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ARTICLE

What the psychiatrist needs to know about the coroner's court in England and Wales

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SUMMARY

It is highly likely that a psychiatrist will be called to an inquest at some point in their career. Our aim in this article is to educate psychiatrists in relation to the law and processes of a coroner's court in England and Wales and provide guidance on engaging with the system. To achieve this we review and discuss the relevant law and medico-legal aspects of inquests. Knowledge and preparation are key to negotiating any inquest and we would hope that the understanding and guidance offered in this article will reduce anxiety, make the situation manageable and aid professionalism, in often tragic circumstances.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the role of the coroner's court
- prepare a comprehensive report for the coroner
- understand the medico-legal aspects of inquests

KEYWORDS

Inquest; coroner; interested person; suicide; regulation 28.

The death of a patient in psychiatry is often sudden and unexpected and if the death is due to suicide, this will add a further layer of emotional complexity. It is not uncommon for psychiatrists to feel overwhelmed, not only by their internal experience but also by the subsequent institutional response and the requirements of an inquest. In certain situations, individuals or the organisation may, in part, unconsciously seek to exonerate themselves and project their internal sense of blame and responsibility on to others (Campbell 2017).

Furthermore, the unfamiliar territory of the coroner's court is then added to the equation. One of the biggest challenges a psychiatrist may have to face is coming to terms with the death of a patient and we would hope that the coronial process would aid this process, by allowing a clear conclusion to be reached:

> 'It should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt.' (*R v South London Coroner ex parte Thompson* [1982])

With that end in mind, we have written this article to support psychiatrists, by giving them the information they need to be able to understand and negotiate an inquest professionally and thoughtfully.

The coroner's court

The coroner's court in England and Wales is distinct from their civil and criminal jurisdictions, which are adversarial, in that it is inquisitorial. Within the coroner's court, there are no parties, only 'interested persons' (Coroners and Justice Act 2009, the CJA 2009). There is no cross-examination, only questioning of the elicit facts. There is no case being presented and interested persons are prohibited from addressing the coroner as to the facts and entirely prohibited from addressing the jury, if there is one. The coroner's court also has no set procedural rules. The result is that the coroner and not the interested persons determine the process of investigation and hearings, the scope of the investigation and inquest, which can be wide (determined by section 5 of the CJA 2009) and which witnesses to call and which experts to instruct. In court, the coroner asks questions first of the witnesses and, although that may expose errors, it is essentially a neutral enquiry to establish the facts and understand decisions, actions and omissions that may have contributed to or prevented death.

The role of the coroner

The coroner has a legal duty under the CJA (2009) (not a discretion) to investigate violent, unnatural or unexplained deaths.

For many years coroners' services were criticised as being opaque, inconsistent and unresponsive to families and various enquiries recommended reform.

A medical qualification no longer fulfils the judicial eligibility criteria and, consequently, doctors

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may no longer be appointed as coroners unless they are also qualified barristers or solicitors (CJA 2009). What must be appreciated by medical witnesses is that no assumption should be made about their knowledge or understanding. Statements and evidence in court must be written or explained for the lay person to understand: a medically qualified coroner cannot use that expertise in court.

Notification of deaths to the coroner and the decision to investigate

Medical practitioners now have a statutory duty to notify the coroner of a death (section 3(1) of the Notification of Deaths Regulations 2019 (SI 2019 No. 1112): www.legislation.gov.uk/uksi/2019/1112/made) where the doctor suspects it was due to drugs, medication, treatment, trauma, self-harm, neglect, was work related, otherwise unnatural, during state detention or with no known medical cause after enquiries and attendance. Very importantly for psychiatrists, state detention includes the deaths of patients detained under the Mental Health Act 1983 (*R (Linnane) v HM Coroner for Inner North London* [1989]). Medical examiners have the legal role of advising medical practitioners on certification and notification to the coroner.

Deaths in the community may first come to the notice of the psychiatrist from the coroner. Section 1 of the CJA 2009 requires the coroner to conduct an investigation if they have reason to suspect:

(1) that a body of a deceased person is within their area; and
(2) the deceased:
    (i) died a violent death
    (ii) died an unnatural death
    (iii) has a cause of death which is unknown, or
    (iv) died while in custody or otherwise in state detention.

The Act contemplates three discrete phases in the coronial process (most notifications to a coroner do not get beyond the first phase):

(1) preliminary inquiries (before formally opening an investigation);
(2) an investigation (with or without an inquest); and
(3) an inquest.

