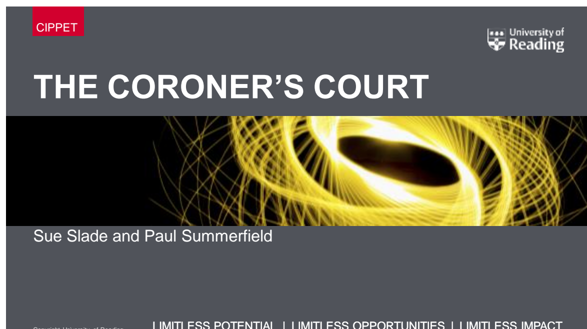

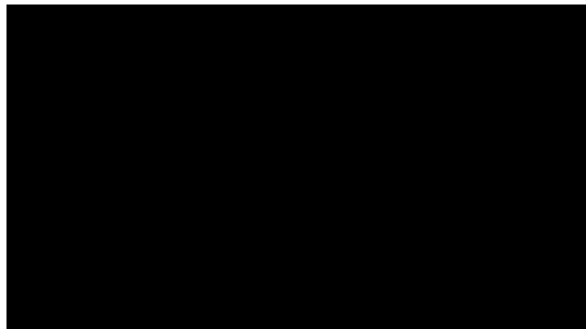

The Coroner's Court – some facts

- The Coroner is an independent judge
- The Coroner's court is a court of record
- Coroners are appointed by County Councils
- Coroners must be barristers or solicitors of appropriate seniority

LIMITLESS POTENTIAL | LIMITLESS OPPORTUNITIES | LIMITLESS IMPACT

The importance of being a good note keeper

- PPX v Aulakh [2019] EWHC 717 (QB)
- Judgment handed down 27 March 2019
- Focused on notes taken during a 5 minute consultation, and the usual practice, of a practitioner from 2012

LIMITLESS POTENTIAL | LIMITLESS OPPORTUNITIES | LIMITLESS IMPACT

The Role of the Coroner

- To investigate a death if she/he has reason to suspect
  - the deceased died a violent or unnatural death
  - the cause of the death is unknown, or
  - the deceased died while in custody or state detention

LIMITLESS POTENTIAL | LIMITLESS OPPORTUNITIES | LIMITLESS IMPACT

The Inquest

- Fact-finding exercise and not a method of apportioning guilt
- A process of investigation (quite unlike a trial where the prosecutor accuses and the accused defends)
- To ensure that the relevant facts are fully, fairly and fearlessly investigated
- The relevant facts are exposed to public scrutiny
- All the witnesses are the Coroner's witnesses
- Properly interested persons are entitled to ask questions by themselves or through a legal representative.

LIMITLESS POTENTIAL | LIMITLESS OPPORTUNITIES | LIMITLESS IMPACT

Purpose

- To establish who the deceased was, where, when and how they died.
- Fact finding and not a fault finding exercise
- No conclusion shall be framed in such a way as to appear to determine any question of
  - criminal liability on the part of a named person
  - civil liability

Outcome

- Where the Coroner's investigation reveals matters which give rise to concern that there is a risk of deaths in the future and that action should be taken to eliminate or reduce such a risk then he has a duty to report such matters to the appropriate authority with a view to prevent any future deaths
- Otherwise he can give a "narrative verdict" where the circumstances of the death are not considered attributable to a named individual

Learning Outcomes – GPhC Standards

- Understand the responsibility that the role of independent prescriber entails, be aware of their own limitations and work within the limits of their professional competence – knowing when and how to refer / consult / seek guidance from another member of the health care team.
- Develop an effective relationship and communication with patients, carers, other prescribers and members of the health care team.
- Demonstrate an understanding of the legal, ethical and professional framework for accountability and responsibility in relation to prescribing
- Maintain accurate, effective and timely records and ensure that other prescribers and health care staff are appropriately informed..

The Educational Theory

- Understanding the human experience
- Transformative learning
- Personal reflection
- Correct and improve practice through self-reflection and criticism
- Generate models of good practice
- Understand the nature and meaning of practice

- Also to give you an idea of what a court case is like!

Volunteers Please!

Rheumatology consultant – Dr O'Brien	Staff Nurse – Staff Nurse Matthews
Dr Jones (Mrs Armstrong's GP)	Pharmacist – Mr/Ms Shah
Locum GP – Dr Anand	Trust solicitor
Locum GP – Dr Brown	GP Practice Solicitor
GP- Dr Cheung	Press
Junior doctor – Dr Desai	Practice Manager
Junior doctor – Dr Edwards	Miss Armstrong (daughter of patient)
Haematology consultant – Dr Hassan	Mr Armstrong (son of patient)

After Lunch

- You will be entering the Coroner's Court
- Please enter in silence and show respect for the court
- All witnesses will be called to the stand in turn and be asked to take an oath as an affirmation
- All other "interested persons" at court are free to ask questions in a civilised manner once the Coroner has finished asking questions
- If the actors don't know the answers either make it up or say you don't know! All part of the fun!