NHS
Yorkshire
Ambulance Service
NHS Trust

# Courts and Evidence Policy

## Document author: Legal Services Manager

**Date approved: March 2024**

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| 6.1 | July 2023 | Benjamin Cowell | D | Insertion of new Medical Reviews of Coronial Caseload SOP as Appendix F and update to 4.3 to reflect this |
| 6.2 | November 2023 | Benjamin Cowell | D | Updates following Quality Committee review and comment. |
| 6.3 | December 2023 | Benjamin Cowell | D | Update following review of EIA by Diversity and Inclusion. |
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| 7.0 | March 2024 | Risk Team | A | Policy approved within March Risk and Assurance Group.<br>Policy moved on to Trust new template. |
| A – Approved D – Draft | | | | |
| Document Author – Benjamin Cowell , Legal Services Manager | | | | |

Associated Documentation

Investigations & Learning Policy
Duty of Candour Policy
Learning from Deaths Policy
Incident & Serious Incident Management Policy
Criminal Incidents Policy
Claims Management Policy
Compliments, Comments, Concerns and Complaints Management Policy
Employee Wellbeing Supporting Staff Involved in an Incident, Complaint or Claim Policy
Disclosure Policy
Freedom of Information Policy

**Staff Summary**

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| • As part of the course of the Trust's activities, employees may be required to provide evidence in relation to incidents involved in legal proceedings, which may result in attendance at a court hearing. All employees must comply with legal requirements and any actions arising. |
| • The common types of legal proceedings are listed as follows, coroner's inquests, magistrates' court, county court, family court, crown court and tribunals. |
| • All requests for documentation, witness statements and court attendances are received, coordinated, and managed by the Legal Services Department. Should any requests for documentation and/support relate to an incident where a YAS member of staff (or the organisation itself) is the victim of a crime, then these will be handed by the Violence Prevention Team with further information contained within the Criminal Incidents Policy. |
| • The Legal Services Department will provide information, support, advice, and guidance to all staff involved in the process, and will be the link to Trust solicitors in those cases where legal representation has been deemed as being necessary. |
| • The Legal Services Department will collate and submit all relevant documentation relating to the request within the appropriate pre-determined and agreed timescales. Further information can be found within the Disclosure Policy which outlines the scope of disclosure requests processed by the department. |
| • The Head of Legal Services/Legal Services Manager/Legal Services Coordinator (Coroners) will authorise all external disclosure of documents and information in relation to legal proceedings. The Head of Legal Services, Legal Services Manager and Legal Services Coordinator (Coroners) will be responsible for the management of inquest cases, and act as a liaison between the staff members, police, coroner, and Trust Solicitors. |
| • Support and advice are available to all staff involved in an incident where legal proceedings are initiated. Staff must inform the Legal Services Department if they receive any direct requests for information or to attend court. Should the request for information or to attend court relate to where a YAS member of staff (or the organisation itself) is the victim of a crime, then these will be handed by the Security Team. |
| • To effectively manage the various legal processes, it is imperative that cooperation is provided to the Legal Services Department during any legal process. |
| • To effectively learn lessons from such cases and reduce identified risks for the future benefit of staff and patients, the Legal Services Department maintain a close liaison with the Investigation & Learning Team in regard to incidents and the Patient Relations Team in regard to complaints. |
| • Under no circumstances should any staff members contact the coroner's office directly, and all correspondence should be made via the Legal Services Department. |

## 1.0 Introduction

1.1 The Trust recognises the need to provide guidance in relation to legal processes, legal requirements, and individual responsibilities when providing statements and giving evidence at court. The Trust has a responsibility to provide support and guidance to employees throughout this process.

1.2 Involvement in inquests and other types of court cases, complaints, claims, and other investigations often require staff to give statements and attend court to give evidence

when required. All employees must comply with legal proceedings and actions that arise.

## 2.0 Purpose / scope

2.1 The Courts and Evidence Policy is designed to provide structure and clarity around the process for receiving, investigating, responding to, and reporting on all requests from the courts to assist in legal proceedings.

2.2 This policy, and its associated guidance, are to advise staff of the functions of the different courts and on the process, they will need to follow if they are requested to provide a statement or to attend court to give evidence.

