Adult Social Care and Health

Working with the Coroner

Version 1

Contents

If you would like to make any comments, amendments, additions etc. please email ASCH.AdultCare.Policy@derbyshire.gov.uk

The function and purpose of the Coroner's Court

A coroner is under a duty to investigate a death in circumstances where a body of a deceased person is within their area and:

- the deceased died a violent or unnatural death;
- the cause of death is unknown; or
- the deceased died while in custody or otherwise in state detention

This includes deaths in prison, police custody and deaths whilst detained under the Mental Health Act.

More information about the local coroner service can be found
Coroner service - Derbyshire County Council

The purpose of a coroner's inquest is to determine who the deceased was and how, when and where the death occurred. The inquest is a fact-finding exercise and not a method of apportioning blame. The coroner plays an inquisitorial role in that they scrutinise the evidence and ask most of the questions of the witnesses.

Upon being notified of a death, a coroner may make preliminary inquiries before deciding whether further investigation is required.

The coroner will determine whether DCC should have interested party status. If so, DCC will be entitled to a copy of the evidence, ask questions of the witnesses, and make submissions to the coroner on key matters. In cases where DCC has interested person status, a legal representative will attend the inquest alongside the witness.

Responsibilities in relation to a death

Staff must:

- avoid touching the body
- shut the door and leave the scene undisturbed
- if a person is found to have died, consider if the police need to be called. Stay at the address until the police arrive
- notify the person's GP
- inform their line manager
- follow the policies, procedures and practice guidance - Derbyshire Safeguarding Adults Board (derbyshiresab.org.uk) if the death appears to have been a result of abuse or neglect
- where abuse or neglect may be a contributory cause of death, a safeguarding concern should be opened and the coroner should be informed
- where appropriate, inform the Care Quality Commission (CQC) and DCC ASCH Contracting and Compliance team

- DCC's ASC Quality and Compliance Team should be notified where the person was cared for in a DCC residential home or were supported by DCC short-term services
- where there is organisational risk, or a significant incident, complete a Notifiable Incident form (the Notifiable Incident form is used to notify significant incidents where there is a loss of life, serious harm, or other incidents that we need to make the DASS aware)

Accountability

The service manager retains the responsibility in relation to what and how information is communicated to the coroner's office, even if the task is delegated to others.

The GP or the police will alert the coroner's office if there are any concerns about the death.

Initial investigation by the coroner

Upon being notified of a death, a coroner may make preliminary inquiries, or they may immediately open an inquest into the death.

The legislative framework for the coronial process is: The Coroners and Justice Act 2009, The Coroners (Investigation) Regulation 2013, and The Coroners (Inquest) Rules 2013. The Chief Coroner's Guidance notes must also be followed.

The coroner may seek information from DCC which can include a request for a witness statement or report. Examples include:

- in situations where an individual had been in receipt of a service commissioned by DCC. The coroner may be assisted by the Contracting and Compliance Team in these cases. See Appendix 1 for information about sharing information about providers with the coroner. The coroner may then refer any fresh concerns about the quality of the service provider back to the service manager of Contracting and Compliance Team, which may result in further information sharing with and/or quality checks by partner agencies
- where an individual was in receipt of social care services. The coroner may be assisted by a range of different people in these cases, for example, a direct care worker, the registered manager of a care home, an allocated social worker or the person who took the lead on any safeguarding enquiries

Requests for information from the coroner should be referred to Legal Services in the first instance who will offer support in responding.

Internal Management Reviews

An internal management review (IMR) is an internal process Adult Social Care and Health (ASCH) undertake where there is potential learning, this can be good practice or learning. The purpose of an IMR is to identify learning and implement appropriate actions to improve quality

and safety. This learning is then cascaded to other relevant parties. If other agencies are involved, then the operational service manager should consider whether a learning review or a safeguarding adult review referral is required.
An IMR must be carried out following:

- a serious incident involving ASCH
- a notifiable incident if learning is identified by a group manager or assistant director
- Departmental Management Team (DMT) or group manager request

See Internal Management Review Policy and Internal Management Review Practice Guidance

Learning Review

A learning review may be required in cases where there is more than one agency involved. A learning review is the process used to review quality and learning when more than one organisation has been involved in an incident. It gives a formal structure to guide the understanding and analysis of what has happened. In addition, it supports more formal, guided reflective practice for workers at all levels. This allows thematic learning informing action to improve quality and safety.

See Learning Review Policy

Safeguarding adults review (SAR)

Consideration should be given as to whether the criteria for a safeguarding adult's review (SAR) is met. If so, the Local Authority Safeguarding Board representative must make a referral to the Safeguarding Adults Board.

