The ins and outs of inquests

PART 1 – Understanding and preparing for an inquest

Following a report of a death to the Coroner, it may be necessary for a consultant, or private practitioner to attend an inquest. Dr Gabrielle Pendlebury, Medicolegal Consultant at Medical Protection advises on what to expect and how to prepare for an inquest.

The purpose of an inquest

A Coroner must investigate deaths that are violent, unnatural or unexplained, and those that occur in state detention. A preliminary investigation may clarify that a death was natural, but if not, the Coroner will proceed to a formal investigation and open an inquest when necessary.

Ultimately, a Coroner's inquest must answer four questions:

- Who died
- Where
- When
- How, or in what circumstances the deceased came by their death.

To answer these questions, the Coroner may require information from a number of sources. This can include *opinion* evidence from experts such as a pathologist or toxicologist, and evidence from *factual* witnesses including clinicians involved in the care of a deceased patient.

An inquest hearing is held in public and is a formal court proceeding. There is no defence and prosecution as it is not a function of the coroner to apportion blame – the coroner's court is one of investigation and inquiry; it is not adversarial.

Notification of involvement in an inquest

In most instances, the doctor will hear from the family or other healthcare professionals that a patient has died. However, on occasion they will find this information out directly from the Coroner either in writing or through a phone call.

If the Coroner has decided an inquest is necessary to investigate the death, one must be opened as soon as practicable after a reportable death, and the process should, where possible, be concluded within six months.

In complex cases the Coroner may hold a Pre-Inquest Review Hearing (PIRH) with interested persons, to decide on the scope of the investigation, identify witnesses, and to plan the inquest date and duration.

As soon as you are aware of an inquest it is sensible to contact your Medical Defence Organisation (MDO) as they can then liaise with the Coroner on your behalf if they believe that this is necessary.

A request for a report

Your MDO can also assist in the preparation of a report, if one has been requested by the Coroner, by reviewing and editing the proposed report and also by gaining relevant information from the Coroner. It is at this stage, that the Coroner may also alert the doctor to the need for a PIRH.

It is often helpful to call your MDO in anticipation of writing a report, as this will prevent procrastination but also allow you to talk through the case and consider how best to structure the report.

Preparation is key when it comes to preparing the report. The production of a comprehensive, clear and preferably concise report can have a number of positive outcomes:

- Aid the Coroner in her understanding of events
- Give closure to the family by answering questions they may have
- Provide some catharsis for the clinician, it is very rare for a clinician to not have doubts about their practise, or if issues/errors are identified, it allows time to remediate and address these issues prior to the inquest
- A well-prepared report is excellent preparation for giving evidence, the clinician while writing the report will be drawn to areas of ambiguity and confusion, which can be addressed first at this stage rather than alighted upon at the inquest.

A common error is to be overinclusive, thus producing an unwieldy report that is difficult to read. It is good to keep in mind American humourist Mark Twain's quote 'I apologize for such a long letter – I didn't have time to write a short one.'[1]

However, it is better to provide too much information than too little. If you are struggling to write a targeted report, your MDO can review and edit. We know the process can be terrifying and it is easy to lose sight of what information is necessary and important.

The report should be based on the medical records, your own recollection and your usual practice.

To what include

- Personal details – your qualifications, number of years working, relevant clinical experience and background
- Who has requested the report and for what purpose – what you have been asked to include in the report
- Details of other healthcare professionals involved
- Patient details
- Summary of patient's medical issues and medication history
- Chronology of important events
- Increasing in level of detail up until the patient's death, with the most detail in relation to the last consultation

[1] 1975 May 7, Chicago Tribune, Traveler's guide: Postcard writing is the vacationer's art, by Carol Baker, Section 3, Quote Page 16, Column 2, Chicago, Illinois. (Newspapers.com)

- Offer to answer any further questions that may arise and condolences to the family
- The report should be clearly dated, and must be signed by you.

Do…

- Write your report honestly; don't be influenced by others
- Write it as soon as possible, while the incident is still fresh in your mind
- Only include details of events that you personally were involved in, unless attributed to others for example "Mr X was seen by Dr Y on…., the medical notes indicate…"
- Only include relevant facts; your opinion is only necessary if specifically asked for
- Don't comment on behalf of others – but you can say "Dr X said…."

Do not…

- Exceed your level of competence
- Deliberately conceal anything – this will cast doubts on your integrity and will make subsequent comments less credible.

Report writing tips

- Write in the first person singular – "I did this…"
- Address the report to an intelligent lay person; avoid jargon and abbreviations
- Bear in mind that the patient or their relatives are likely to see the report; avoid any pejorative, humorous or unnecessary subjective remarks
- Organise the report chronologically – give actual dates, and use either a 24-hour clock to give times, or state whether you are referring to am or pm
- Give each incident or event a separate paragraph or section
- Check spelling, punctuation and grammar before submitting, even minor errors can be viewed negatively by a grieving family
- Your report should be typed, signed and dated
- Keep a copy of the report in your notes and a note of how, when and to whom you submitted it.

If you are asked to change the report, you should think very carefully about the event before doing this, and only make changes if a factual mistake needs to be rectified.

Making a supplementary report

Sometimes it is necessary to make a supplementary report to deal with issues that come to light after you have written your original report. Before doing this, make sure that you review your report, the medical records and any new documentation.

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