2.3 This policy is part of the Trust's internal control system and provides assurance to the Board that robust procedures are in place to mitigate the risks associated with the management of inquests and other court proceedings. Key elements of the process include investigations, data analysis and reports, which can provide a valuable source of learning, to improve the quality of care and the safety of staff, patients and others affected by the activities of the Trust

## 3.0 Initiation of request

3.1 All requests for documentation, witness statements and court attendances are received, coordinated, and managed by the Legal Services Department or should any of the same relate to an incident where a YAS member of staff (or the organisation itself) is the victim of a crime, then these will be handed by the Violence Prevention Team. The Criminal Incidents Policy is followed for further information regarding such matters.

3.2 The Legal Services Department will then request the relevant information from the individual staff members involved. When a request from the Legal Services Department is received it should be complied with in a timely manner, and within the timescales set. The Legal Services Department work to strict deadlines set externally by the courts and judiciary system whereby fines can be imposed on the Trust/and or the individual employee for failure to meet these. Should a fine be issued by the courts and judiciary system to an individual, it is the individual's responsibility to pay this fine.

3.3 Any difficulties meeting the timescales should be communicated at the earliest opportunity to the Legal Services Department. Requests for information should not be ignored under any circumstance. If a request is not complied with by an individual and a fine is imposed as a result, the Trust reserves the right to make representations for the fine to be imposed on the individual or to recover monies from the individual.

3.4 If any requests are received directly from an external source, staff must inform their line manager and the Legal Services Department immediately and before responding to the request

## 4.0 Statements

4.1 In general, requests to staff for statements, or to attend court, will be received via the Legal Services Department. However, requests for attendance regarding criminal matters being heard at magistrates and crown court will most likely be sent to individual's home addresses. This is due to how the Criminal Justice system operates in regard to Witness Care, which are operated by local police forces. Should a request be

received by an individual at home, the request must be referred to their line manager and the Legal Services Department for advice and guidance. For any matters relating to an incident where a YAS member of staff (or the organisation itself) is the victim of a crime, then all enquiries would need to be made to the Security Team.

4.2 The Legal Services Department will provide staff with relevant support relating to the provision of witness statements. There is a standard witness template, including relevant documents, for example the electronic patient record ("ePR"), the computer aided dispatch ("CAD") incident log and other applicable documentation that should be used unless otherwise advised. Guidance is available in completing the statement (see appendices to this policy) and staff may also wish to seek support from their line manager. It is expected that staff members are allowed to complete their statements within working hours and should not complete them during personal time or breaks whilst on shift.

4.3 All evidence and statements are reviewed by the Legal Services Coordinator (Coroners / FOI & Disclosure) in the first instance and additionally by the Legal Services Manager or Head of Legal Services, if required. In regard to coronial cases, medical reviews are undertaken by the Area Consultant Practitioners to identify any organisational risks from the available evidence and documents. A full standard operating procedure can be located at Appendix F. The Legal Services Department can advise and support staff on the presentation and structure of their statement but will not seek to influence content. In certain circumstances, statements may be taken and/or reviewed by Legal Services Departmental staff and/or solicitors.

4.4 Depending on the type of proceedings taking place, the statement will be captured on a criminal style MG11 template or in the form of a civil statement. Police officers will usually take statements using the MG11 template and staff may also be asked to provide a self-written statement on the aforementioned template. Solicitors or Legal Services Department staff will usually take statements using the civil style template.

4.5 Individual members of staff who weren't directly involved in an incident may be asked to prepare and present reports giving their opinion of particular facts in relation to an incident or subsequent investigation based upon their own experience and expertise. Members of staff must notify the Legal Services Department for advice if they receive such a request as normally the provision of expert reports will not be during their Trust employment unless directed to senior members of staff with specialist skill or knowledge.

4.6 Staff who have provided a statement or information in relation to any potential or on-going legal proceedings may be asked to attend court as a witness. Such requests are a legal and contractual requirement and staff asked to go to court to give evidence must do so.

## 5.0 Attending court as a witness

5.1 All requests to attend court are to be coordinated and managed by the Legal Services Department, except for employment related hearings (such as employment tribunals and fitness to practice hearings) which are coordinated and managed by the Human Resources Department and any hearings where a member of staff has been the victim of a crime (which are handled by the Violence Prevention Team). As mentioned within section 4.1 of this policy, requests to attend court for non-coronial matters (i.e., magistrates', youth, and crown courts) are likely to be sent to the witness directly. Should

this occur, the Legal Services Department should be informed without delay. There may be some occasions, for example during the claims process, that solicitors acting for the Trust will communicate directly with the staff member. This should be agreed in advance with the staff member involved, and the Legal Services Department will be kept updated throughout the process.

5.2 Wherever possible, witnesses will be told in good time of the date and place of the hearing. There may be rare occasions where the request will be received at short notice, for example where there has been an unexpected change throughout the course of the legal proceedings. On these occasions every effort will be made to accommodate this.