The Care Act 2014 states that the Safeguarding Adults Board is the only body that can commission a SAR and it must arrange a SAR if:

- the case involves an adult in the Derbyshire area with care and support needs (whether or not the Local Authority was meeting those needs); and
- there is reasonable cause for concern about how the Safeguarding Adults Board, its members or other persons with relevant functions worked together to safeguarding the adult

AND

- the person died (including death by suicide) and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the person died)

OR

- the person is still alive, but the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect

The criteria for a SAR should be raised with a line manager who will raise this with the Safeguarding, Practice Standards and Quality group manager.

See Safeguarding Adults Review Protocol

Legal Support and Learning

If any DCC ASCH employees are contacted by the coroner's office for information, disclosure of documents or to request a statement, the responsible service manager should inform legal services immediately by email adultcare.legal@derbyshire.gov.uk who will support staff through the process, including statement/report writing in anticipation of the hearing. At this point a decision should be made as to whether the responsible safeguarding quality manager should also be contacted to see if the case needs to be tracked for learning.

The Hearing

A pre-hearing review may be held prior to the main inquest. This is a hearing in which the coroner and any potential interested persons discuss the scope of the inquest, what evidence is required, which witnesses are to be called and when the final hearing will be.

On the day of the inquest, a coroner usually sits alone although a jury is required if there is reason to suspect that:

- the deceased died while in custody or otherwise in state detention and the death was a violent or unnatural one, or the cause of death is unknown;
- the death resulted from an act or omission of a police officer or a member of a service police force in the purported execution of the officer's or member's duty as such; or
- the death was caused by a notifiable accident, poisoning or disease

An inquest may also be held with a jury if the coroner believes there is sufficient reason for doing so.

Inquests usually take place in open court. The inquest will be recorded and the recording will be retained by the coroner.

Hearsay evidence is admissible in the coroner's court, so long as it is considered relevant by the coroner. The coroner also determines which documents should be produced, which witnesses will be called and the order in which they will be called. However, the interested persons have the right to ask the coroner to take evidence from witnesses or for additional disclosure to be made.

The coroner will receive evidence on identification of the deceased at the opening of an inquest, either through oral evidence or in written form. In most cases, there will be no need for the family to attend to give evidence of identification.

Where it is suspected that a criminal act led to the cause of death, an inquest will be adjourned until the outcome of any criminal proceedings is finalised.

The Witnesses

The coroner will usually call witnesses in an order that establishes a clear account, in sequence, of the events leading up to the person's death.

The witnesses are required to swear or affirm and to identify themselves before giving their evidence.

Once each witness has given their evidence, the coroner will ask the interested persons whether they would like to ask further questions. If a witness has a legal representative present, they will usually be the last person to ask questions and is often used as an opportunity to further clarify points which may have been overlooked or misunderstood during evidence.

Reports

Witnesses may be expected to prepare a report/witness statement prior to the hearing. The report must be carefully written and must concentrate on the facts of the case and address any specific points raised by the coroner. It must be checked with the colleague's line manager before submission to Legal Services. Legal Services can provide a template statement and an example witness statement is available in Appendix 3. The witness statement should tell the story of DCC's involvement with the deceased in a methodical way. Please note that it is not sufficient to copy and paste case notes into a statement template and seek to rely on this. Legal Services can provide further direction on how to approach drafting the statement/report as necessary and the responsible group manager should approve the draft witness statement prior to it being sent to Legal Services.

The coroner will ask questions of the witness based on the content of their statement and any other issues which the coroner considers relevant. This may include:

- their knowledge of the deceased person
- the witness's job role and involvement with the deceased from a professional perspective
- the events leading up to or including the incident leading to the death
- the deceased person's general state of wellbeing at the time of death which may include whether the deceased had capacity to make various decisions

Whilst a witness should seek to assist the coroner as much as possible, they should only give evidence that is relevant for their role, responsibilities and area of expertise. For example, the witness should not answer questions on the side effects of medication if they are not a medically trained professional. In these instances, the witness should indicate to the coroner that this information is beyond the scope of their role, responsibilities or area of expertise.

Care should be taken at all times to keep data secure in accordance with the General Data Protection Regulations (GDPR).

The standards set out in the record keeping guidance must be followed at all times. Records should be accurate and clear. Copies of reports may be given to the deceased person's family and other agencies.

In some cases, a witness statement/report will be sufficient and the witness will not be called to provide oral evidence.