The preliminary inquiry will establish that the body lies within the jurisdiction and whether a medical certificate of cause of death (MCCD) can be obtained that records the death as 'natural'. If the coroner is satisfied a Form A is issued to the Registrar. An autopsy is often needed to secure an MCCD (39% of deaths reported have autopsies (www.gov.uk/government/coroners-statistics-2019-england-and-wales)) and if the coroner is satisfied that there is no duty to investigate, he or she then issues a Form B to the Registrar.

The coroner must discontinue the investigation if the post-mortem examination reveals a natural cause of death and the coroner thinks it unnecessary to continue the investigation; if it is deemed an unnatural death or the death is in state detention the investigation must continue (CJA 2009). The coroner may resume an investigation if new information about the death is presented. There is no provision to discontinue, if there is no autopsy, but this anomaly is being corrected in proposed legislation (Justice Review & Courts Bill). In cases of 'unnatural deaths' the CJA 2009 does not provide a definition of natural or unnatural. Medical practitioners should advise coroners of the meaning of the MCCD and whether it relates to an intervention. Circumstances may mean that scientifically natural death is regarded as unnatural (*R (Touche) v Inner North London Coroner* [2001]) or a scientifically unnatural death is legally ruled natural (*R v HM coroner for Birmingham and Solihull ex p Benton* [1998]; Harris 2019).

COVID-19 as a cause of death (or contributory cause) is not reason on its own to refer a death to a coroner under CJA 2009. COVID-19 being a notifiable disease under the Health Protection (Notification) Regulations 2010, to Public Health England, does not mean a referral to a coroner is required by virtue of its notifiable status. Section 30, Coronavirus Act 2020 removes the requirement for a jury inquest to be held in COVID-19 cases but does not remove the need in certain cases to establish whether it is a work related death.

Section 1 CJA 2009 requires coroners to open an inquest even in the event of a natural death in state detention (such as being sectioned). There is no necessary requirement to have an inquest with a jury when the death is from natural causes (section 7(2)a CJA 2009).

The scope of the inquest

Under section 5 of the CJA 2009, there are four questions to be determined at an inquest: who the deceased was (their identity), and how ('by what means'), when and where they came by their death.

By 'how', the question to be asked by the coroner is on the balance of probabilities (i.e. was that probably or likely the means by which the deceased came by their death (Chief Coroner 2021)). In most inquests, the inquiry must focus on matters that are directly causative of the death, sometimes to the frustration of families who seek answers to questions such as previous mental healthcare plans or failures to communicate with relatives, which may

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lie outside the scope of the inquest. But a coroner can initially investigate wider matters and determine whether they are in scope and can also record matters that have contributed to death more than minimally or trivially.

The Human Rights Act 1998

The Human Rights Act 1998 gave effect in English law to the European Convention on Human Rights (the ECHR). If Article 2 (the 'right to life') of the ECHR is engaged, the inquest must be conducted with 'how' the deceased came by their death broadened out into 'how and in what circumstances' they came by their death *(R (Middleton) v HM Coroner for Western Somerset* [2004]). The principal effect is that the Record of Inquest may record a variety of circumstances that contributed to the death with a more in-depth inquiry, taking several days. In addition, the coroner may also in certain specified circumstances of admitted failures record matters that may have *possibly* (as opposed to probably) contributed to the death (*R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016]). The matter is less clear in non-jury cases (*R (Carole Smith) v Assistant Coroner for NW Wales and Betsi Cadwaladr University Health Board* [2020]).

Deaths in prison (or in hospital while still a prisoner) and in police custody engage the procedural duty automatically (*R (Letts) v Lord Chancellor* [2015]). The death of a psychiatric patient detained under the Mental Health Act will also engage Article 2 but not the death of a patient on a community treatment order (CTO). These deaths only need a jury when they are unnatural (*R (Letts) v Lord Chancellor* [2015]). But the threshold for engagement for deaths in hospital of non-detained patients is high (*Savage v S Essex Partnership NHS FT* [2009]).

Engagement of Article 2 of the ECHR

Whether an inquest engages Article 2 involves complex analysis of case law, which determines how to judge if there is an arguable breach of the operational or general duty.