5.3 The Legal Services Department will inform both the staff member and their line manager of their requirement to attend at court by way of a court warning. They will be provided with the following information:

- Date and time of court attendance
- Location of the court
- Information in relation to the support available and guidance documents
- A copy of the relevant documentation, for example, the witness statement, ePR, CAD incident log etc.

5.4 Please note that for a criminal hearing (magistrates', youth, and crown), the Trust will not have a copy of the statement, and this will be provided on the day by the court clerk

5.5 Giving evidence in court may be a stressful and daunting experience and every effort will be made to advise and support the member of staff leading up to and during the court proceedings. The level of support and guidance will be provided to staff on an individual need basis, determined by previous experience and the nature and complexity of proceedings. Individuals should always seek to contact the Legal Services Department or their line manager in the first instance, should they be worried or concerned over any aspect of the proceedings and additional support will always be provided.

5.6 If the coronial case is deemed to be straightforward with no issues for the Trust, as a minimum and if requested, support at court will be provided by a line manager. For operational staff this is usually a Team Leader or Area Operations Manager. For cases where more complex issues have been identified, a senior member of the Legal Services Department may attend in addition to support the member of staff and represent the Trust. Should it have been deemed appropriate, the Trust solicitor will attend to represent the Trust and provide support to the staff involved. The solicitor may sometimes instruct a barrister to act as counsel at the inquest.

5.7 Inquests and most other court cases are usually held in public, and members of the press may be present. Any approaches by any member of the media for comment regarding the case should be referred to the Corporate Communications Team, who will have been briefed and who are responsible for dealing with all such matters.

5.8 Guidance on the court procedure can be provided to witnesses before the hearing and in complex cases, staff members may be asked to attend a pre-inquest or pre-court support meeting with a member of the Legal Services Department and/or the Trust solicitor to help them to prepare for giving evidence. Members of staff should attend in

uniform unless advised otherwise by the Legal Services Department and for non-operational staff, members of staff should attend in smart clothes.

5.9 Members of staff should be aware that it is a legal requirement to attend court when requested. Should any member of staff have problems or concerns about going to court, they must inform their line manager and the Legal Services Department as soon as possible in order that they can provide assistance and advice. In circumstances where there is a request to attend court, a formal witness summons may be issued against that member of staff. Should a member of staff fail to attend court without a good reason, the court could find the member of staff 'in contempt of court' in which a judge can impose sanctions such as a fine or in the most serious of cases, arrest, and imprisonment.

## 6.0 Staff Support

6.1 In addition to line management support, the Legal Services Department will provide information, support, advice, and guidance to all staff involved in the process, and will be the link to Trust solicitors in those cases where legal representation has been deemed as necessary. If the matter involves a crime upon a member of YAS staff, staff support will be handled by the Violence Prevention Team. For more information, please see the Criminal Incidents Policy.

6.2 It is important for staff who are involved in any legal proceedings to know that they may raise any queries or concerns with the Legal Services Department who will be happy to assist but are unable to tell witnesses what to say as their evidence will be given under oath and must be a factual account which has not been influenced.

6.3 The Trust recognises that some cases can be on-going for a significant period which may cause anxiety and stress for the staff involved. Through this policy and its associated guidance, the Trust will ensure that support will be offered, and staff will be kept informed throughout the process by the Legal Services Department. Additional support can be sought from individual line managers and through the Trust's Employee Assistance Programme. If the matter involves a crime upon a member of YAS staff, ongoing support will be handled by the Violence Prevention Team.

6.4 All staff members are entitled to equitable support in relation to this policy which may translate into different levels of support depending on individual circumstances and protected characteristics. Consideration should also be given in relation to staff members who may require additional support given the circumstances of the proceedings and the potential for past trauma. Line Managers can seek additional support and advice from the Diversity and Inclusion Team alongside the Legal Services Department.

6.5 All individuals have a responsibility to seek appropriate advice and support, and to advise, in the first instance, their line manager and the Legal Services Department. In addition to the support structures provided within the Trust, members of staff who are experiencing difficulties associated with the event may also wish to seek assistance from regional and local trade union representatives and professional bodies such as the Nursing and Midwifery Council ("NMC") and the Health and Care Professions Council ("HCPC").

6.6 In most cases, the Trust will be named as the body with liability on behalf of its staff for events that occurred during their employment. There are some instances in which

individuals may be held personally accountable and liable, or a conflict of interest may arise between the position of the individual and the Trust. Should this occur, the member of staff will be advised by the Legal Services Department to obtain separate legal representation, which in some circumstances may be available to access through Trade Union Membership. An example would be a member of staff who is under criminal investigation.

