16 September 2025

Shared Insights

Coroner's Question Time

Panel of Speakers

Nicola Evans, Partner at Browne Jacobson
Miss Louise Pinder, Senior Coroner for Rutland and North Leicestershire
Mr Zak Golombeck, Area Coroner for Manchester City
Mr Christopher Stark, Assistant Coroner for Northamptonshire & Director of Legal Services for University Hospitals of Derby and Burton NHS Foundation Trust

Browne Jacobson

Introduction

This session of Coroner's Question Time, chaired by Nicola Evans, featured three experienced coroners focusing on expert evidence in inquests.

We explored the fundamental principles governing when expert evidence is required, how experts should be instructed, and the practical considerations coroners face when determining whether independent expert opinion is necessary to answer the statutory questions in an inquest.

The discussion covered key areas including the scope and purpose of expert evidence, proportionality considerations given budget constraints, the duties and independence requirements for experts, and the challenges faced by bereaved families navigating the inquest process. The insights shared aim to assist health and social care providers in understanding best practices for the instruction and use of expert evidence in coronial proceedings.

Contents

How we can help

Advisory and Inquest Team

Browne Jacobson's specialist inquest team is one of the largest in the country and we have a national reputation for representing Local Authorities, NHS and independent health and care organisations at complex inquests across the country. Located across each of our regional offices, our people are known and well respected by Coroners nationally. We are trusted by clients to provide user-friendly, straightforward advice and excellent representation in court and to support witnesses and organisations through the inquest process from start to finish, having particular regard to reputational impact and prevention of future death strategy.

Mock inquest course

Our mock inquest training course is essential for clinicians and health and care professionals seeking to understand the inquest process.

The course is delivered virtually over a series of lunchtime modules and covers the entire inquest process – from reporting deaths and certification through to writing reports for the coroner and giving oral evidence in court.

We hear insights from a range of speakers including six Coroners and an experienced Medical Examiner.

The course includes several pre-filmed mock inquests filmed in Coroner's courts before real Coroners, to provide a realistic experience of an inquest hearing.

Delegates will also learn about the wider ramifications of an inquest, such as media coverage, compensation claims, disciplinary and professional implications.

Our next mock inquest course will be running from 5 – 26 November 2025 and there are still some spaces available. The course is delivered virtually and all modules are recorded and can be watched on catch-up to fit around clinical commitments. For further details and to register your place, please click here.

Inquest resources

Our website provides several free inquest resources, including several useful guides on the inquest process:

Guide to coroners' inquest process for witnesses.

Guide for clinical witnesses writing coroner's inquest statements.

Guide to inquests for mental health patients.

Inquests and Article 2 of the European Convention of Human Rights.

Guide to preparing and delivering a prevention of future deaths report.

You can access these and other resources here.

Inquest fundamentals and expert evidence principles

Mr Zak Golombeck – Area Coroner for Manchester City

Inquest fundamental principles

Mr Golombeck explained that when a death is reported to a coroner, the Coroner must determine whether the statutory duty to hold an inquest is triggered i.e. whether there is reasonable cause to suspect that the death was an unnatural or violent death, the cause of death is unknown or the death occurred in custody or state detention (which includes a death in prison or detention under the Mental Health Act). If so, the Coroner must hold an inquest.

Turning to the purpose of an inquest, the Coroner must always answer four statutory questions:

- **Who** has died?
- **When** did they die?
- **Where** did they die?
- **How** did they die?

In most inquests, the answers to the first three questions are uncontroversial and answered straightforwardly. The fourth question as to 'how' the deceased died usually requires additional analysis and can be complex, both factually and medically.

An inquest is a summary, inquisitorial, fact-finding exercise that stands separate from civil, criminal or family proceedings. Importantly, the purpose of an inquest is not to apportion blame, either to an individual or an organisation, or to determine matters of civil or criminal liability and the Coroner is prohibited from doing so by the legislation.

