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REQUESTS FROM THE CORONER PROTOCOL

Introduction and Aim

A formal protocol is required for requests for Statements and attendance by the coroner.

The protocol aims to ensure that any requests from the coroner are monitored in order to ensure good governance and minimise costs.

Linked Policies, Procedures and Written Control Documents

[All corporate policies and procedures are available on the Public Health Wales website](#)

Scope

This protocol details the process for dealing with requests made by the Coroner for witness statements and attendance at Inquests.

It aims to ensure staff are supported when any requests are made by the Coroner to attend Inquests or if staff are required to provide Witness Statements. There are some instances where the Coroner has requested a Statement but the content of the request may mean that the Coroner should actually be requesting a privately funded expert report, as opposed to a Witness Statement. The Claims Manager will assist in assessing any requests and determining whether or not you will need to provide a Witness Statement.

Equality and Health Impact Assessment	An Equality, Welsh Language and Health Impact Assessment has been completed and can be viewed on the policy webpages.
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Author	Stefanie Harvey-Powell, Claims Manager

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the [Corporate Governance](#).

Summary of reviews/amendments

Vers ion num ber	Date of Review	Date of Approval	Date published	Summary of Amendments
2	01/02/2023	01/02/2023	08/02/23	New Protocol

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1 Introduction

This protocol details the process for dealing with requests made by the Coroner for witness statements and attendance at Inquests.

It aims to ensure staff are supported when any requests are made by the Coroner to attend Inquests or if staff are required to provide Witness Statements. There are some instances where the Coroner has requested a Statement but the content of the request may mean that the Coroner should actually be requesting a privately funded expert report, as opposed to a Witness Statement. The Claims Manager will assist in assessing any requests and determining whether or not you will need to provide a Witness Statement. Please see [Appendix 1](#).

2 Background of the Coroner and Coroner Court

Coroners are independent judicial officers, appointed by the local authority, and are either doctors or lawyers responsible for investigating the cause of deaths in accordance with the Coroners and Justice Act 2009.

The Coroner may hold an Inquest which are legal inquiries to establish if a death was sudden, unexpected, violent, occurred in prison or police custody, or the cause of death even after a post-mortem may still be unknown. The purpose of the Inquest is to answer the following 4 questions:

1. Who died;
2. Where did they die;
3. When did they die; and
4. How did they die;

The Coroner will investigate the death by collating evidence from the police investigation, as well as obtaining Witness Statements from witnesses who may be able to shed light on one of the above 4 questions the Coroner must attempt to address. The Coroner will consider both oral and written evidence. The Inquest is a fact finding exercise to establish certain facts surrounding the death. In this sense, it may be that elements of care provided to the deceased

are found to be below the standards expected. It is therefore open to HM Coroner to attribute some element of possible fault on a party if the Coroner is satisfied that it is linked to a death.

It is therefore important to bear in mind that although the aim of the Inquest is not to apportion blame, if the factual circumstances establish there have been shortcomings in the care provided, it may be referred to by the Coroner when reaching a conclusion.

3 Public Health Wales Involvement

If you have received a Witness Summons to attend an Inquest, it is because the Coroner believes you may be of use to the Inquest in answering one of the 4 questions the Coroner must attempt to address. Please refer to the flowchart for our [internal process](#) for dealing with requests from the Coroner.

Please make the Claims Manager aware, as soon as you receive a Witness Summons or any communication from the Coroner. The Claims Manager will open a case on Datix Cloud and will record all correspondence on the record.

The Claims Manager will assess the request from the Coroner and advise you whether or not a Witness Statement must be provided. If not, the Claims Manager will return to the Coroner and advise that a formally and privately instructed expert report is required.

The Coroner will occasionally request a Witness Statement where our Clinician has no proximity to the care of the deceased and the Coroner is requesting an opinion on the cause of death. Such requests must be reviewed on a case by case basis with the Claims Manager, Executive Director for QNAHPS and the Chief Executive. It may be the case that the request is in fact one for a medico-legal opinion which should be funded on a private paying basis by liaising directly with the relevant Clinician and will not fall under the remit of a witness statement. The Claims Manager will assist in determining if a Witness Statement is required with reference to legal advice obtained from [Legal and Risk](#).

