf of the coroner for a statement – this does not mean that any criminal activity is suspected. If there is reason to suspect criminal activity, the coroner will open an inquest and, thereafter, suspend the inquiry pending the outcome of the criminal investigation/trial after which, the Coroner will review matters and decide whether or not to resume the inquest. By way of an example, if a child has died and someone is held responsible and convicted, the coroner may have nothing further to explore, however, if there are concerns about the involvement of children's services or CAMHS which may not have been explored as part of the criminal investigation then the coroner may decide to resume the inquiry.

Managers should ensure that the General Manager/Hospital Director/Clinical Director is informed of the Inquest and of any wider implications for the HB.

All Inquests which are opened in matters involving clinical care will require a review by the HB department in which the deceased was receiving treatment. This will result in a written report (Proportionate Investigation) providing clear information about patient care preceding the death, any areas of concern and any lessons learnt. This document is disclosable to the Coroner (and to the other interested persons if requested) who will need reassurance that remedial action has been taken where it is apparent that the care was not of the required standard.

The Legal Services Team will co-ordinate the witness statements and will file it at court. Closer to the inquest date, once the Coroner has decided who will be called to the hearing, the HB's solicitor will arrange to meet with the witnesses to go through the purpose and process of an inquest and what to expect in court.

Any areas of concern the witness has can be raised with the advocate representing the health board on a one to one basis, however, the solicitor/barrister is not permitted to go through a “dummy run” of questions the witness is likely to be asked.

Although, not necessarily required, staff can be accompanied by a representative of their professional body, medical defence organisation, trade union or friend when attending any meetings with the HB Legal Services Team.

Witnesses should ensure they retain a copy of their statements as they will want to read them though prior to attending court.

All staff are reminded that prompt contact with the Legal Services Team allows adequate time to prepare witness evidence and provide support to individual staff members. Members of staff should not be contacted by the Coroner’s officer for statements without prior arrangement and staff should make contact with the Legal Services Department if contacted by the coroner’s court directly.

The Legal Services Team will liaise with the Communications Team and relevant senior managers to ensure press releases are prepared to respond to any media interest. If approached by a journalist in court, staff should not give any comments to the press other than to confirm their name if asked to do so. If requests for further information are made the press should be directed to the advocate who will contact speak with them. Any requests from the media should be dealt with by the communications department and any press statements made by senior managers.

THE INQUEST

All witnesses will be informed of the date, time and place of the Inquest and should make every effort to be punctual aiming to arrive at court at least half an hour prior to the start of the hearing and be smartly dressed. It is advisable not to wear brightly coloured clothing, out of respect for the deceased and their relatives. If staff are giving evidence remotely and give evidence during a shift, wearing their uniform to attend is permitted, however, if they attend in person then smart clothing should be worn.

Witnesses may bring a friend, work colleague, representative of their professional body, medical defence organisation or trade union to support them on the day of the Inquest. The accompanying persons will not be permitted to speak on behalf of the witness unless the person has individual interested person status and has their own legal team in court. This may occur if there is a conflict of interest between the evidence of the witness and the position taken by the Health Board or if the witness has been through the disciplinary process in relation to the person’s death. In these circumstances, the advocate representing the Health Board would not be able to represent both if they had conflicting evidence to provide to the court. This happens rarely. A member of the Legal Services Team and/or the HB Solicitor will also be present.

The Coroner should be addressed as Sir or Ma'am. The Coroner will sit behind a bench at the front, with Counsel (barristers) and/or solicitors on the first row and the Interested Persons in the subsequent rows. Priority will be given to the family of the deceased person.

The Coroner will decide in which order witnesses will be called.

Witnesses are called to the witness stand and will be sworn in by the Coroner's Officer before giving their evidence (the witness will be asked to swear on a holy testament to tell the truth or if the individual does not have a faith, an affirmation can be given). Some holy books of different faiths are available but it may be wise to provide your own.