However, this does not prevent coroners from making findings of shortcomings or inadequacies in care. Coroners can also look at causation and hypothetical scenarios if there was an omission in care. In addition, a Coroner can add a neglect “rider” to an inquest conclusion, which is a finding that there was a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position.

Evidence

Evidence is key to an inquest and there needs to be a level of transparency with regards to it. However, a coroner need only obtain and disclose evidence that is relevant to their investigation. Coroners have a wide discretion in setting the scope of their investigation and determining what evidence is relevant. This discretion allows coroners to initially cast a wide net when collating evidence, then narrow the scope based on relevance before fulfilling disclosure obligations to interested persons.

Evidence can take various forms beyond traditional oral testimony. Written statements may be read under Rule 23 of The Coroners (Inquest) Rules 2013 where there is no dispute as to the evidence within it.

A witness statement should therefore be carefully prepared, and cover all issues, so that it can potentially be read without the author having to attend court to give oral evidence.

With technological advances, different types of evidence are increasingly being admitted at inquests, including CCTV footage, body-worn camera footage, and social media evidence. This wide discretion in setting scope now includes a broad pool of potential evidence.

Expert evidence

The question as to whether expert evidence is required at an inquest is usually raised at a pre-inquest review (PIR) hearing, often by the family or their legal representative. Expert evidence is permitted at an inquest provided it will assist the coroner in answering one of the four statutory questions; typically, it will be required to help answer the question as to 'how' the deceased came by their death. Chapter 14 of the Chief Coroner's Guidance for Coroners on the Bench provides helpful guidance on expert evidence.

Coroners must determine whether they need expert evidence and, if so, on what specific issue.

It may be that a factual witness (someone involved in the care of the deceased) can address the issue in their evidence. However, coroners must consider whether that it appropriate in the circumstances. It may be that someone independent of the care is required to give an opinion, or maybe even someone who is independent of both the care and the organisation.

An expert might be required to give a view on whether there were failures in the care provided, but such issues are usually addressed by the health or social care provider in its own internal investigation. Therefore, for deaths in health and care settings, expert evidence is usually required in relation to causation (i.e. whether any failures or shortcomings were more than minimally causative of the death), since this is often not addressed by the investigation.

The key considerations therefore are the purpose of the expert evidence, the issue(s) it will address, and whether the evidence can come from someone involved in the care of the deceased or whether an independent view is required – either independent of the care or independent of both the care and the organisation.

Proportionality and speciality considerations

Mr Christopher Stark – Assistant Coroner for Northamptonshire & Director of Legal Services for UHDB NHS Foundation Trust

Mr Stark, speaking from both a Trust and coroner perspective, highlighted that expert evidence is becoming increasingly common in inquests, but coroners must consider proportionality and budget constraints. He provided an example of a complex maternity case involving multiple specialities where the Trust had admitted there were issues with the care, but the clinicians genuinely could not come to a view on causation. Expert evidence was therefore sought in this case to unpick the complex issues.

Mr Stark reiterated Mr Golombeck's point that an expert must be instructed to answer a specific issue or issues. It is crucial to be open and explicit about the required speciality. Sometimes there can be difficulties in determining what specialism is needed, which potentially means an expert is engaged who cannot ultimately help. Additional experts are then required, resulting in additional time and cost. If expert evidence is suggested, Coroners should ensure that careful thought or discussion is had as to exactly what is required and this would usually be explored at a PIR hearing.

Instruction of experts and their duties

Miss Louise Pinder – Senior Coroner for Rutland and North Leicestershire

Miss Pinder emphasised that instructing an expert is only required when there is a specific issue to be addressed, such as a gap in or a dispute over the evidence. During the investigation stage (before the inquest takes place), coroners should be able to identify in advance whether expert evidence is required.

