

Called to the Coroner's Court



David Quinn, Beauchamps Solicitors, examines how medical professionals are obliged to comply when called to the Coroner's Court as a witness

Statistics provided by the Dublin City Coroner's office show a rise in deaths reported, post mortems carried out and inquests held in recent years. From 2000 to 2009 in Dublin city alone, there was a rise of nearly 29 per cent in the number of inquests held (from 456 to 587.)

All sudden, unexplained, violent or unnatural deaths must be reported to a coroner. The coroner must then establish whether or not the death was due to natural or unnatural causes. Unnatural causes of death cannot be certified by a doctor. If a death is due to unnatural causes, then an inquest is held.

The purpose of an inquest is to establish whether or not the death was due to natural or unnatural causes and the coroner has the power to determine the medical cause of a death.

The Coroner's Act 1962 (the Act) is the main governing leg-

islation. There is a Coroner's Bill 2007, which incorporates most of the recommendations of the Coroner's Review Group report 2000 and the Report of the Coroners Rules Committee 2003.

Collectively they aim to replace the Act and consolidate and extend the law relating to the role, duties and responsibilities of coroners. It has not progressed since October 2007, but many coroners refer to the Bill for guidance.

Reportable deaths

The person in charge of an institution or premises where the person who died was residing at the time of death has a responsibility to inform the coroner of that death if it was sudden, unexplained, violent or unnatural. From a healthcare perspective, the relevant reportable deaths include:

- Deaths which are directly or indirectly the result of any surgical or medical treat-

ment or any procedure, or a death during a surgical procedure or while under anaesthesia;

- A death where there is any allegation of medical negligence, misconduct or malpractice on the part of any registered medical practitioner, nurse or other person;
- Deaths from septicaemia which may be caused by injury;
- Death from an abortion (other than natural), certain stillbirths and maternal deaths;
- The death of a person in prison, including deaths in hospital while a sentence is being served;
- The death of a patient in a mental hospital;
- The death of a child in care or detention;
- Where a person is brought in dead (BID) or dead on arrival (DOA) to a hospital's accident and emergency department;

- Deaths occurring in an accident and emergency department and certain deaths which occur in particular departments of a hospital, for example, the radiology department;
- Where a death occurs within 24 hours of admission to hospital or the administration of an anaesthetic, surgical procedure or any procedure;
- Where a patient dies in hospital, having been recently transferred or discharged from a nursing home or other residential institution;
- A death in any public or private institution for the care of elderly or infirm persons;
- Any death involving a healthcare-associated infection.

Attending an inquest as a witness

The Coroner's Court is inquisitorial in nature, not adversarial as in the civil courts. An inquest is an inquiry held in public by a coroner, sometimes

with a jury. It is a fact-finding inquiry and questions of civil or criminal liability cannot be considered or investigated at the inquest.

Similarly, no person can be exonerated. All inquests are held in public and reporters may be present.

As a healthcare professional, it is important to note that:

- You attend an inquest as a medical witness and give evidence as to facts within your own knowledge and no more;
- You must attend the inquest if requested to do so by the coroner;
- Before the inquest, witnesses are generally asked to submit a written statement/deposition: a full, factual account, in chronological order, of the medical personnel's attendance on the deceased;
- You should bring with you a copy of the statement/deposition and any other relevant notes you wish to refer to at the inquest;
- The original medical chart should be in evidence at the inquest and available for consultation;
- The witnesses will give evidence on oath or affirmation;

- The coroner will generally request each witness to read their statement/deposition 'on to the record';
- You do not sign the statement/deposition until you have read it into evidence, giving you an opportunity to amend it if necessary;
- The coroner may then take you through the statement/deposition and ask questions to clarify any matter.

When the coroner has concluded his or her examination of a witness, any properly interested person or a lawyer, acting on their behalf, may examine the witness. The coroner must allow these interested parties to examine the doctor/witness. Any question which directly or indirectly impugns the competence of the healthcare professional will be disallowed by the coroner.

The coroner will hope to conclude the inquest within the period allocated, delivering his/her verdict at the conclusion. He or she can also make recommendations in the interests of patient safety.

● **David Quinn**, Solicitor
Beauchamps Solicitors
Email:
d.quinn@beauchamps.ie