Operational duty

The state's operational duty is engaged if there is knowledge (or should have been knowledge) of a real and immediate risk to an individual's life and the state failed to take steps within the scope of its powers which, judged reasonably, might have been expected to avoid that risk (*Osman v UK* [1999]). This would very rarely apply to NHS alleged failures without other factors. A recent judicial decision by the chief Coroner found no operational duty was owed to a voluntary psychiatric patient in a community rehabilitation unit to protect her against the risk of accidental death by taking recreational drugs (*R (Morahan) v HM Coroner for West London* [2021]). It has been held that a State Benefits Agency did not owe an operational duty to safeguard a mentally unwell benefits claimant from the risk of suicide (*Dove v HM Coroner for Teeside and Hartlepool* [2021]).

In certain circumstances, the threshold for engaging Article 2 may be lowered (*Kemaloglu v Turkey* [2012]). Circumstances include: the patient's vulnerability, assumption of control over the patient by the hospital and whether the nature of the risk was exceptional (being sufficiently at risk to be detained under the Mental Health Act). However, there is no general duty to prevent everyone from taking their own life (*Savage v South Essex Partnership NHS Trust* [2008]).

Suspicion of system failure

The state's general duty is engaged if there should be a system that puts in place a framework of laws, precautions, procedures and means of enforcements which will, to the greatest extent reasonably practicable, protect life. An example would be where there are inadequate procedures in a psychiatric ward to protect life, such as a wholly inadequate system of preventing drugs of misuse from being brought into the ward and distributed, as opposed to a failure to follow those procedures (which would not be a breach of the systemic duty but may well be a breach of the operational duty) (*Lopes De Sousa Fernandes v Portugal* [2015]).

The threshold for finding a system failure in healthcare as sufficient to engage Article 2 is particularly high; an example may be a lack of assessment of ligature points in an acute in-patient setting. It requires:

(1) an act/omission that goes beyond negligence but equates to a denial of treatment despite knowing that this risk's the person's life;
(2) this dysfunction must be objectively identifiable as systemic or structural;
(3) the dysfunction must be causative of the harm to the patient; and
(4) the dysfunction must arise from the failure of the state to put in place a regulatory framework (*Rabone v Pennine Care trust* [2009]).

Deaths involving suicide

In providing evidence in these cases, the coroner and family will want to understand if the suicide risk was known. Professional evidence on the predictors of suicide, the validity and reliability of risk assessments and an interpretation of assessments

conducted are often useful. Where the deceased falls into a higher risk category such as in-patient or post-discharge or the death was related to opioid prescriptions, evidence will be needed on steps taken to mitigate the risk (University of Manchester 2019). Evidence not known in life that comes to light in an inquest from family, friends or electronic devices should be considered by a psychiatrist opining on suicidal intent.

The judgment in *Maughan* (*R (Thomas Maughan) v Senior Coroner for Oxfordshire* [2020]) held that in an inquest suicide should be proved by the civil standard of proof (proof on the balance of probabilities) rather than the criminal standard (proof beyond reasonable doubt). The coroner decided that the evidence was insufficient to enable the jury to conclude to the criminal standard that the deceased intended to take his own life and so withdrew the conclusion of suicide and directed them to conclude with a narrative verdict. The deceased was found hanging in his prison cell. He had made previous attempts at suicide and self-harm. The jury concluded that the prison staff should have been more vigilant.

The High Court, the Court of Appeal and the Supreme Court subsequently confirmed that the standard of proof to be applied in cases of suicide in inquests is the civil standard of proof. The Court of Appeal found that it was not bound by a previous decision (*R (McCurbin) v Wolverhampton Coroner* [1990]), as that was a case about unlawful killing rather than suicide. This was for several reasons: suicide is no longer a crime, proceedings are inquisitorial rather than adversarial and the civil standard means that a broader enquiry may be made. The lower standard of proof makes it easier for coroners and juries to reach a conclusion of suicide. Consequently, it will inevitably have an impact on government statistics relating to the number of deaths that are recorded as suicides.

Mental health investigation/serious untoward incident review/root cause analysis

Where a death is unexpected the National Health Service (NHS) trust/health board involved will usually conduct an internal investigation or occasionally commission an external investigation to ensure lessons are learned from the incident. Psychiatrists should not defer writing their statements for court until this investigation is complete, but may reserve the right to make a supplementary statement when the report has been published.

The coroner has powers to direct the disclosure of the interview records from the incident investigation, mortality case reviews, audits or any documents that may be relevant to how the death occurred. The trust may submit that these are confidential and they may be disclosed to the coroner only in confidence (*R (AP) v HM Coroner Worcestershire* [2001]). They usually only become potentially disclosable to the interested persons if other evidence is given that conflicts with the undisclosed.