Miss Pinder reiterated the costs associated with instructing experts, as their fee must be paid by the coroner, who is in turn funded by the local authority. The local authority may ask for justification as to why an expert is required. More often than not, factual witnesses can provide the necessary opinion on the issue(s) the coroner has raised. Further, in medical deaths, there is often already an expert of sorts, since the pathologist instructed for the autopsy can provide an entirely independent opinion on cause of death. However, pathologists can be reluctant to comment on issues such as causation because this may involve expressing clinical opinion on issues outside their expertise.

The coroner instructs the expert, and it is preferable that once the expert report is received and circulated, it is agreed by all the interested parties if possible. If the report is not agreed, it is up to the coroner to decide whether the expert should be called to give evidence and answer questions on their report in court at the inquest.

Where litigation is running alongside the inquest (e.g. a clinical negligence claim), experts may have already been instructed to comment on the civil claim by the family or by one of the organisations involved in the inquest. However, Miss Pinder is reluctant to agree to using existing expert evidence commissioned by the parties for the purposes of the inquest. Miss Pinder said that if one of the parties invited her to review their own expert evidence she certainly would not do so without seeing the letter of instruction and documents sent to the expert by the party.

However, Miss Pinder prefers to instruct her own expert, since this gives her more control over the choice of expert, the letter of instruction and the issues she wants the expert to comment on.

There are also issues of legal privilege to consider as any reports commissioned by the family or organisations involved in the inquest may be privileged if they were commissioned for the primary purpose of separate litigation (i.e. a compensation claim by the family which may be running separately from the inquest).

Duties of experts

The overriding duty of the expert is to the court, and not to any of the interested parties. An expert must give a specific undertaking to the court when writing their report and giving evidence confirming the duties they owe to the court.

It is crucial for experts to stay within their area of expertise. The same applies to witnesses of fact, when asked to give an opinion. Miss Pinder has seen clinicians straying outside their expertise and getting into difficulties, including one case that resulted in a GMC referral when a clinician made comments at inquest well outside their area of expertise.

All witnesses should remember to stay within your area of expertise and if you do not know the answer to a question say so!

Discussion and questions

Medical examiners versus independent experts

The panel discussed the distinction between medical examiners and independent experts. Miss Pinder explained that medical examiners are involved at the start of the process, when a death is referred to a coroner. Medical examiners are senior doctors who provide independent scrutiny of all deaths that are not investigated by a coroner. Their role is to determine the cause of death. Where the cause of death cannot be agreed, the medical examiner will refer the death to a coroner for further investigation. Medical examiners are therefore not involved in patient care. Further, the legal test that medical examiners apply is whether there is reason to suspect the death was unnatural. This is different from the legal test applied once an inquest is underway, which is whether any deficits in care made a more than minimal contribution to the death. For all these reasons, the panel agreed it was unlikely to be appropriate to call a medical examiner as an expert witness at an inquest.

We have previously held a Shared Insights session with the National Medical Examiner and have written an article on death certification reforms and the medical examiner system.

Expert view is not determinative

Mr Golombeck highlighted that expert evidence is not automatically preferred over all other evidence and coroners are not obliged to agree with an expert's opinion. He has instructed experts before who have changed their original opinion and have given unreliable evidence, which, after careful analysis, he has not accepted. Coroners are not therefore bound to follow an expert's opinion and can reject their evidence if it does not withstand questioning and analysis.

Disagreements between pathologists and clinical teams

A question was raised about cases where the pathology findings don't correlate with the clinical picture before death, and where there is a disagreement between the pathologist's and the treating team's view on the medical cause of death.

Miss Pinder explained that pathologists should have all the clinical notes available to them and are expected to review them at the time of conducting the autopsy. Where disputes arise between pathologists and clinicians, the reports written by each will usually be exchanged before the inquest, to see if an agreed position can be reached. If the dispute remains unresolved, then the clinician(s) and the pathologist will be called to the inquest to give oral evidence and answer questions to assist the Coroner in considering the medical cause of death. The coroner will then need to decide whose evidence and opinions are preferred. It is not unusual for the final cause of death at the conclusion of the inquest process to have changed from the provisional cause of death provided by the pathologist at autopsy, because of additional clinical information that comes to light during the inquest process.

