CO GUIDANCE - SUMMARY

INTRODUCTION

- **Police files** – the investigation is still the responsibility of the police but the format of the file is overseen by the coroner's officer. The CO needs to check the statements collated before submitting the file
- **Quality Assurance** – The file is passed to the SCO for QA who then signs confirming the file is in the correct format
- **After submission** – the responsibility of the file still remains with the CO
- **Correspondence from Solicitors** – always dealt with by a coroner
- **Disclosure requests** – judicial decision to be taken by a coroner
- **General queries** – i.e. non-judicial – try the SCO or ASCO first

KEEPING THE FAMILY INFORMED

- **Communication** - Vital to keep NoK updated
- **Complaints** – Senior Coroner must be informed
- **Inquests hearings** – be clear to families as to what an inquest is or isn't, and that they have the right to ask witnesses *relevant* questions
- **Legal representation** - We CANNOT advise families on whether legal representation is appropriate for them or not

AVOIDING DELAY

- **File reviews** – done fortnightly by the ASCO
- **Inquests and Investigations spreadsheet** – maintained by the SCO and sent to the coroners monthly. Gives the coroners visibility on cases likely to be delayed, or likely to go over 6 or 12 months.

INQUEST FILE SUBMISSION

Format – ALL files must be submitted in the same format;

1. Coloured front sheet
2. File Contents List (NEW document)
3. Statements and reports ***in the correct order***

File order:

1. CoD (PMR or Drs report)
2. Tox report
3. NoK statement
4. Lay witnesses
5. Medical evidence (GP / consultant / MH / Drug + alc etc)
6. Police officer statements
7. RCA/SUI (if any)
8. Misc items

- Remember to notify the coroner of any potential issues
- Any file queries – discuss with SCO / ASCO
- Remember to pass the file to the SCO for QA and signing off

RCAs / SUIs

- These are internal investigations NOT carried out for the coroner and hence may not always be relevant to the inquest
- The CO needs to find out; **if** there is such an investigation, what **level** it is, and an **ETA** for completion.
- Keep the coroner updated on the above!
- Don't delay submission of the file if a report is outstanding

NOK STATEMENTS

- The **CO should take the NoK statement**
- It should be taken **early** to identify any issues in case further investigation is required
- It should contain **registration** details (full name / DoB and PoB / Address / Occupation / Marital status and details of spouse)
- **Types** of cases dictate the content required (see overleaf)
- **Length** should be 2-3 sides of A4 (may be longer if there are concerns)
- If there are **concerns** – forward to HMC ASAP
- Try to obtain the statement in person. If not, via telephone is acceptable. **Avoid** using questionnaires (*only as a last resort)*

READ ONLY INQUESTS

- **2 types**: Open + Close; or closed as a ROI after submission of file
- **CO statement**: 'the proforma' – detailing spoken to NoK / NoK accept CoD / No concerns with care / NoK do not want to attend / NoK confirmed registration details
- **Additional info** may be required for some Open+Close inquests proforma i.e. details of a fall etc

TRANSFERS

- Decision either OUT or INTO Cheshire is made by the **coroner** only
- The discussion should be coroner to coroner – if not, notify the duty coroner ASAP
- Accepting coroner will request confirmation of ID (if any difficulty – CO to contact duty coroner for advice)
- Once transfer is complete, CO to contact the family / IPs

TYPES OF CASES - SUMMARY

SUSPECTED SUICIDES

- Coroner has to establish **intent** (and not **why**)
- **File should at minimum contain**: NoK / Finder / Attending PC / CID / Tox / PM / GP *(and poss others depending on the case).*
- **NoK statement needs to include**: Any previous self-harm / suicidal thoughts / previous attempts / mood or demeanour prior to death etc.
- **Statement** also required re state of mind or intent prior to death (if not NoK)
- **Attending police statement needs to include:** Scene appearance when first arrived / ligature itself and ligature point / items found at the scene / any sus circs identified
- **CID statement**: confirming in more detail how they came to the conclusion there were no sus circs (*can include FME findings in this stmt*)
- **Notes:** Coroner requires the original. Stmt needed to cover who recovered the note and where it was found. If handwritten – confirm writing matches. NB rare for coroner to read note out in court
- **Electronic devices:** Should only be analysed if directed by HMC (usually if there is no other evidence of intent). They should not be routinely analysed.
- **CSI photos:** Whilst not often referred to in court, they are still useful in case issues re the scene arise.
- **GP report:** Ensure that the GP is aware the case is a suspected suicide so they know how to focus their report (relevant evidence includes MH hx and medication regime etc).
- **MH services:** If there has been MH services involvement in last 2-3yrs – a report from the relevant practitioner is needed.
- **RCA / SUI reports:** Check if there is one, what the ETA is and update the coroner

MEDICAL CASES

- These are deaths in hospital / post-op care / or in the community where the focus is GP care
- **NoK stmt** needs to be obtained **at the outset**
- **NoK stmt** needs to detail any concerns re care & treatment, as well as names of relevant practitioners / wards / medication / procedures of note etc
- Seek **early guidance** from HMC once NoK stmt is obtained
- Hospital reports are identified and provided by the **relevant trust** – HMC may request additional reports.
- **Medical notes:** HMC will direct if required
- **RCA / SUI reports:** Check if there is one, what the ETA is and update the coroner
- Important to obtain **early** guidance from HMC for these cases!

FALLS

- **Where** did the fall occur? Location can impact on nature of evidence required
- **What** caused the fall? Natural or mechanical?
- **Circs** of the fall: when / where / cause / was it witnessed / were there trip hazards / hx of falls? / any PMHx of note? / any sus circs?
- HMC will decide on type of inquest (ROI or full)
- ROI: if no concerns and NoK doesn't want to attend
- Full inquest: If there are concerns or risk of future deaths etc
- **File should contain at minimum:** NoK / witness(es) to the fall / Ward manager (if in hosp / CH) / Consultant (re post fall care) / GP / PMR (if done)
- **Documents required:** Falls risk assessment / care plans / moving+ handling risk assessments / bed rails RA / Accident book
- **NoK statement needs to include**: Hx of previous falls (dates, times, places) / If in hospital or CH – any concerns regarding care or supervision by staff?
- Is there a **RCA/SUI**?

RTCs

- **Type of PM** depends on the case
- Ensure **good communication** with the FLO and keep the NoK updated
- RTC files can be **delayed** due to lack of resources
- RTC files do **not** require a lot of CO input – usually limited to GP / PM / Tox and sometimes NoK statement.

INDUSTRIAL DISEASE

- PM not always needed
- Inquest can be ROI or full
- **In life statements:** Presence of this may negate the need for a NoK statement.
- **NoK statement needs to include**: Past work hx / smoking hx / medical hx (if not covered in med report) / details of asbestos exposure
- **Also** need GP / Hosp / PM
- **HMRC reports** – ONLY if requested by HMC!

HSE

- There can be a joint HSE/police investigation
- Disclosure requires careful management!
- Identify who HSE investigator is
- Identify type of investigation and likely duration
- Ask HMC what items are required
- Keep NoK informed!

PRISON DEATHS

- PPO carry out investigation & provide a report
- PPO / Police should decide who obtains what
- CO obtains GP / PM / Tox / NoK