Before attending court, it is useful to revisit the incident review. If this highlights any issues, such as factual inaccuracies, it allows time to evaluate and prepare an explanation in advance of giving evidence.

The psychiatric statement for the court

The psychiatric witness should know why they are being asked to make a statement. The psychiatrist is entitled to ask what questions they should address. For example, it could be to respond to a criticism of care or to state the nature of a condition and its treatment; it could be to establish whether the deceased had an intent to take their life; it could be to explain matters to the family.

The production of a comprehensive, clear and concise report can have several positive outcomes. It can help the coroner in their understanding of events; give closure to the family by answering questions they have; and provide some catharsis for the clinician, as it is very rare for a clinician not to have doubts about their practice, and if problems or errors are identified, it allows time to address and remediate these before the inquest. A well-prepared report is also excellent preparation for giving evidence, as the clinician, while writing the report, will be drawn to areas of ambiguity and confusion which may be addressed at this stage rather than remaining unchanged until brought to light at the inquest.

A common error is to be overinclusive; the most important consideration is to answer the questions posed by the coroner. That might not require preparation of a full psychiatric history. Box 1 outlines what you should include in your statement and Box 2 lists some do's and don'ts.

A medical witness is under no legal obligation to prepare a statement or report for the coroner unless served with a notice under Schedule 5 of the CJA 2009 or a common law summons. However, psychiatrists should be extremely wary of declining to assist the Court, as medical witnesses are under a professional duty to assist the coroner.

A pre-inquest review hearing (PIRH) and Rule 23

Following submission of your statement, in complex cases the coroner may hold a pre-inquest review

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hearing (PIRH) with interested persons to decide on the scope of the investigation, direct further disclosure, identify witnesses and plan the inquest date and duration. The purpose is to assist in the management of the inquest itself, which is particularly useful in complex cases.

Furthermore, before the inquest or at the PIRH if you are being called to give live evidence but your medical defence organisation (MDO) feels that the statement could be read, an application in writing may be made to have the statement read under Rule 23 of the Coroners (Inquests) Rules 2013 (SI 2013 No. 1616: www.legislation.gov.uk/uksi/2013/1616/made/data.pdf), either before the PIRH or at the hearing.

The psychiatrist as witness

Psychiatrists frequently play a pivotal role in proceedings, as either witnesses of fact or as expert witnesses, or both. The coroner decides what witnesses to call to give evidence. A failure by a coroner to call relevant witnesses may be a ground to quash the inquest and order a fresh inquest to be heard (*R (Hair) v HM Coroner for South Staffordshire* [2010]). Where there have been a series of failings, the High Court has held that it is necessary to call witnesses who have direct knowledge and responsibility in relation to the treatment of the patient (*R (Mack) v HM Coroner for Birmingham and Solihull* [2011]).

Psychiatrists should discuss with their legal advisors which witnesses are most appropriate to be suggested to the coroner, although ultimately the decision is that of the coroner.

You can be called to attend an inquest hearing as a witness in two ways:

- as a 'witness of fact': your statement will form the basis of your oral evidence and you may be asked relevant questions to clarify certain aspects
- as an interested person: if you are granted interested person status, it would indicate that the coroner believes you to be more centrally involved in the circumstances leading to death and you may be subject to criticism.

Interested persons

It is crucial that a psychiatrist being asked to make a statement in a coroner's court understands their legal status and why they have been asked. There are several statutory grounds under which a person or organisation can be given interested person status. They are set out at section 47(2)(a–m) of the CJA 2009. Doctors and medical professionals are usually recognised as interested persons under section 47(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 also has a 'catch all' discretion under section 47(2)(m) to grant interested person status to anyone who is deemed to have 'sufficient interest'.

BOX 1 What to include in a psychiatric statement for the coroner's court

- Personal details – your qualifications, number of years working, relevant clinical experience and background
- Who has requested the report and for what purpose
- Details of other healthcare professionals involved
- The patient's details
- Summary of the patient's medical problems and medication history, including assessments of risks of self-harm
- 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
- If you have written the medical certificate of cause of death, the reasons and basis for it; if you have not, the relevance of the medical history and your care to the medical cause of death
- An offer to answer any further questions that may arise and condolences to the family

Note that the report should be clearly dated and must be signed by you.

BOX 2 The do's and don'ts of writing a psychiatric statement for the coroner's court

Do:

- write your statement honestly, with no influence 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. You are entitled to explain why you took a particular decision and its basis, as a witness of fact.