Mr Stark mentioned that his Trust has an agreement in place with one of its local pathology services. If a clinician considers they have pertinent information that may assist a pathologist with their deliberations, the clinician can attend the post-mortem or provide that information to the pathologist, either orally or in writing. Other Trusts wishing to implement a similar arrangement in complex cases should obtain express permission from the relevant coroner's service, to avoid any suggestion of impropriety.

Internal investigations and position statements

Mr Golombeck explained that where there has been an internal investigation into the death, which has identified shortcomings in care, he usually requests a position statement from the Trust. This involves the Trust seeking an opinion from someone independent of the care (but not independent of the Trust) to give an opinion on causation, i.e. whether (on the balance of probabilities) the deficits in care have more than minimally or trivially contributed to the death.

If the Trust is unable to give a view on causation – either because the issues are very complex or the care is so specialist that there isn't anyone available to give an independent opinion – then the Trust can suggest that an independent expert is instructed instead. Position statements are helpful because they make it clear to a coroner whether a factual witness can deal with causation questions or not.

Witness of fact or expert witness?

A question was raised as to whether a paramedic, involved in the care of the deceased, would be an expert witness or a factual witness. It was clarified that a paramedic who is called to provide evidence at an inquest about their involvement in the care of the deceased would be a witness of fact. An expert witness is one that is completely independent of the care provided and unconnected to the Trust/provider organisation.

Being used as expert witness

A palliative care consultant explained that they often look after patients in the last 3-4 days of their life and are the named consultant at death. Coroners often use them as an expert witness and ask them to explain or comment on the care provided in the preceding weeks.

In terms of how to approach this, it will be case specific and depend on the issues and the extent of comment that is being requested by the Coroner. A brief factual overview just to set out the background to the death may be something you feel you can provide from the notes, whilst making it clear you were not involved during that that period and have provided a brief clinical history from the notes as background to your own involvement. However, it would be inappropriate to provide a detailed report on care provided prior to your involvement or commenting on that care. You should never stray outside your area of expertise.

If in doubt, raise the issue with your legal team.

PSIRF

There has been a recent spate of Prevention of Future Deaths (PFD) reports issued by Coroners raising concerns about investigations conducted by NHS Trusts under the Patient Safety Incident Response Framework (PSIRF).

Seven PFDs have been issued highlighting concerns about PSIRF producing inadequate reports or no safety investigation at all.

This has resulted in some Trusts running separate parallel investigations for deaths that may be subject to a coroner's inquest, to ensure the coroner receives the required information. Mr Golombeck commented that it is more likely that an inadequate internal investigation will necessitate the instruction of an expert, to address gaps in the evidence.

Medical examiner records

A question was raised as to whether medical examiner records could be used by an interested party or the coroner at an inquest. Mr Golombeck explained he usually obtains the medical examiner records at the outset when deciding whether to proceed with an inquest or not as this assists him to determine whether the statutory duty to hold an inquest is triggered.

There may be times when a medical examiner has identified something in the notes that the referring hospital doctor or GP didn't mention, but upon disclosure of statements from clinicians any such issues are usually clarified. Mr Golombeck's view is that the medical examiner process should cease once an inquest is opened, and the medical examiner should not have any involvement in an inquest at all. However, there is no national guidance on this point and other Coroners may take a different approach.

Family support and representation

A question was raised about inequity in the system regarding families' ability to navigate the inquest process and access legal representation or advocate for themselves. Some families find this very difficult, and the whole inquest process can be very traumatic and harmful for them. Miss Pinder acknowledged this is difficult for coroners to navigate as most families appear unrepresented whilst other interested persons typically have lawyers. It's not the coroner's role to represent the family, but the Coroner does need to ensure the family is at the heart of the process and that the inquest is explained in an accessible way at the outset. It can be a daunting process but hopefully the coroner's officer will be in regular contact with the family prior to the inquest to provide support.