## 7.0 Coroner's Inquests

7.1 The most common request for staff to provide statements and attend court as a witness, is in relation to a coronial investigation and subsequent inquest, which is held in a coroner's court.

7.2 An inquest is a fact-finding inquiry to establish four key questions: (1) who has died, (2) when they died, (3) where they died and (4) how the person came by their death. The hearing is inquisitorial and is not a trial and unlike in other courts, there is no prosecution or defence or "sides" within an inquest. The coroner, others who are 'interested persons' ("IP") and juries (in some circumstances) seek the answers to the aforementioned questions.

7.3 All requests from HM Coroner are coordinated and managed centrally through the Legal Services Department. Unless otherwise indicated by the coroner, all requests for documents (i.e., statements from staff members involved) must be provided within 10 days to the Legal Services Department. Under the Coroner and Justice Act 2009 and the associated Rules, a coroner can impose a personal fine of up to £1,000 if the timescale is not met. If a staff member has difficulty in completing the statement in the timescales given it is the responsibility of the staff member to alert and communicate with the Legal Services Department and their line manager at the earliest opportunity, so that assistance can be provided. The Trust reserves the right to invoke the fine on the individual if there is non-compliance with timescales and genuine concerns have not been communicated in a timely manner as detailed above.

7.4 Once the coroner has received all the information, they will list the inquest date and inform the Legal Services Department who is required to attend the inquest to give oral evidence. A request to attend an inquest may be received via a formal 'summons' or by a more informal request from a coroner's officer. The Legal Services Department will then notify the witnesses by way of a court warning via e-mail.

7.5 Unless there are extreme and exceptional circumstances, and non-attendance has been agreed with the coroner, staff must attend the inquest when requested. In circumstances where staff experience difficulties in complying with this request, staff should contact their line manager or the Legal Services Department for advice without delay. Under no circumstances should staff contact the coroner's office directly regarding any matter.

7.6 The Trust is committed to supporting bereaved families and should any concerns be raised throughout the coronial process, the Trust would engage with any concerns raised and the Legal Services Department would liaise with the Investigations & Learning Team, ensuring a consistent approach is provided. This will be delivered in line with the NHS England's Learning from Deaths framework and the Trust's Learning from Deaths Policy.

7.7 More detailed guidance in relation to attending an inquest, writing a coroner's statement, and a copy of a witness statement place can be found as appendices to this policy.

## 8.0 County Court or High Court

8.1 County Courts deal with civil (non-criminal) matters. Unlike criminal cases in which the state prosecutes an individual, civil court cases arise where an individual or a business believes their rights have been infringed.

8.2 Types of civil cases dealt with in the County Courts include:

- Businesses trying to recover money they are owed
- Individuals seeking compensation for injuries
- Landowners seeking orders that will prevent trespass.

8.3 The most common reason for attending this court will be in relation to a claim that has been brought against the Trust. Support will be provided by the Legal Services Department, and the solicitors acting on behalf of the Trust.

## 9.0 Family Court and the Court of Protection

9.1 Family Court deal with family cases such as childcare proceedings, adoption, parental disputes regarding custody (amongst others) and these are heard by a specialist family circuit judge. The Family Court also includes the Court of Protection.

9.2 The cases heard at Family Court are separated into two types of work, the first is private cases which are disputes involving parents about their children.

9.3 The second type of case is public work – when local councils take action to protect children. Further assistance and advice regarding child protection matters can be obtained from the Safeguarding Team.

9.4 Following the introduction of the Mental Capacity Act 2005, the Court of Protection was created and came into force from 1 October 2007. It is a specialist court which makes specific decisions or appoints other people known as deputies to make decisions on behalf of people who lack the capacity to do so for themselves. The Court of Protection can:

- decide whether a person 'has capacity' (is able) to make a particular decision for themselves
- make declarations, decisions, or orders on financial or welfare matters affecting people who lack capacity to make these decisions
- appoint a deputy to make ongoing decisions for people lacking capacity to make those decisions

## 10.0 Criminal Proceedings

10.1 The process for criminal cases differs from that for civil claims, as they are investigated by the police and the evidence is passed to the Crown Prosecution Service ("CPS") who decides whether the case will proceed.