Do not:

- comment on behalf of others – but you can say 'Dr X said …'
- exceed your level of competence
- deliberately conceal anything – this will cast doubts on your integrity and will make subsequent comments less credible.

Interested persons are appointed by the coroner, mostly on the basis of a statutory right and this gives them rights to make submissions to the coroner as to the key issues and the appropriate witnesses and the rights to disclosure of evidence and to question witnesses in court. The legal representative of the witness usually asks questions last, followed by the jury, if there is one. Under Rule 19(2) of the Coroners (Inquests) Rules, the coroner must disallow questions that the coroner considers irrelevant.

If a mental health trust is being criticised they will automatically be an interested person and if the psychiatrist works for that trust they need to consider whether they should be an interested person in their own right, if they feel criticism may be directed at them. This is a decision that can be made with the support of your MDO. If there is criticism, then they should be provided with the allegations made by the family, the reasons for criticism and/or the autopsy report, to assist in constructing a statement.

If an individual psychiatrist is subject to criticism about a matter that might concern a regulatory body, it is important to take advice from their MDO about the merits of self-referral to the General Medical Council (GMC). Coroners have the power to refer healthcare professionals to their regulatory body, although they are often reluctant to do so. Self-referral avoids that public censure, shows the value that the practitioner attaches to standards and transparency and demonstrates a positive approach to learning. Referral to the GMC is a rare occurrence but if it does happen, the MDO can guide the psychiatrist through the process and direct targeted continuing professional development around the issues raised to demonstrate evidence of remediation to the GMC.

On the day

In most courts the coroner sits at the head of the courtroom, with the witness box usually to one side. The advocates' bench is in front of the coroner and behind that is general seating. Inquests are held in an open (public) forum and some will generate media attention, so reporters may be present. Following the pandemic most inquests are now held remotely, with the coroner in court and the witnesses and interested persons remote. Press and public may be admitted on an audio line (disapplying section 9 Contempt of Court Act 1981). Sometimes there is a hybrid arrangement. The current parliamentary Bill proposes to permit coroners to be remote. Interested persons may submit who should be in court and witnesses may request that they are remote (Coroners (Inquests) Rules 2013, Rule 17). It is illegal to take your own recording of proceedings (section 4192)(a) Criminal Justice Act 1925). All hearings are audio-recorded and interested persons have the right to have a copy of the court recording. Box 3 gives guidance on what expect, what to do and what to avoid.

interested persons (through their legal representatives, if instructed) are invited to make submissions before the coroner concludes and this is usually focused on the format of the record.

BOX 3 What to expect and what to do in the coroner's court

- When called, you will be asked 'to swear' by reading an oath on a holy book, or to give a non-denominational statement of truth ('to affirm'). After this point any failure to tell the truth would amount to perjury (contempt of court).
- Direct answers to the coroner, addressed as 'Sir' or 'Madam'.
- Answer the question you have been asked. If you are unsure of the question, seek clarification.
- Keep your answers brief and factual.
- Use non-technical language whenever possible. Ideally, you should answer in lay terms.
- Keep calm.
- Express sympathy or regret where appropriate.
- Direct the coroner to relevant documents where that assists in understanding your answer.
- If you do not understand a question ask for it to be rephrased. If you think the question unfair or the manner of questioning inappropriately aggressive, raise the matter with the coroner, who should ensure everyone is treated respectfully.
- If you are feeling stressed and unable to construct replies as you would wish, ask for a short break.
- Remember that media may be in attendance, dependent on the level of press interest in the case.

Avoid:

- discussing the facts of the case outside the courtroom
- the temptation to fill silences by speaking – the coroner may be making notes from the evidence or preparing their next question
- losing your temper with the questioner, especially as a professional witness
- straying into the remit of an expert unless you are qualified to give such an opinion – remember that a witness of fact should confine evidence to facts within their direct experience
- leaving court before the coroner releases you

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Post-inquest

When the coroner has heard all the evidence, they will 'sum up' which must include the reasons for any significant decisions (*R (Lewis) v Senior Coroner NW Kent* [2020]) and deliver their conclusion (if there is a jury they deliver the Record). This may be in 'short form' (e.g. suicide, accident, misadventure or natural death) or a narrative conclusion. If you are legally represented, the lawyer will make sure to obtain the outcome of the inquest. If you are without legal representation, it is important to find out the outcome by contacting the coroner's office directly. In some instances, doctors who give evidence do not learn the final outcome and thus never know about any criticism or whether a Prevention of Future Death (PFD) report will be issued. Once an inquest concludes, the coroner cannot comment and the only challenge can be in the High Court.