At the hearing, if attending in person, there will be a bundle of documents in the witness box with the witness statements among them. The witnesses will be told where to find the statement in the bundle and asked to verify it is their statement and their signature on it. If attending remotely, it is usual to have an electronic bundle, but important that the witnesses have a hard copy of their own statements to hand as they are likely to be asked questions about what they have written and it may be easier to refer to the hard copy when answering questions rather than trying to read it on screen.

Usually Coroners will have some understanding of medical terms and conditions, however, they will want clear jargon-free explanations of any medical and/or nursing terms. Reading over the prepared statement and medical records in advance will allow the witness to respond with greater ease. If a witness needs to refer to the medical records (hard copy or electronic), they can ask the Coroner for the opportunity to do so before answering. Witnesses should only answer the question they have been asked by giving the facts but not opinion. They should not answer questions outside of their area of expertise. They should not give opinion on a colleagues practice, the coroner has the opportunity to instruct expert witnesses to give opinion. Witnesses should not speculate and should only give evidence from within their own knowledge or from reviewing their entries in the medical records. If a witness does not know the answer to a question then they should say so.

If a question is unclear then the witness should ask for it to be clarified before answering.

Interested persons as well as jury members (if there is a jury) can ask questions. The order of questions are;

- 1 the Coroner
- 2 the family
- 3 the other interested persons
- 4 the final interested person on whose behalf the witness is giving evidence.

A witness is not expected to answer any question which could incriminate themselves and they should be warned against self-incrimination by the coroner prior to answering if such a question arises. The witness can then decide whether or not they wish to answer. If individual or professional conduct or competence is called into question an adjournment can be requested, if necessary so that the individual can instruct their own legal team to represent them.

Once the witness has given evidence they will be asked to step down and will be released from court. Witnesses must remain in Court, until they are formally released by the Coroner.

The Inquest is recorded and a copy of the recording can be obtained upon request after the Inquest. There is usually a small charge for this.

A guide for witnesses can be found [at Appendix 2](#).

EVIDENCE FROM THE PATHOLOGIST

Before the start of the Inquest, it is usual for the Post Mortem Report to be disclosed to the HB. As with any disclosure this is at the discretion of the Coroner. If criminal activity is suspected, disclosure of the post mortem may be denied until after the criminal investigation/trial.

Even though pathologists are usually employed by HBs, they are directly accountable and reportable to the Coroner for all matters relating to post mortem examinations, subsequent reports and attendance at Inquests.

On occasion, a senior clinician may be asked to remain in court until the pathological evidence is heard if there are any queries over the cause of death as a discussion between them and the pathologist might assist the coroner in determining the cause of death.

JURY INQUESTS

Since the Coroners and Justice Act 2009 came into force in 2013, the coroner must sit without a jury unless specific criteria are met. These are where a person is in state detention and the death was violent, unnatural or cause of death is unknown or that the death resulted from an action or omission of a police officer or member of a service police force or that the death was caused by a notifiable accident, poisoning or disease. The coroner also has discretion to hold an inquest with a jury if he/she thinks there is sufficient reason for doing so.

A jury is selected in the same way as when summoned to Crown Court and the jurors are selected from the electoral register. A jury will consist of no less than seven and no more than eleven members.

The role of the jury is to listen to the evidence, ask appropriate questions, make findings of fact and reach a conclusion, based on the evidence provided. The jury will be given directions by the coroner on the procedure for reaching its findings and conclusions.

ARTICLE 2 EUROPEAN CONVENTION ON HUMAN RIGHTS

Article 2 of the European Convention on Human Rights (ECHR), conveys duties on the state to put in place systems and frameworks to protect life and laws to investigate deaths where appropriate (the systems duty). There is also an operational duty to protect life in certain circumstances where the state

knew or ought to have known of a real and immediate risk to life and did nothing to mitigate against that risk. In relation to inquests, where there has been an “*arguable breach*” of a state obligation, Article 2 of the ECHR is said to be engaged and provides for an enhanced investigation to be conducted by the Coroner to examine not just how the person died but how and in what circumstances they died.