Giving Evidence

All witnesses called to provide oral evidence will do so under oath or affirmation. Any lawyers attending on behalf of the interested persons will be given the opportunity to ask questions of the witnesses about the facts; they are not permitted to ask questions which seek to apportion blame.

The coroner can call any witness to attend the hearing who they feel can assist them in establishing the four facts referred to above, who the deceased was and how, when and where the person died.

Any member of staff who has received a summons to appear at an inquest should inform their line manager, who will then determine who should contact Legal Services for further advice. The line manager will then also consider appropriate support and representation for the staff member. Where DCC has interested party status, the staff member will usually be supported at the inquest by the line manager and Legal Services. A staff member may still be called to give oral evidence in cases where DCC does not have interested person status. In these cases, Legal Services would not attend the inquest but can provide support and guidance prior to the inquest.

All staff must:

- attend coroner's court training if available
- not book or take annual leave at times when they may be expected to attend an inquest. The coroner has the power to fine and even imprison a witness who is summoned to court but fails to attend
- recognise that in attending the coroner's court, they are representing DCC and they must be appropriately and formally dressed
- act professionally at all times and remain mindful that the press and/or family may be in or around the court building
- the witness may be released from the inquest after giving evidence and therefore may not be required for the rest of the proceedings. However, the court may choose to recall a witness after being released and the legal representative may require the witness to remain in court for the remainder of the inquest to provide instructions

Practical tips:

- plan to arrive early. It is likely that any legal representative in attendance will arrange to meet you before the inquest commences
- the coroner is referred to as Ma'am/Madam or Sir
- familiarise yourself with your statement/report, relevant social care records and policies/procedures prior to the inquest
- a copy of the inquest bundle will be provided for all witnesses to refer to during their oral evidence. The coroner or interested persons may direct you to a specific page or paragraph
- listen to the question asked and answer only that question; do not try to predict what the next question may be

- if you did not hear the question, or you did not understand the question, ask for the question to be repeated or rephrased
- if you do not know the answer or you cannot remember, advise the coroner of this and do not try to guess. Advise the coroner if you need to refer back to your statement or social care records to refresh your memory
- do not be defensive, answer in a clear and simple manner, remaining courteous at all times
- avoid using acronyms and bear in mind that the coroner will not be familiar with DCC policies and procedures so you may need to provide additional detail in this regard
- if you are providing evidence remotely, please ensure you are in a private room where you will not be interrupted

Additional staff support available:

- the line manager is the key source of support - both through informal and formal supervision
- Legal Services can offer legal guidance and support around what to expect on the day. Arrangements can be made to observe an unrelated inquest if this would assist staff to familiarise themselves with the process
- if it is expected that the inquest will attract media attention or there is a risk of adverse findings against DCC, the communications team should be put on notice and can provide support in advance with how to deal with any approaches by the media as well as respond to any media enquiries on the day
- counselling - this can be accessed via the Derbyshire County Council employee counselling service or the witness can refer themselves through their GP in order to discuss wellbeing and emotional support. However, confidentiality about court matters must be maintained in line with GDPR
- additional information and resources can be found on the What is wellbeing? Connect page and Your mental health
- trade unions can assist with any employment matters

Summing up & the verdict

After considering all the evidence, the coroner will sum up and return a conclusion. The following short form conclusions are available to the coroner:

- accident/misadventure
- alcohol/drug related
- industrial disease
- lawful/unlawful killing
- natural causes
- open
- road traffic collision

- stillbirth
- suicide

As an alternative to the short form conclusion, the coroner may record a brief narrative conclusion.

Whilst a finding of neglect is not in itself a conclusion, it may be used alongside a short-form conclusion or as part of a narrative conclusion.

Other court proceedings

Other court proceedings may follow an inquest, for example if there is any concern of a criminal offence, the inquest would generally be adjourned pending the criminal investigation.

Prevention of future death reports

Where an investigation gives rise to concern that future deaths will occur and the coroner is of the opinion that action should be taken to reduce the risk of death, the coroner must make a report to the person who they believe has the power to take such action; this is known as a prevention of future deaths report. Upon receipt of such a report, Derbyshire County Council have a duty to respond to the coroner within 56 days detailing the action taken or to be taken, perhaps by way of updated procedures and policies. The coroner may publish the report or response.

Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths
The Coroners (Investigations) Regulations 2013

Reporting concerns

Staff are expected to be vigilant in protecting the people in their care. All staff must follow the Derbyshire Safeguarding Adults Procedures if they are concerned about the abuse or neglect of an adult at risk. Staff should use the Derbyshire County Council's Whistleblowing policy if their concerns do not appear to have been addressed.

