

## New Rules for Inquests

### The impact on psychiatric hospitals

Inquests have become increasingly important and contentious in the healthcare sector over recent years. New rules came into force this summer which are likely to continue this trend.

Inquests are required where there is an unnatural death or a death has occurred in detention. As a result of the new rules, inquests are now to be completed within six months of the date on which the Coroner is notified of the death, although there is no penalty if that does not happen. There will nevertheless be increasing pressure on dealing with these efficiently and effectively.

Inquests into the deaths of patients detained under the Mental Health Act will now always be heard before a jury. This increases the length of the hearing and probably the detail of the investigation.

### Disclosure

Previously, disclosure was dealt with differently by each Coroner. The new rules impose a duty on a Coroner to disclose documents to an interested party, including the Post Mortem, any reports he holds and indeed a recording of the inquest. The Coroner may refuse to disclose, however, if:

- the document is irrelevant to the investigation.
- the consent of the author cannot reasonably be obtained.
- the request is unreasonable.
- the document relates to contemplated or commenced criminal proceedings.

This enhanced disclosure duty will clearly assist families in preparing claims against healthcare providers and will enable an earlier assessment of the possibility of pursuing a claim for compensation, including a potential claim by the family of the deceased for compensation under Article 2 of the Human Rights Act. There is also an increased prospect of a complaint to the criminal or regulatory authorities.

### Evidence

The new rules have clarified the position regarding the provision of written evidence (i.e. documentary evidence that is given without the attendance at Court of the person making the statement). The general rule is that written evidence is not admissible unless the Coroner is satisfied that the evidence is unlikely to be disputed, the maker cannot give oral evidence at the inquest or there is a good and sufficient reason why he should or will not attend the inquest.

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## Schedule 5 reports

The Coroner has been able to make a report (previously under Rule 43) on action required to prevent future deaths. This is now enshrined as a duty in schedule 5 to the Coroners and Justice Act and more reports are therefore anticipated.

## Action required

- All healthcare providers should take all inquests seriously and decide at an early stage how to respond.
- If the matter has not already been investigated, this should be done without delay and consideration given to the provider's position and the likely extent of any criticism of them at the inquest.
- Consider preparation of witness statements at an early stage when the recall of witnesses is likely to be clearer.
- Consider obtaining legal advice and representation at the inquest. It may well be appropriate to request to be an interested party at the inquest in order to obtain documents and have the right to ask questions.
- Consider the likelihood of media interest and the response to this.
- Consider the potential impact on action by CQC, the HSE or Commissioners.

## Inquest service

RadcliffesLeBrasseur offer a special inquest service for healthcare providers. Further information is available from [andrew.parsons@rlb-law.com](mailto:andrew.parsons@rlb-law.com).