This area of law is very complex and has generated much case law. There has been a recent Supreme Court Ruling on Article 2 engagement in inquests (Maguire – see link below) drawing together all of the case law in this area.

[Maguire, R \(on the application of\) v His Majesty's Senior Coroner for Blackpool & Fylde & Anor \[2023\] UKSC 20 \(21 June 2023\) \(bailii.org\)](#) (opens in a new tab)

The implications for the Health Board of Article 2 being engaged are that the coroner can make judgemental findings and reach a judgemental conclusion whereas usually, the findings and conclusion have to be neutral.

The family is also automatically entitled to legal aid subject to means.

CONCLUSIONS (Formerly known as Verdicts)

When all evidence has been adduced the coroner will give a summary of the evidence and will usually tailor it to addressing the issues they have identified in the scope of the inquest. Following the summary they will give their findings of fact and then reach a conclusion. This can be a short form conclusion such as suicide, accident, misadventure, unlawful killing etc., or if a short form conclusion is insufficient to give the true nature of the death, a Narrative conclusion can be given. This is a short, 2 or 3 sentence, factual description of how the person died. The standard of proof required for the conclusion is the civil standard – The Balance of Probabilities. This is what is more likely than not to have happened after weighing up and balancing all of the evidence. It is a lower standard of proof than that required in the criminal court which is beyond reasonable doubt.

NEGLECT

Neglect is not a conclusion of itself but it can be added to a conclusion if there is sufficient evidence to warrant it. Neglect in the coronial sense is distinct from negligence as it is a gross failure to meet basic human needs. In the medical treatment context it relates to not providing life-sustaining treatment to someone in a vulnerable position when it was known, at the time, that without that treatment the person would be unlikely to survive. There has to be a direct causal connection between the neglect and the death for it to be added to a conclusion.

PREVENTION OF FUTURE DEATHS REPORTS

Where the coroner has concerns there is a risk that deaths may occur in the future in similar circumstances and not enough has been done to mitigate against that risk, he/she is mandated to provide a Prevention of Future Deaths Report and send it **to anyone whom they believe is in a position to**

remedy the situation. This could include Health Bodies, Local Authorities, Chief of Police, Commissioning Bodies and Governments. The coroner can only raise concerns within the report but cannot give recommendations. Those to whom the report is sent have 56 days to respond - this can be extended with permission from the coroner. The Prevention of Future Deaths Report and the responses are published on the Chief Coroner's website.

[Reports to Prevent Future Deaths - Courts and Tribunals Judiciary](#) (opens in a new tab)

PRESS AND PUBLICITY

As Inquests are held in public, the press will often be present. Staff attending an Inquest should not speak to the media individually (save to confirm their name if asked) but should refer any enquiries to the communications department within the Health Board. Staff should be aware that the press are permitted to report the details of an inquest which may including the names of witnesses.

AFTER THE INQUEST

The conclusion and any recommendations/comments will be shared with the relevant departments for consideration. Discussion will take place regarding lessons learnt and actions to be taken in order to minimise the risk of similar incidents occurring in the future. A subsequent review / audit should be undertaken and an assurance report presented to the Listening and Learning Sub-Committee and relevant Quality, Experience and Assurance Sub-Committee.

CRIMINAL PROCEEDINGS

In cases where an inquest is suspended to allow a criminal investigation to take place, the Health Board should allow the investigation to continue unhindered and cease any investigation that may have been started immediately so that there will be no interference with the criminal investigation. In the event of any ongoing patient safety risk please seek advice from the Legal Services Team. It is imperative that any criminal investigation is not compromised by health board staff talking amongst themselves about their evidence or taking statements from the staff involved in an incident where there may have been criminal activity in the knowledge that the police are carrying out an investigation. Any discussions about the evidence with witnesses involved in the matter may well weaken the prosecution case and lead to the perpetrator being wrongly acquitted.