10.2 Staff will frequently be asked to give statements or interviews to the police to assist in the prevention or detection of crime, or the apprehension or prosecution of offenders. All requests in hours are dealt with via the Legal Services Department. In the event of an emergency request that is received out of hours, dependent on the nature of the request, these will be processed by either the Duty Manager or equivalent Senior Manager within the Emergency Operations Centre (EOC), or a Senior Manager within IUC in line with the Disclosure Policy (Appendix B – Emergency out of hours disclosure procedure).

10.3 Should proceedings arise against the Trust and/or any employee then the case will be reviewed by the Legal Services Department and assessed to determine whether a conflict of interest arises between the position of the individual and the position of the Trust and in addition if the individual would be better placed to be separately represented. If this is the case the staff member will be advised to inform their trade union and to seek separate legal advice. It should be noted that this is an uncommon situation, and an example would be where the staff member is charged with a driving offence.

10.4 Most criminal cases are heard in a Magistrates' Court. The magistrates are usually people who live in the local community, sometimes called Justices of the Peace.

10.5 Magistrates' Courts are not as formal as Crown Courts and the magistrates do not wear wigs and only the ushers (court officials) wear black gowns. Magistrates' Courts can only hear summary offences and 'either way' offences where the defendant (the person accused of the crime) has elected for the case to be heard in the Magistrates' Court.

10.6 A smaller percentage of cases are heard in the Crown Court. There are three situations where a case may be 'tried' at the Crown Court:

- Indictable offences (can only be heard at the Crown Court)
- 'Either way' offences where the defendant has asked to have his/her case tried by a jury
- Magistrates may send a case to the Crown Court if they feel they do not have the power to set a sentence as severe as the crime deserves

10.7 Cases at the Crown Court are tried by a jury. These are 12 people from the public who listen to the evidence presented during the trial and decide if the defendant is guilty of the crime. The judge makes sure the trial proceeds in a fair way. At the end of the trial if the defendant is found guilty the judge decides the sentence for the crime (for example how long the defendant must spend in prison).

## 11.0 Tribunals

11.1 There is many different types of appeals and disputes which are heard in tribunals. Proceedings in tribunals are often relatively informal compared to the courts. Although some types of hearings take place in rooms which look very much like a court (for example in Immigration and Asylum cases) others have the tribunal's judges and members and the user sitting around a table (for example in Social Security appeals).

11.2 Tribunal users can represent themselves. If the Trust is called to a tribunal, most commonly for an employment related matter, it is likely that legal representation will be in place. All matters pertaining to employment tribunals and hearings are dealt with by the Human Resources Team and advice/support can be received by this team.

## 12.0 Professional Accountability

12.1 In cases where the actions of Trust staff result in disciplinary proceedings by the Trust or professional body (such as the NMC or HCPC), the Trust will not fund or provide legal representation for the case. Individuals are advised to arrange their own cover for such an eventuality.

## 13.0 Data Collection

13.1 The Legal Services Department routinely record inquest data related to incident type, number, location, and issues identified. The data is analysed to determine themes, trends and lessons learned to inform changes in practice across the Trust.

13.2 The anonymised data collected is included in reports containing both quantitative and qualitative data analysis and is reported to Trust committees as required, within their respective reporting timescales.

13.3 To effectively learn lessons and to reduce the risks associated with inquests, the Legal Services Department maintains a close liaison with the Quality & Safety Team in regard to incidents and the Patient Relations Team in regard to complaints.

13.4 It is possible that a request for information from a coroner may be the first indication that an incident has occurred. Where an inquest case has not previously been reported as an incident, but should have been, it will be immediately reported in accordance with the Trust's Incident and Serious Incident Management Policy. The investigation as an inquest, and as an incident, will then be graded in line with the investigation grades (detailed in the Investigations and Learning Policy) and allocation to an appropriate manager to complete the investigation which will proceed as a single process.

13.5 Where there is an indication that an incident resulting in an inquest may lead to a potential civil claim against the Trust, the Legal Services Department will notify NHS Resolution ("NHSR") in advance and if required, inquest funding for representation can be requested.

13.6 Where an incident or complaint involving a death of a patient is followed by allegations of negligence, or is identified as carrying a significant litigation risk, this is referred by the Quality & Safety and Patient Relations Teams to the Legal Services Manager. The Legal Services Department will undertake a preliminary analysis and will actively inform the coroner.

13.7 Incidents, complaints, and inquests are discussed collectively by the Central Incident Review Group which meets on a weekly basis. Links between incidents, complaints, and inquests are made routinely at this meeting, along with agreed management actions. In addition, inquests, claims, and any cases relating to other ambulance services are discussed at the Learning from Deaths Group to capture any learning for the organisation which may not have been captured via other established routes. Please see the Learning from Deaths Policy for more information.