Quality assurance and learning

Once made aware of a coroner's investigation, a service manager from the Safeguarding, Quality Assurance and Development team will log the case and track it through the coronial process through the coroner's court tracker spreadsheet.

A decision will be made on how in-depth this will be based on the amount of learning and need for quality assurance action. Internal management reviews and witness statements should be shared so that themes can be identified.

On some occasions, it may be appropriate for a member of the Safeguarding, Quality Assurance and Development team to attend the inquest.

Actions will be recorded through the tracker and learning from good practice and where interventions could or should have been completed differently will be logged. The effectiveness of actions will be measured and reported on.

Training

Training sessions are periodically made available by the coroner's office. The purpose of the training is to make sure that staff understand:

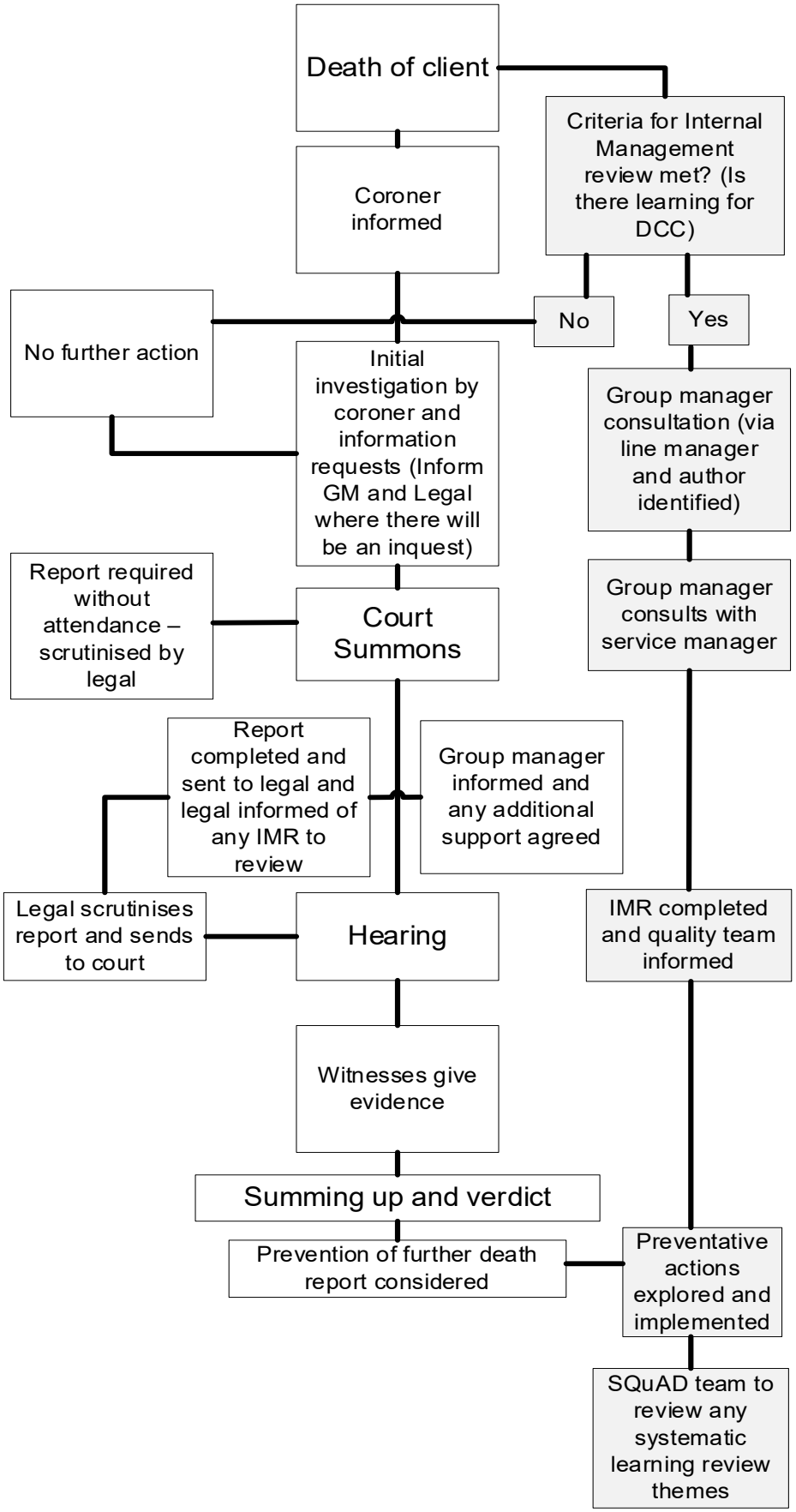
- what is involved in giving evidence in coroner's court
- the importance of good record keeping
- how to deal with questions asked by other agencies and the media.

