FACTSHEET

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Coroners' Inquests

Doctors are often asked to provide a report for a Coroner and / or to attend an inquest to give evidence in relation to a patient's death. This factsheet provides information about the purpose of inquests. If you are asked by a Coroner to prepare a report and / or attend an inquest, please contact us for advice and we will assist you in drafting the report and / or accompany you to the inquest if required.

Nature of an Inquest

An inquest is an inquiry in public by a Coroner, sitting with or without a jury, into the circumstances surrounding a death.

An inquest is normally held where the death was sudden, unexplained or violent.

The purpose of an inquest is to establish the identity of the deceased person, how, when and where the death occurred, and to the extent that the Coroner considers it necessary, the circumstances in which the death occurred.

The purpose of the inquest is not to determine civil or criminal liability. It is to establish the facts surrounding the death and to place those facts on the public record.

A jury is required at an inquest in the following circumstances:

- Where death may be due to murder, manslaughter or infanticide
- Where death occurred in prison
- Where death was caused by accident, poisoning or a disease requiring notification to a government department or inspector
- Where death resulted from a road traffic accident
- Where death occurred in circumstances which if they continued or recurred would be prejudicial to the health or safety of the public
- Where the coroner considers it desirable to hold the inquest with a jury.

A verdict will be returned in relation to how the death occurred. The range of verdicts open to the coroner (or jury, if one is present) include:

  - Accidental death
  - Misadventure
  - Suicide
  - Natural causes
  - Unlawful killing
  - Open verdict - meaning that there is insufficient evidence to decide how the death occurred-the matter is left open in the event that further evidence comes to light.

Where an inquest is held with a jury, the jury returns the findings and verdict together with any recommendation designed to prevent a similar death occurring.

Obligation to report deaths to the Coroner

Doctors should be aware that certain deaths must be reported to the Coroner and these obligations have recently been expanded.

The Coroner's (Amendment) Act 2019 (the "Act") clarifies the persons obliged to report death to the Coroner, and provides that it is an offence for such a person to knowingly fail to report a mandatory reportable death to the Coroner.

The Act is very prescriptive in terms of those persons required to report a death to the Coroner unless they have reasonable grounds for believing the death has already been reported. The categories of those practitioners who must report a reportable death to the Coroner include:

- Any medical practitioner, nurse or midwife who had responsibility for, or involvement in, the treatment of care of the deceased in the period immediately before death, or who was present at the death.
- Any medical practitioner who examines the body of the deceased.
- Any paramedic or advanced paramedic who had responsibility for, or involvement in, the treatment of care of the deceased in the period immediately before death, or who was present at the death.

The obligation on an individual such as a medical practitioner is discharged if the death is reported as soon as practicable to the Gardaí.

Deaths for which mandatory reporting applies

In addition to the new categories of mandatory reportable deaths described below, the Act restates the types of deaths where mandatory reporting was previously required, namely:

- Deaths occurring in a violent or unnatural manner or by unfair means;
- Deaths by misadventure; unexpected deaths from an unknown cause or unexplained manner;
- Deaths as a result of negligence, misconduct or malpractice on the part of others; and
- Deaths which occurred in such circumstances as may in the public interest require investigation.

In addition, a medical practitioner described above can have a mandatory obligation to report following deaths:

I. Maternal and late maternal deaths

There is mandatory reporting, post mortem and inquest for maternal and late maternal deaths. A maternal death is defined as a death of a woman during pregnancy or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy. A late maternal death is a death of a woman occurring between 42 and 365 days following the end of pregnancy, from any cause aggravated by the pregnancy or its management.

II. Deaths occurring while in State Custody / Detention

The Act also introduces mandatory reporting and a requirement to hold an inquest in relation to a death occurring in state custody / detention. This includes Garda custody, prison and also individuals who are involuntarily detained under the Mental Health Act, 2001. In these circumstances, if a medical practitioner can confirm another individual has reported the death, they do not have to report it.

III. Stillbirths

The Act makes the provisions of the original Act applicable to a stillborn child, and further it provides for mandatory reporting of stillbirths, intrapartum deaths and infant deaths (within 365 days of birth). It is important for medical practitioners, particularly those in a hospital setting, to be aware of this.

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Assisting the Coroner

In the course of your practice, you may be asked by the Coroner to prepare a report in respect of the death and you may or may not be called as a witness. When preparing a report, it is important to review the deceased's medical records carefully.

If you are called as a witness, you will be required to swear the oath / affirmation and may be asked to read your report to the inquest.

Your role as a witness is to provide honest impartial evidence and your duty is to the inquest alone.

The Coroner has broad powers to make any direction deemed necessary for the proper conduct of an inquest, including directing the taking of an oath/affirmation by a witness, directing a witness to answer questions, directing the production by any person of any document or article in their possession, power or control.

If you are not sure of the answer to a question, you should say so. If a question is outside your area of expertise you should explain this to the Coroner.

Any person who has a proper interest in the inquest may personally ask you or any other witness questions and they may be legally represented by a solicitor or a barrister who can do so on their behalf. The Coroner decides who is classified as an "interested person" but such persons may include the following:

- The family of the deceased
- Representatives of a board or authority in whose care the deceased was at the time of death e.g. hospital, prison or other institution

Questions asked by or on behalf of interested parties such as family members of the deceased may be challenging and confrontational. It is important to remain composed in these circumstances and to remember that a Coroner does not have the power to make a finding of clinical negligence.

However, there are circumstances in which the phrase "aggravated by lack of care" can be added to the verdict by the Coroner. Such a finding could result in a referral of the matter to the Medical Council by the Coroner.

Please also refer to our related factsheet: Coroner's report guide, available on our website. If you are asked to prepare a report for an inquest or are called as a witness at an inquest and you have any concerns you should contact Medisec and we can provide you with advice.