## 14.0 Training expectations for staff

14.1 Training is delivered as specified within the Trust Training Needs Analysis ("TNA") and at the request of departments across the Trust.

14.2 Additional bespoke training sessions will be developed and delivered, as required to meet any identified training needs.

14.3 As the majority of courts are open to the public, there are opportunities for staff members to attend hearings such as inquests to observe. These can be facilitated via the Legal Services Department or individually.

## 15.0 Implementation plan

15.1 The following stakeholders have been consulted in the development, consultation, and review of this policy:

- Legal Services Department
- Quality Committee members

15.2 This policy has been reviewed by members of the Quality Committee and has been recommended to the Risk and Assurance Group for approval.

15.3 The latest approved version of this policy will be posted on Pulse for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

15.4 Archived documents will be stored electronically within the Legal Services Department section of Sharepoint and copies of previous versions of the policy will additionally be held by the policy author.

## 16.0 Monitoring compliance

16.1 Document management and regulatory compliance reports are presented by the Head of Legal Services/Legal Services Manager throughout the year to a range of Trust committees. The committees review the reports, note any deficiencies and remedial actions in their minutes. Progress against actions will be monitored as part of routine business and will be subject to the Trust's performance management process.

16.2 The effectiveness of this policy is monitored against adherence to external timescales set by the various legislation and the judiciary. Key Performance Indicators ("KPI") based on the legislative timeframes have been agreed, and performance against these KPIs is monitored through reports to executive committees.

16.3 Compliance with timescales and KPIs are monitored by the Legal Services Manager and Head of Legal Services monthly, following reports completed by the Legal Services Administrator. Ad hoc reports to any committees or groups shall be provided by the Legal Services Manager regarding any aspect of this policy upon request.

## 17.0 References


- The Coroners and Justice Act 2009 https://www.legislation.gov.uk/ukpga/2009/25/contents
- The Coroners (Inquests) Rules 2013 https://www.legislation.gov.uk/uksi/2013/1616/contents/made
- The Coroners (Investigations) Regulations 2013 https://www.legislation.gov.uk/uksi/2013/1629/contents/made

- The Data Protection Act 2018
  https://www.legislation.gov.uk/ukpga/2018/12/contents
- The Access to Health Records Act 1990
  https://www.legislation.gov.uk/ukpga/1990/23/contents
- Guidance for attending court
  https://www.judiciary.uk/you-and-the-judiciary/going-to-court/
- Crown Prosecution Service giving evidence
  https://www.cps.gov.uk/victims-witnesses
- HM Courts and Tribunals Service
  https://www.gov.uk/government/organisations/hm-courts-and-tribunals-service
- NHS Resolution – giving evidence, a well prepared witness
  https://resolution.nhs.uk/resources/giving-evidence-at-inquest-a-well-prepared-witness/
- NHS Resolution – Inquests: A guide for health providers
  https://resolution.nhs.uk/resources/inquests-a-guide-for-health-providers/

## 18.0 Appendices

18.1 This document includes the following appendices:

- Appendix A – Roles and responsibilities
- Appendix B – GUIDANCE: Writing a statement for HM Coroner
- Appendix C – TEMPLATE: Witness Statement
- Appendix D – GUIDANCE: Attending an Inquest
- Appendix E – GUIDANCE: Giving Evidence at Non-Coronial Courts
- Appendix F – Medical Reviews of Coronial Caseload SOP

## Appendix A – Roles and Responsibilities

### Trust Board
The Trust Board is responsible for ensuring that effective systems are in place for the management of inquests and other forms of legal proceedings. The Trust Board seeks assurance regarding the Trust's response to inquests, through the Chief Executive and the Associate Director of Corporate Affairs.

### Quality Committee
The Quality Committee undertakes objective scrutiny of the Trust's clinical governance and quality plans, compliance with external quality regulations and standards and key functions associated with this, including processes to ensure effective learning from adverse events, comprising of incidents, complaints, and claims. The Committee scrutinises bi-monthly and annual reports provided by the Head of Legal Services/Legal Services Manager and supports the Board in gaining assurance on the effective management of inquests.

### Central Incident Review Group
The Central Incident Review Group is a working group that meets on a weekly basis, and which is responsible for reviewing and instigating appropriate action to address issues identified in relation to incidents, serious incidents, formal complaints and concerns, claims, coroners' inquests, and clinical case reviews.