Regulation 28 reports – Prevention of Future Deaths

Following the inquest, the coroner has a duty to make recommendations in cases where the evidence suggests that further avoidable deaths could occur and that, in the coroner's opinion, there is a body or person who can and should consider taking preventive action should be taken (Schedule 5(7)(1) of the CJA 2009). Under Regulation 28 of the Coroners (Investigations) Regulations 2013 2013 (SI 2013 No. 1629: www.legislation.gov.uk/uksi/2013/1629/made/data.pdf) the coroner will prepare a report, which will be sent to the person or authority that has the power to take the appropriate steps to reduce the risk, and they have a duty to provide a response within 56 days of the date the report is sent (Regulation 29(4)). If you are the subject of criticism, be prepared to answer in court the question 'What have you personally learned from this incident?' This will be different from the organisational response and may involve peer discussion and appraisal, greater awareness of something or an actual change of practice. A thoughtful answer may avoid a PFD report.

If a doctor is concerned that they may be (or have been) criticised in the context of a coroner's inquest, then they should contact their MDO at the earliest opportunity to seek advice about the appropriate steps to take. It may be appropriate to make submissions as to why referral to the GMC is not necessary in a Regulation 28 report. Submissions on PFD reports should be made after the conclusion has been delivered, but all evidence on which the decision is based should be disclosed to all interested parties before that point. No new evidence should be admitted. Submissions can point to evidence heard and additionally recommend the appropriate people or organisations to whom to address the report.

The Regulation 28 report will be sent to the Chief Coroner and published (on the judiciary.gov.uk website) and may also be made available to the media. If this occurs your MDO can assist with preparing for any media reports and monitoring for coverage.

Conclusions

Knowledge and preparation are the key components to successfully negotiating these highly complex situations. Support is available on many fronts, but it is often your peers who are most useful at these times, having experienced the same conflicting emotions when faced with these tragic circumstances. With careful preparation, all eventualities are manageable.

There will always be challenges in a profession that requires emotional competence but none of these challenges are insurmountable. We cannot offer easy solutions but hope that this article helps demystify the processes and will aid preparation, should you be called to give evidence at an inquest.

MCQ answers
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A.v.D. and A.H. sit as coroners. A.v.D. represents interested persons at inquests. G.P. and C.S. are employees of Medical Protection (part of the Medical Protection Society, MPS). The MPS provides the right to request access to expert advice and support on clinical negligence claims, complaints, GMC investigations, disciplinaries, inquests and criminal charges.

ICMJE forms are in the supplementary material, available online at https://doi.org/10.1192/bja.2021.70.

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R v HM coroner for Birmingham and Solihull ex p Benton [1998] 162 JP 807 QBD.

R v South London Coroner, ex parte Thompson [1982] 126 SJ 625 as per Lord Lane LCJ at [30].

Rabone v Pennine Care trust [2009] EWHC 63-65 CA.

Savage v South Essex Partnership NHS Trust [2008] UKHL 74.

Savage v S Essex Partnership NHS FT [2009] 1 AC 681.

MCQs

Select the single best option for each question stem

1 It is outside the scope of an inquest to determine:
- a who the deceased was (their identity)
- b how (by what means) the deceased died
- c who is responsible for the death
- d when the deceased died
- e where the deceased came by their death.

2 As regards the coroner's court:
- a evidence is given under oath or affirmation
- b coroners are addressed as 'your honour'
- c applications can be made to hold the proceedings in private
- d witnesses may ask questions of each other
- e the coroner may rule that not all close family members will be interested persons.

3 As per section 1 of the Coroners and Justice Act 2009, it is not an indication for a coroner's investigation to be conducted as soon as practicable if the deceased:
- a died a violent death
- b died an unnatural death
- c died a natural death
- d has a cause of death which is unknown
- e died while in custody or otherwise in state detention.

4 The inquest process is:
- a inquisitorial
- b adversarial
- c not subject to any appeal process
- d intended to identify who has made a failure which contributed to death
- e meant to establish facts that cannot be revisited in any subsequent civil claim.

5 All of the following statements about Prevention of Future deaths reports are true except:
- a they are also known as regulation 28 reports
- b there is a duty to provide a response within 56 days
- c they may be made available to the media
- d they require self-referral to the GMC if personally criticised
- e preventive action should never be taken until after the inquest.

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