Any further actions which might be necessary to ensure patient safety, should be guided by legal advice in liaison with the police.

As the inquest will have been suspended in such cases, the coroner will not ask the health board to obtain statements from its staff unless and until he/she decides to resume the inquest after the criminal

investigation/trial has concluded. However, staff may still be approached by the Officer in Charge of the Investigation (the OIC)

If staff are asked to provide documentation to the Police or Health and Safety Executive (HSE) they must contact the Legal Services Team. The officer should be asked to produce the s29 Data protection form together with their contact details and informed that the Health Board will respond as soon as it can. That form should then be sent to the Information Governance Department for review whereupon a decision will be made on lawful disclosure of the documents. If staff are unable to contact the IG Department, they could contact the Legal Services Team and if they are not available, the officer should be asked to contact the Chief Executive's Department.

Under no circumstances should any original hospital records be released to the police or investigating body or information given over the telephone. There is a specific Health Board process for the police to obtain copies of medical/personnel records and that should be adhered to upon such a request. Staff should not personally hand over any records or copies of records to anyone. In some circumstances it may be permissible for staff to provide copies to the police but only after the written request has been screened by IG and under its direction. This may be where the evidence is on an A&E records that is currently in use of the like.

In some circumstances, a police officer will request verbal information regarding a patient's condition/injuries, without at that stage requiring a full statement (e.g. when deciding whether an alleged assailant should be charged with causing Grievous Bodily Harm or not). Such verbal information may be released by a Doctor, provided the patient consents to the release. If the patient is unable to consent and, in the Doctor's opinion, there is an duty to do so within the Data Protection Act 2018 for example a patient arrives with a gunshot wound or child abuse is suspected, then information may be given but it would be wise to seek advice from the Legal Services Team or Information Governance or, if unavailable, ask for advice from the A&E consultant before any information is provided.

If a police officer or HSE inspector requests a statement from a member of staff in connection with an ongoing investigation, the individual should ask them to confirm the nature of the statement, i.e. are they asking for a voluntary witness statement. Staff are not obliged to provide a witness statement, this is a decision for the member of staff. However, if they are a key witnesses an application may be made to the court for directions that the witness is to make a statement. The only people who cannot be compelled to give evidence by a judge is a person's spouse.

If you are a witness to an incident or have treated a victim or alleged perpetrator of a crime, the HB would advise staff as follows:

- Provide a statement to the police if you so wish. You do not need to seek permission from anyone first.
- If you are concerned, you can seek legal advice from the Legal Services Team prior to providing your statement. The person in legal services will not want to discuss your evidence with you and you should not discuss your evidence with them. You should ask whether or not the officer in charge is content or you to seek assistance from the Health Board Legal Team first. If so, you can make arrangements for the officer to return at a mutually convenient time

- Take the officer's contact details;
- Contact the Legal Services Team, your union, or seek independent legal advice if you wish.

Where staff are required to attend an interview under caution, staff are advised to:

- Ask the police officer to agree a suitable date for the interview so that you can take independent legal advice;
- Take the officer's contact details;
- Obtain your own legal advice either initially from your union or from a suitable solicitor

If a police officer compels a member of staff to attend an interview under caution and the staff member is arrested and taken to the police station, staff are advised to seek legal advice from a suitable independent solicitor or from the duty solicitor who can meet them at the police station.

The Health Board Legal Team cannot be involved in those circumstances. The Health Board legal team represents the Health Board and not individual members of staff.

Where the Health Board has been given Interested Person Status and witness statements are requested from staff members, the solicitor/barrister representing the Health Board can provide some support and advice to those witnesses as they sit under the umbrella of the Health Board. In the event the staff member has allegedly committed a crime, been through a disciplinary or acted outside of policy, legal advice cannot be sourced from the Health Board's legal team as they will be advising the Health Board and a conflict of interest may well arise.