### Director of Corporate Services / Company Secretary
The Director of Corporate Services / Company Secretary shall lead and take accountability of the Legal Services Department and ensure that the legal functions of the organisation operate smoothly.

### Head of Legal Services/Trust Solicitor
The Head of Legal Services has overall responsibility for the management of the Legal Services Department, which includes inquest management and that of other legal processes. The Head of Legal Services has responsibility for the collation and analysis of inquest related data and for providing detailed reports to the Incident Review Group and Quality Committee within their reporting schedules, and to Trust Executives, as required. This can be delegated to the Legal Services Manager as required. The Head of Legal Services may act in the capacity of Trust Solicitor and represent the Trust in legal proceedings and has authority to instruct external lawyers where required.

### Legal Services Manager

The Legal Services Manager has responsibility for the operational function of the Legal Services Department which includes the management of inquests and other legal processes. The Legal Services Manager will support the Head of Legal Services in the collation and analysis of inquest related data and for providing detailed reports to the Incident Review Group and Quality Committee within their reporting schedules, and to Trust Executives, as required. The Legal Services Manager has delegated authority to instruct Trust Solicitors on behalf of the Trust for representation at court hearings.

### Legal Services Department
The Legal Services Department consists of several coordinators and administrators, each of which is allocated with specific aspects of Legal Services responsibilities. They support the Head of Legal Services and Legal Services Manager in the operational delivery of departmental objectives and in the achievement of mandated performance standards.

**All Trust Managers**

All managers are required to co-operate with the Legal Services Manager and the Legal Services Department, by responding in a timely manner to requests for any information or support required during their business. Managers may also be asked to participate in the investigation of inquests, and it is expected that they will apply due diligence to this process, provide support to affected staff, and facilitate effective organisational learning and improvement.

**All Trust Staff**

All Trust staff have a responsibility to co-operate with the Legal Services Department by responding in a timely manner to requests for any information and by active participation in a legal process. All individuals must inform their line manager and the Legal Services Department of any requests made direct to them. They have a duty to provide a written statement/information as requested by the Legal Services Department, and to appear in court to give evidence if requested by the court.

**Appendix B – GUIDANCE: Writing a Statement for HM Coroner**

## GUIDANCE: Writing a Statement for HM Coroner

Her Majesty's Coroner investigates the cause of unexplained deaths. The purpose of the coroner's inquest is to answer four questions about the deceased:

1. Who was the deceased?
2. When did they die?
3. Where did they die?
4. How did they die? I.e., by what means did they come by their death?

In relation to deaths following medical treatment, the coroner usually requests witness statements from medical staff who were involved in providing care to the deceased. This is so that the coroner can understand what medical problems the deceased was suffering from, what treatment was given and what may have contributed to the death.

The statement needs to explain to the coroner what treatment was provided by the author and on what dates. The coroner will use the information in the statements to decide who to call as a witness to the inquest hearing to answer questions and explain further. The statement will be disclosed to the family of the deceased and any other interested persons to the inquest.

The points below are given as guidance only and may be areas that are applicable to address in the body of your statement:

1. Start each statement with your full name, the name of your employer, work address, current job, grade, and specialty.

2. Ensure you have all the relevant information and documents to help you produce your statement. Use full sentences to explain your involvement, the date and time, your actions, and the reasons for them.

3. Avoid jargon and abbreviations and use simple and clear language. Where possible, include the names of other individuals that you refer to. Ensure that you explain medical terms. Remember that an inquest is a public hearing, and your statement may be read out to the court and family of the deceased.

4. The coroner requires factual information e.g., dates, times, the identities of those involved and a factual explanation of the medical treatment given. If you are called to give evidence at the inquest it will be as a 'witness of fact' to explain what actions you took.

5. End your statement by making it clear the last date and time that you had any involvement with the deceased.

6. Read through your statement carefully once completed – make sure it is accurate and well presented. The coroner and family of the deceased will expect you to have taken sufficient time to ensure that your evidence for the court is correct. When you are happy with your statement then **sign and date it**.

7. If you need help or advice in writing a statement, please ask your line manager or contact the Legal Services Department. Your final statement should be sent to the Legal Services Department (yas.coroner@nhs.net) who will disclose it to the coroner. **Please do not send your statement directly to the coroner under any circumstances.**

8. Keep a copy of your statement and take it with you to the coroner's Court if you are called to attend. You can take it into the witness box when giving evidence to help you with relevant facts and dates.