There are various materials and guidance online, including the Chief Coroners Guidance for Coroners on the Bench and a Guide to Coroners Services for Bereaved People. There are other organisations who can support families in preparation for the inquest, including INQUEST. Whilst coroners cannot be seen to be biased towards the family, they do have a duty to look after the family before and during the inquest itself.

Mr Golombeck emphasised that the role of the coroner is to be the voice of the deceased and establish how the deceased came by their death. Regardless of whether a party is legally represented, his duty is to cover all necessary themes through questioning and to lead a thorough investigation.

Clinical records and witness statements

A query was raised as to whether a patient report form, completed by a paramedic, could be submitted as written evidence for an inquest or whether a witness statement from that clinician would be required as well. It was clarified that the contemporaneous records are relevant evidence, which will be disclosable to the coroner. However, if there are questions about the care provided or the coroner requires factual information from the crew, then a statement will likely be needed in addition, rather than the coroner simply relying on the clinical records.

Causation evidence

A delegate queried whether a Trust should seek to obtain causation evidence from a clinician independent of the care at the outset, rather than waiting for a coroner to request it. It was agreed that it is often prudent to obtain this evidence as early as possible, and as part of the Trust's investigation into the death. If there are issues with obtaining such evidence e.g. there is no clinician able to provide such a view, then the coroner can be informed of this at an early stage, and can decide whether an expert's opinion on causation is required.

Investigation period for mental health deaths

A delegate asked how far back in a patient's history a coroner was likely to investigate, for a patient who died whilst detained under the Mental Health Act and on section 17 leave. A coroner has a wide discretion to set the scope of their investigation and therefore the decision as to how far back to investigate will go depends on the facts and issues arising. Patients on section 17 leave are still considered to be "detained" at the date of their death and therefore Article 2 of the European Convention on Human Rights might be engaged and a jury may be required, which could make the investigation more complex, but there is no standard or set timeframe to investigate as it depends on the facts of the case. The Coroner will need to determine what is relevant to their investigation.

What makes a good statement?

A delegate asked what made a witness statement "good" from a coroner's perspective and they were directed to Browne Jacobson's Guide to Writing Statements for the Coroner

Key takeaways

- If the parties consider that expert evidence would assist the Coroner you should raise this with the Coroner as soon as possible.
- Expert evidence in inquests must go towards answering one or more of the statutory questions (who the deceased was, where, when and how they died). Usually, expert evidence will be obtained to address the fourth question of 'how' the deceased came by their death.
- Coroners must consider proportionality and budget constraints when instructing experts, being clear about the required speciality to ensure inappropriate experts are not instructed.
- The Coroner is not bound to accept the expert evidence and must consider all the evidence and what weight to place on it when reaching a conclusion.
- To avoid an expert being instructed, a coroner may ask a factual witness, or a Trust witness who was not involved in the care of the deceased, to provide a view on causation instead. There may be reasons why this is not always possible or appropriate, however.
- Expert evidence is relatively unusual, instructed only for specific gaps or disputes in the evidence, with coroners preferring to instruct their own experts rather than relying on experts instructed by any of the interested persons for the purposes of parallel litigation proceedings.
- Experts have an overriding duty to the court, and not to any of the interested parties.
- Once an expert report has been obtained, it will be circulated to all the interested persons. If the expert evidence is not agreed, it will usually be necessary to call the expert to the inquest to answer questions.
- Both experts and factual witnesses must stay strictly within their areas of expertise when providing opinions.
- A coroner is not bound to accept the opinion of an expert, if their evidence does not stand up to questioning and scrutiny.
- The inquest process presents challenges for unrepresented families, requiring coroners to balance their investigative role with ensuring families understand the process.
- The inquest process can also be challenging for the witnesses and organisations involved and it will be important to ensure that they too are supported throughout the process. You can find some useful resources on Browne Jacobson's inquest webpage and our Mock Inquest course also provides essential knowledge and tools to help navigate the inquest process.

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