SUPPORT FOR STAFF

The HB is committed to developing a working environment that promotes the health and well-being of its employees. They may become anxious or experience distress if they are involved in traumatic incidents, complaints, claims or have to attend court. For some staff, the distress and loss of confidence can affect their ability to work and/or maintain a normal home life.

The first line of support is the person's line manager, who can allay some fears by informing the staff member of the process and referring them to appropriate resources and services. It may be possible for the manager to intervene during the incident if called. A risk assessment should be carried out to assess the ability of the person to continue with their duties and appropriate measures taken to mitigate against any identified risks eventuating.

The line manager should be aware of vulnerable staff members, perhaps due to similar past experiences or who have particularly close involvement with the incident or with those involved in it. Staff should be seen individually and extra support provided if required.

Assistance can be provided from the Occupational Health Department, as well as the Staff Psychological and Well-Being Service. Contacts can be found at [Appendix 3](#).

A list of contacts can be found at [Appendix 3](#).

The Law Governing Inquests

- Coroners Investigation Regulations 2013
- Coroners Inquest Rules 2013
- Coroners and Justice Act 2009
- Notification of Death Regulations 2019
- Coroners Allowances, Fees and Expenses Regulations 2003

APPENDIX 1 - CORONER STATEMENT REQUIREMENTS

DO NOT DISCUSS YOUR WITNESS EVIDENCE WITH ANYONE ELSE.

DO NOT WRITE YOUR WITNESS STATEMENT IN COLLABORATION WITH ANY OTHER WITNESS IF YOU ARE ASSISTED TO WRITE YOUR STATEMENT BY YOUR LINE MANAGER, ENSURE THAT WHAT YOU WRITE IS YOUR RECOLLECTION OF EVENTS AND IF THEY ARE ASSISTING ANOTHER PERSON WITH THEIR STATEMENT IN RELATION TO THE SAME MATTER, ENSURE THAT THEY DON'T INFORM YOU ABOUT WHAT THE OTHER PERSON HAS SAID OR THAT THEY DON'T INFLUENCE WHAT YOU WRITE IN ANY WAY.

IF YOU HEAR OR ARE TOLD THAT YOUR EVIDENCE DIFFERS FROM THAT OF SOMEONE ELSE – DO NOT CHANGE YOUR EVIDENCE. PEOPLE OFTEN REMEMBER THINGS DIFFERENTLY OR HEAR THINGS DIFFERENTLY AND IT IS NOT UNUSUAL FOR THERE TO BE A DISPUTE OF FACTS. PLEASE DISCUSS THIS WITH THE LEGAL REPRESENTATIVE WELL IN ADVANCE OF THE COMMENCEMENT OF THE INQUEST.

The following is a guide on how statements for the Coroner should be prepared and the information they should contain:

Format

The statement should be typed on the Health Board statement template using Times New Roman 12 font and numbered paragraphs. Having the paragraphs numbered makes it easier to refer to specific parts of the statement if called to give oral evidence.

In paragraph 1, you should clearly identify your employer, your current role within the organisation and how long you have had the role, your qualifications with the dates you obtained them, your past professional experience if appropriate (eg the total number of years you have held a particular role even if that is in different hospitals), where you are currently based.

"I, XXXXXXXXXXXX, of, XXXXXXXXXXXXXXXX Please insert your professional address Will Say:

1 I am employed by Hywel Dda University Local Health Board asinsert your current role.....I have occupied this role foryears. If you have changed roles since the time you cared for the deceased person please say what your role was at the time of their death. My qualifications arePlease insert your qualifications with dates. Include any post grad qualifications you have. I have also had training

in the following:.....Insert the training you have had with dates – in particular WARRN training Risk assessment and care planning training.”

In the second paragraph you should set out your role in more detail outlining your responsibilities and your day to day activities.

The statement should include, to the best of your knowledge, the numbers of staff on duty and the number of patients on the ward where appropriate.