If a Statement is required, the Claims Manager will provide support to you, by providing you with a precedent Witness Statement for you to prepare and will review your witness evidence. In certain circumstances, the Claims Manager may instruct a Solicitor/ Barrister to represent Public Health Wales at the Inquest.

The Claims Manager will keep you fully updated of dates for the service of witness evidence and attendance at the Coroner Court, as ordered by the Coroner. We will keep you as updated as far as possible, to ensure you can manage your commitments around the Inquest.

If called as a witness, you may either be required to give a statement which will be read out at the Inquest or you may be called to give evidence in person.

All Witness Statements will be verified by you signing a Statement of Truth. By signing this, you are attesting to the truth of a Witness Statement and if it transpires that there is any information included by you which is not truthful, you may be found to be in contempt of Court. It is important to be truthful, clear and chronological in providing your Witness Statement. Aim to provide a factual account, avoid giving opinion or comments.

The Claims Manager will review the Witness Statement and provide any advice as to whether any additional information is required or necessary.

The Witness Statement must be approved by the relevant Divisional Leader and sighted to the Chief Executive.

Once approved and signed, the Claims Manager will file the Witness Statement with the Coroner and continue to keep you updated of any Court dates.

4 Inquest Formalities

The Claims Manager will keep you informed of the location of the Inquest, it will typically be held in a Coroner's Court, Civic Centre or Local Town Hall. The Court will require you to be dressed formally.

Expenses will be paid and you will be granted paid time off from work.

Who will be present at the Inquest?

At all Inquests there will be the Coroner, interested parties (such as the Family and Trust/ Health Board) and sometimes lawyers. If an Inquest involves a death whilst in custody (for example a prison death) a jury may be called to attend. A jury is only called in accordance with Article 2 (2) of the European Convention of Human Rights where the death may have occurred in the following: in prison or police custody, death was caused by a police officer in execution of their line of duty, death occurred due to an accident, disease or poisoning, similar deaths may result causing concern for public health and safety.



It is common for the family and friends of the deceased to attend and to be present throughout the Inquest which understandably will no doubt be a distressing experience for them.

The Inquest is a public hearing, anyone has the right to attend; therefore, if those who are called to an Inquest feel they may benefit from support, they are able to bring a family member, friend, work colleague or work manager with them. Additionally, the Inquest may attract members of the press and media coverage, which may also be distressing for some. However, the press and media do have a code of conduct and ethics to follow when reporting on an Inquest.

As a witness, during the Inquest, you may be asked questions by the Coroner or they may require you to go through your statement. You may also be asked questions by legal representatives of interested parties or by the interested parties themselves and also by members of the jury. The Coroner will ask questions first. Once you have provided your evidence, the Coroner may then permit you to leave the Inquest.

Be mindful of the use of medical language during the Inquest and ensure that every attempt is made to answer questions using plain English.

The length an Inquest may last may vary, depending on the circumstances of a death. If the circumstances are less complicated, an Inquest can last a couple of hours or even less. If however the circumstances of death are more complicated then the Inquest could last days or even weeks. The length of Inquest may also depend upon that particular Coroners approach to it. The dates and duration of the Inquest will be determined by the Coroner at a Pre-Inquest Review Hearing which you will not need to attend.

