Practice Guidance

Submission of evidence to the Coroners Court

February 2025

Hull Social Work Academy
Grow and thrive together

Hull City Council

1. Introduction

Coroners inquire into violent and unnatural deaths, sudden deaths of unknown cause, and deaths that have occurred in prison and certain other categories.

A death is reported to a Coroner in the following situations:

- the cause of death was sudden, violent or unnatural such as an accident, or suicide
- the death is unexpected or unexplained or it occurs in suspicious circumstances
- the cause of death was murder
- a doctor did not treat the person during their last illness did not see or treat the person for the condition from which they died within 28 days of death
- the cause of death was an industrial disease of the lungs such as asbestosis
- the death occurred in any other circumstances that may require investigation
- there is a question of negligence or misadventure about the treatment of the person who died, they died before a provisional diagnosis was made and the general practitioner is not willing to certify the cause, or the patient died as the result of the administration of an anaesthetic.

After a death is reported the coroner will first gather information to investigate whether a death was due to natural causes and if a doctor can certify the medical cause of death.

The coroner will ask the police to gather the information about the death. This will usually include speaking to the family of the deceased, anyone who was caring for the deceased and anyone who was there when the death happened.

If the Coroner is satisfied that death was from natural causes and no further investigation is necessary, then they may accept the medical cause of death that a doctor gives and issue a Coroner's notification to allow the death to be registered.

If a doctor cannot certify the medical cause of death, then a Coroner will investigate the death and may order a post-mortem examination to be carried out.

A coroner’s investigation takes between 4 and 12 weeks.

2. If an inquest is needed

A Coroner must hold an inquest if the cause of death is still unknown.

The coroner may decide a post-mortem is needed to find out how the person died. This can be done either in a hospital or mortuary.

An Inquest is not a trial, and the coroner is not permitted to apportion blame. It is a fact-finding exercise into the circumstances of a person's death.

3. Guidance for social workers

You may be involved in an inquest into the death of a child or young person you have worked with. Social workers may be ordered to prepare a statement and called to give evidence at the hearing itself.

- The Head of Service **must** be made aware of the request for a statement or to give evidence.
- The statement provided should **not** contain any 3rd party information.
- It is important to bear in mind that the statement could be read out at the inquest and bereaved relatives may be present.
- The statement needs to be checked by both the manager, and legal colleagues, before it is submitted.
- The statement needs to be signed by the Head of Service to indicate that she/he is satisfied that the information is correct.
- In addition to providing a statement, bear in mind that any information requested by the police will be forwarded to the coroner. This should not be provided to the police without the agreement and signature of the Head of Service.
- It is the decision of the coroner what evidence they require for the inquest.
- If in doubt seek advice from the Group Manager and legal dept.

4. Requests/Orders from Coroners court

- On the basis of this guidance (which incorporates the coroner's court protocol below), the coroner's court has been asked to send orders for reports from Children and Family Services via the Social Care legal team (as is the case with orders that come from the family courts).
- The email address given to the coroner's court is: - **SocialCareALOS@hullcc.gov.uk** with the Social Care legal team manager copied in: - Louise.Garner2@hullcc.gov.uk
- If Social Workers, Team Managers, Group Managers receive orders directly from the coroner's court, please contact legal services immediately for advice.

His Majesty's Coroners Protocols for the East Riding of Yorkshire and the City of Kingston Upon Hull - HM Senior Coroner– AUGUST 2024

KEY MESSAGES for the Local Authority

This protocol, written in 2022 and updated in 2024, along with similar documents sent to other stakeholders, ensures the obligations imposed upon the LA when dealing with this court.

Coroners Instructions

Duty to the Coroners Court:

- The LA is required to disclose any information or documentation that is relevant to the enquiry. It is for the coroner to decide what is relevant. If in doubt, please ask the coroner.

General Correspondence:

- If one of the coroner's court officers contacts the LA it is expected that you provide a response within 48 hours, unless a quicker response is requested by the officer. A "read receipt" is not sufficient, the reply must set out the answer required or details of how the matter is progressing.
- Please be aware that often requests are court orders and should be treated as such.

Statements:

- All statements must be received within 4 weeks of the opening of the inquest or within the requested time set down by the coroner. Failure to do so will result in the person and their line manager being expected to attend a case management hearing (pre-inquest review hearing) in person to explain the reason for the delay.
- To assist and streamline the process please note that Coroner's court officers will request one of two type of statement – "Brief" or "Full". Unless you are specifically requested to provide a full statement then a brief statement will be sufficient.
- Start each statement with your FULL name (surname in capitals), the name of your employer, your work address, your current job title and your specialty.
- All paragraphs should be numbered.
- Avoid jargon or abbreviations.
- The statement must be signed (an electronic signature is only acceptable if the statement is sent from the author's named email).

Internal/External Investigations, Reviews and Reports:

- If the LA is investigating/review or writing a report of any kind regarding the death of a client/patient/person you must disclose this information to the

coroner immediately. The coroner will need to know the name of the author of the report and the expected timescales of its completion. Please ensure that your reports are completed in a timely manner, bearing in mind the coroner's obligation to conclude inquests within 6 months.

- If the LA decides to complete an internal investigation/review/report after they have been made aware of a request for statements from the coroner, it must be completed in a timely manner if requested by the coroner. Delays to reports cause upset to bereaved families and other witnesses. If there is to be an unnecessarily delay due to your internal processes, you must provide a statement with an outline of your initial enquiry and findings, with a caveat to say the final report is yet to go through organisational process.
- No investigation/review/report usurps the coroner's enquiry. Once provided to the coroner, they will decide if it has any relevance/usefulness to their enquiry and whether to disclose it to interested persons.
- If the author of the report is called to court to provide evidence, they must be fully aware of their duty to the court and the oath/affirmation they undertake. If your organisation wishes to apply for interested person status, please do so in writing citing your reasons.

Attending Court:

- All those requested to attend court are warned for the duration of the inquest. Wherever possible a timetable will be set, but flexibility will be expected from witnesses to utilise court time effectively.
- Attendance should, wherever possible, be in person.
- All organisations granted interested person status have the right to have an advocate attend.