In the footer the statement the pages should be numbered, it should have a statement of truth which is worded in a specific way and it should be signed and dated. The signature should be a handwritten signature or an electronic copy of your handwritten signature. Typing your name is not sufficient for the court.

HINTS AND TIPS FOR WRITING A STATEMENT

DO's

- 1 Write your statement as if the person reading it knows nothing about health care.
- 2 Number the paragraphs
- 3 If you are describing an assault include all the **details you saw** such as:
 - a. The exact position of the assailant and victim as you recall
 - b. The details of the assault – who did what when and how
 - c. What was said and by whom
 - d. What happened in the immediate aftermath and thereafter.
- 4 If you are giving evidence about a fall
 - a. Describe what you witnessed
 - b. What position the person was found in and their proximity to items in the room such as the bed, door, locker etc., so that those reading your statement can form an exact picture of what you saw.
 - c. If you did not witness the fall say so and include what you saw when you came upon the incident.
 - d. What were your immediate actions and those of others that were within your sight.

- 5 Explain your rationale for any **decisions that you made**. Do not be tempted to try to explain someone else's rationale for doing something – they will be able to speak for themselves.
- 6 You can give details of discussions about a patient if you had first-hand knowledge of them ie during an MDT/ward round or you are quoting from the records. (You must clarify which). Do not give evidence about a discussion you have been told about, those party to those particular discussions can do that.
- 7 If the statement is about an incident on the ward, include how many patients there were on the ward at the relevant time, what the staffing levels were on that shift and the acuity of the ward at the time.
- 8 If you wish to refer to guidelines or policies in place **at the relevant time**, the full document in operation at the time will need to be exhibited to your statement. If you have departed from any policies or guidelines, you must explain why it was necessary to do that. The legal team can help with how this is introduced as part of your statement.
- 9 Write the statement in chronological order providing an account of your involvement with the patient. This should include, dates you were involved, the details of any encounters, how they presented and any other relevant detail. Do not speculate. Do not include anything you don't know to be factually correct.
- 10 You can include what you have been told by the patient and/or others.
- 11 The statement must not contain any hostile, offensive or unnecessarily defensive comments.
- 12 The statement should be written in the first person singular, e.g. "I saw....." Write in plain English, with properly constructed sentences and correct spelling and grammar. Do not copy and paste the entries from the notes into your statement unless they are specific quotes used to illustrate something. Records are often abbreviated or not written in full sentences. The Coroner will have a copy of the records. How your statement is written will be a reflection on you and your practice.
- 13 Only include things that are within your own knowledge or based on a review of your entries in the records.
- 14 You must be as accurate as possible in relation to dates, times and dosages of drugs etc.

- 15 Clearly state what you can and cannot recall from memory and what has been taken from the records.
- 16 If you use abbreviations, ensure that full terminology is given at least once, with the abbreviation to be used in brackets. Technical terms can be used but you should try to explain them in lay terms where possible.
- 17 Your statement has to be verified by a statement of truth as shown below. The wording is as it is stated in the Civil Procedure Rules and should not be changed.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed

Dated"

- 18 **DO NOT sign your statement** until you are satisfied that it has been finalised. A document **that has been signed by you is discloseable to the coroner** and to the family whatever form it is in at the time it is signed.
- 19 Your statement is likely to be disclosed to a patient’s family, representative and legal adviser and to any other interested person in the event of an inquest.
- 20 Always retain a copy of your statement for future reference.

DON'Ts

- 21 Do not Speculate
- 22 Do not give your opinion on anything and in particular on the practice of another health care professional. **You are a witness of fact.** If the Coroner wants an opinion, he will instruct an independent expert witness.