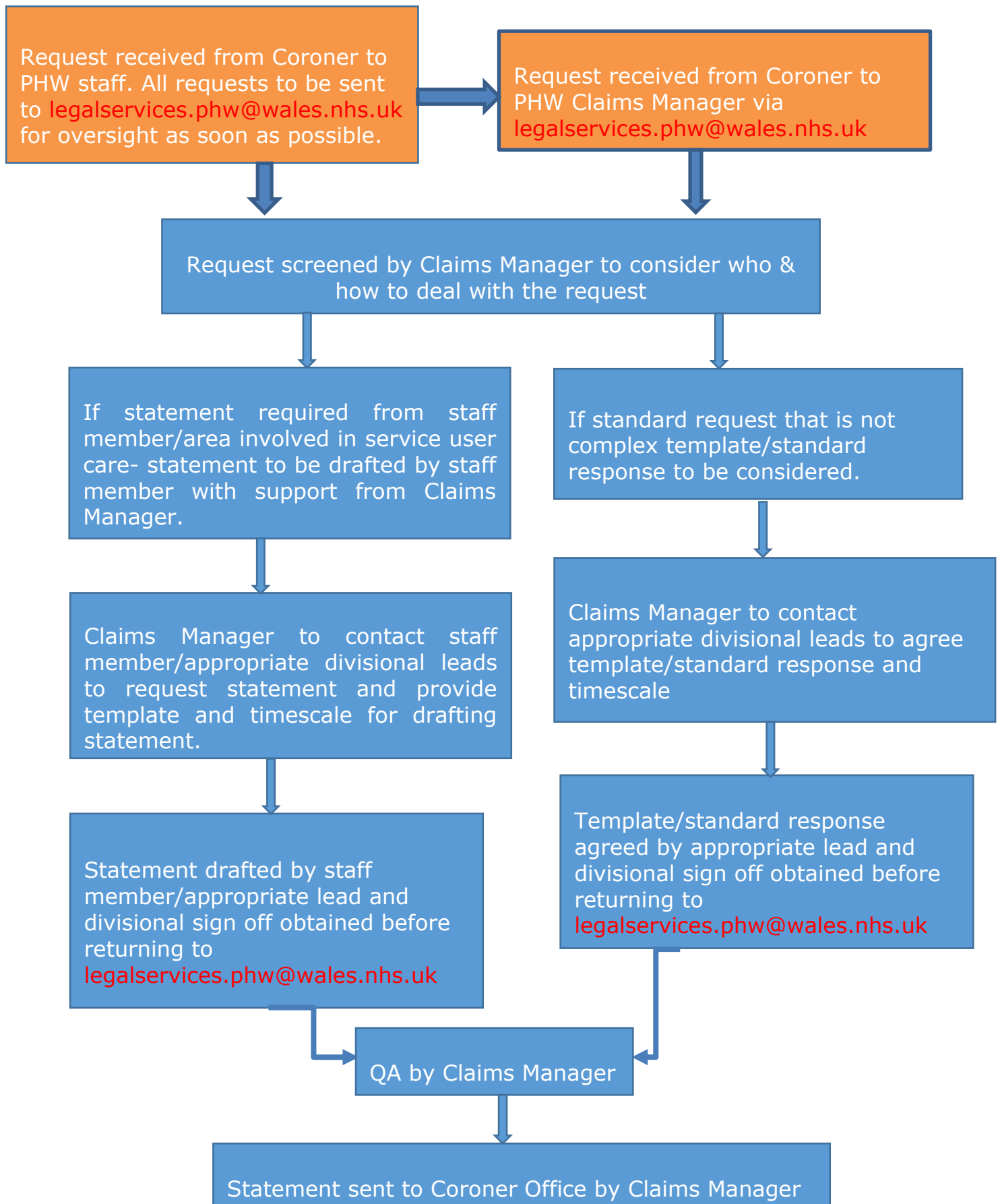
Once all evidence has been heard and questions asked, the Coroner will sum up what has been found. After this, the Coroner or jury will give their conclusions. The Inquest is not a criminal trial; therefore the conclusion will not place any civil or criminal liability on a person or organisation. The Coroner or jury can reach one of these conclusions once satisfied of the necessary facts to the required standard of proof. The civil standard of proof is applied 'on the balance of probabilities', except for conclusions of unlawful killing and suicide where the criminal standard of 'beyond all reasonable doubt' applies.

The Coroner does not decide if someone is responsible for the death but they give a conclusion. There is no definitive list of conclusions available to a Coroner, however the following are the most commonly give:

- Accident or misadventure;
- Industrial disease;
- Dependence on drugs/non-dependent abuse of drugs;
- Attempted/self-induced abortion;
- Disasters subject to public inquiry;
- Lawful killing (such as deaths caused during acts of war, or self-defence);
- Unlawful killing;
- Suicide;
- Open verdict (where there is insufficient evidence for any other verdict);
- Natural causes (including fatal medical conditions);
- Alcohol/ drug related death;
- Road traffic collision.

If you receive any direct requests from Her Majesty's Coroner please refer them directly to legalservices.phw@wales.nhs.uk so that we may suitably support you.

5 Internal process for dealing with requests from the Coroner



6 Appendix - Links

Please find below, helpful links to various resources to support this procedure.

Resource Title	Externally available	Internally available
Criteria to determine whether PHW support Coroner's Requests		✓
Inquests Legal Advice from Legal and Risk		✓
Coroner Guidance for Staff		✓
Witness Statement Template		✓