Additional guidance will also be provided by Legal Services in the lead up to an inquest.

Appendix 1 – Sharing provider quality information with the coroner

- investigations by the coroner will be supported by the provision of information on the quality of care provision by providers named in the investigation
- the Contracting and Compliance team will do so where a contract exists between ASCH and the named providers. Contracting and Compliance team will also signpost on requests where the lead commissioner is known to be another local authority or health body
- information requested will be provided to the coroner's office within a timely manner and as requested by a Contracting and Compliance team service manager or contracts manager
- the request must specify the full name and address of the provider(s) for which information is required. The request should specify areas of specific concern where detail is requested; medication, recording or care planning, for example
- the coroner's office should inform the provider that the Contracting and Compliance team has been requested to provide quality information
- the Contracting and Compliance team will collate known information about provider quality from the ASCH. Requests for information to systems partners such as the ICB etc. will need to be made to the relevant organisation
- the information provided to the coroner will state the outcomes of quality inspections and audits, including identified core issues, current concerns, and improvement plans
- it will state the number of known, current, safeguarding enquiries and the number of current complaints made via the ASCH. The complaints raised to DCC will be accessed through the Quality and Information team
- the Contracting and Compliance team will share the information provided by the coroner's office with the Derbyshire Information Sharing Meetings, with the CQC. This may then trigger further quality investigations by participating agencies

Appendix 2 - Coroner's flowchart



The process for what to do following the death of a client.

A number of processes take place to review the situation:

1. The coroner is informed
2. Checks are carried out to ensure the criteria for internal management review has been met (Is there learning for DCC)
3. If “No”, then no further action required and the process moves on to step 5.
4. If "Yes", then group manager consultation (via line manager and author identified) takes place:
    a. The group manager consults with service manager
    b. IMR completed; Quality team informed
    c. Preventative actions explored and implemented
    d. SQUAD team reviews any systematic learning review themes
5. Initial Investigation by Coroner and Information Requests (Inform GM and Legal where there will be an inquest)
6. Court Summons
    a. Report required without attendance – scrutinised by legal
    b. Report completed and sent to legal; Legal informed of any IMR to review
    c. Legal scrutinises report and sends it to the court
    d. Group manager informed and additional support agreed
7. Hearing takes place
8. Witnesses give evidence
9. Summing up and Verdict
10. Prevention of Further Death Report Considered
    a. Preventative actions explored and implemented
    b. SQUAD team reviews any systematic learning review themes

Appendix 3 - Template report

IN THE XXXXX CORONER'S COURT

In relation to the death of: NAME OF DECEASED (DOB – xx.xx.xxxx)

Statement prepared by: NAME OF PERSON COMPLETING, JOB TITLE, TEAM NAME,
Adult Social Care and Health Department, Derbyshire County Council.

Introduction:
Explain general role within social care; for example: I have worked for Derbyshire County Council for 10 years as a social worker in the XXXXXX team. My role requires me to assess and consider the support needs of the people of Derbyshire under the Care Act 2014. As a social worker I am also required to undertake Section 42 enquiries as a safeguarding investigating officer.

I make this statement to the coroner following the notification that an inquest is to be held into the death of xxx.

Recent chronology of Staff Member/Team involvement with NAME OF DECEASED

Use this section to supply factual evidence of involvement with the deceased. The coroner will stipulate what information they would like to be included in the statement, but examples may include:

- a summary of how the deceased was known to DCC and any services they were provided with
- details of contacts with the deceased and the purpose of your contacts e.g., assessment or undertake a safeguarding enquiry?
- relevant information from assessment and details of support plan - care and support; risk assessment and enablement record (Risk Enablement Guidance) or MCA (Mental Capacity Guidance) if completed
- any contact you have had with relevant people e.g., GP, family and other professionals
- any other information that needs to be included, keep to the facts avoid opinions
- details of sources of information for your report e.g., assessment or case notes, etc. (but please do not copy and paste large sections of text from case notes or documents).

I believe that the facts stated in this statement report are true to the best of my knowledge and belief. 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: SIGNATURE
Name:
Job Title:
Date:

Approval and Authorisation History

Approval and Authorisation History

Name	Job Title	Date
Authored by	Thomas Brown	January 2024
Approved by	Lynne Hyland	January 2024

Change History

Version	Date	Name	Reason
Version 1	January 2024	Thomas Brown	Development of new guidance