- 23 Do not explain the rationale for decisions made by others that will be for them to explain.
- 24 Do not make comments on anything outside your area of practise.
- 25 Do not make your statement without first considering any entries you have made in the records. If you are called to give oral evidence, you may be taken to entries you have made in the notes and asked questions about them. Therefore, it is important that you have read your entries before you write your statement and that any references to documentation are accurate.
- 26 **Copies of statements must not be placed in a patient's records. This also applies to any complaint, or claim correspondence or any legal advice or emails passing between you and the legal team**

APPENDIX 2- WITNESS GUIDANCE

When giving evidence in Court

DO:

- Speak clearly and slowly
- Answer the specific question asked
- Keep the answer as succinct as possible
- Ask the question to be repeated if it was not audible
- Reply “I don’t know” if you do not know the answer
- Reply “I can’t remember” if you cannot remember a particular point
- Be courteous
- Take your time
- Think about the question and the answer before giving it
- Stick to what you know from your own knowledge or from your review of the records
- Ask to refer to the witness statement if you need to refresh your memory
- Tell the Coroner you do not understand the question if that is the case
- Direct all answers to either the Coroner or the jury
- Familiarise yourself with the contents of your witness statement at least the night before and, if necessary, again during the morning before the Inquest starts
- Inform the barrister or solicitor, before the start of your evidence, if any of the contents of the statement are incorrect
- Tell the truth
- Only provide evidence on what is within your area of expertise. If you are asked a question that is not within your own practice then inform the coroner of that.

DON'T:

- Guess or speculate on the answer to a question
- Argue with the barrister, solicitor or family
- Ask questions of the barrister or solicitor other than to clarification the question
- Ask rhetorical questions
- Get angry or upset – remain professional at all times
- Keep going if you need a break
- Be rushed into giving an answer without thinking
- Be forced to answer questions at a pace with which you are uncomfortable, answer questions at your own pace
- Allow yourself to be browbeaten into saying yes when you have said no to the same or similar question several time already
- Give the barrister or solicitor the answer he wants simply to get him off your back
- Speak to other witnesses about your evidence
- Speak to anyone about the case if there is a break and you are still in the middle of giving your evidence – you will still be under oath and any discussions may be construed as interference with the evidence.
- Swear or use coarse language unless you are repeating something you overheard which is relevant to the case;
- Turn up at Court only 5 minutes before the case is due to start; arrive either at the time the solicitor has directed or, in any other case, at least half an hour before the case is due to start;

- Worry or concern yourself with the argument the barrister or solicitor is seeking to make; stick to the facts;
- Try and anticipate the questions the barrister or solicitor is going to ask you in a few minutes' time; take each question one at a time;
- Refuse to answer a question, unless you are told by the Coroner that you may do so.
- Turn up and tell the Coroner that you have had not had the chance to read your witness statement recently or you are not sure if the contents of it are true (this will cause unnecessary delay)
- Tell the Coroner the contents of your statement are true, even though you know one or two points are not, but you feel that you must stick to the statement because you have signed it on a previous date (if the statement contains an inaccuracy that must be corrected at the outset)
- Worry or concern yourself about how you will come across; if you can be as relaxed as possible in the circumstances and be yourself you will be fine.

APPENDIX 3 - CONTACTS

Legal Services Team

Louise O'Connor, Assistant Director (Patient Experience / Legal Services)
Louise.O'Connor@wales.nhs.uk

Gaynor Kynaston Head of Legal Services
Gaynor.kynaston3@wales.nhs.uk

Rachel Anthony Deputy Head of Legal Services
Rachel.anthony@wales.nhs.uk

Communications

(Hywel Dda UHB - Generic Press Office Email) MediaOffice.Hyweldda@wales.nhs.uk

Medical Records

Steven Bennett, Health Records Manager
Steven.bennett@wales.nhs.uk

Staff Psychological and Well-Being Service

Tel: 01437 772527

wellbeing.HDD@wales.nhs.uk

Occupational Health Department

Occupational.health.hdd@wales.nhs.uk

Chaplaincy

Euryl Howells, Senior Chaplain, Hywel Dda University Health Board
Euryl.howells2@wales.nhs.uk