Appendix C – TEMPLATE: Witness Statement

**IN THE MATTER OF AN INQUEST TOUCHING THE DEATH OF [INSERT NAME OF DECEASED AND REMOVE HIGHLIGHT]**

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**WITNESS STATEMENT OF [INSERT YOUR NAME AND REMOVE HIGHLIGHT]**

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I, [insert your full name], of [insert work address], shall say as follows:

1. I am a [insert your full job title] and employed by Yorkshire Ambulance Service NHS Trust. I have been employed by the Trust since [insert start date].

2. I make this statement for the purposes of the inquest into the death of [insert the name of the deceased]. I have been provided with a copy of the [insert the list of documents you have been provided with. If you have not had access to a particular document, please note this] to assist me with this statement.

3. On [date of the incident], I was working a [insert shift details] shift as a [insert job title – especially if this was different to what you are now] from [insert base station]. [We / I] were allocated to attend at [insert incident address / location] following a report of [please provide any information about the details given about the incident and/or what was provided on the MDT].

4. The computer aided dispatch (CAD) log records our time of allocation as being [insert time] and our arrival at the scene as being [insert time].

5. [Use the following paragraphs to provide a detailed account of the events which followed. The following points are given as guidance as to what may be appropriate to include in the body of the statement – it is not an exhaustive list. Please do not treat the points as simply questions and answers; the text needs to flow naturally.

    - What you saw / observed on arrival at the scene i.e. who was there, what was happening when you first arrived?
    - Where was the patient found?
    - What were your initial observations of the patient?
    - What clinical observations were recorded?
    - What treatment was provided?
    - An explanation / rationale for any decisions that were made in relation to the patient's care, this should include rationale behind treatment not given e.g. medication contraindication
    - An explanation / rationale for any anything that wasn't undertaken or discounted
    - Details of any conversations that occurred with the patient, colleagues and other people that were in attendance.]

6. **[IMPORTANT IF IDENTIFICATION BRACELETS HAVE BEEN PLACED UPON BODY – delete this whole section if not applicable]**
At [date] and [time], [name of relative / friend] identified the deceased to me as being [name of patient] and I applied an identity bracelet to the deceased.

I believe that the contents of this witness statement are true.

Signed: [This needs to be a wet signature with ink or an electronic signature – this does not refer to simply typing your name]

Dated: [The date **must be entered**]

**Appendix D – GUIDANCE: Attending an Inquest**

## GUIDANCE: Attending an inquest

Her Majesty's Coroner, who may be a doctor or a lawyer by profession, investigates the cause of unexplained deaths. The coroner will investigate deaths that have been reported to them if it appears that:

a. The death was violent or unnatural
b. The cause of death was unknown
c. The person died in prison, police custody, or another type of state detention If the death was expected and the cause is clear, an inquest will not usually be held.

The purpose of the coroner's inquest is to answer four questions about the deceased:

1. Who was the deceased?
2. When did they die?
3. Where did they die?
4. How did they die? I.e., by what means did they come by their death?

In relation to deaths following medical treatment, the coroner usually requests statements so that s/he can understand what medical problems the deceased was suffering from, what treatment was given and what contributed to the death. The coroner uses the information in the statements to decide who to call as a witness to the inquest hearing to answer questions. The statements will be disclosed to the family of the deceased and to any other interested persons to the inquest.

### Prior to the inquest

The coroner conducts an investigation and decides what statements to request and who to call to give evidence at the coroner's court. A request for a statement will normally be sent to you by the Legal Services Department with associated documents. If a request is received from another source the Legal Services Department **must be informed without delay**. You should seek further support and advice from your line manager and the Legal Services Department if required.

Statements should be completed and returned to the Legal Services Department within 10 days of the request, unless otherwise informed by the Legal Services Department. Under the Coroner and Justice Act 2009 (associated Rules) a coroner can impose a fine of up to £1,000 to the individual concerned if the timescale is not met. If a staff member has difficulty in completing the statement in the timescales given it is the responsibility of the staff member to alert the Legal Services Department and/or Line Manager at the earliest opportunity so assistance can be provided. The fine is payable by the individual if there is non-compliance with timescales and concerns have not been communicated as above.

If you are required to attend coroner's court to give evidence, you will be notified by a member of the Legal Services Department and informed in advance of the arrangements. If, on the rare

occasion you receive notification directly from the Coroner's Office, you must inform the Legal Services Department immediately so that appropriate advice and support can be arranged.

If the case is deemed to be straightforward with no issues for the Trust, as a minimum, court support will be provided by a line manager. For operational staff this is usually a Team Leader (or in some circumstances an Area Operations Manager). For cases where more complex issues have been identified, a senior member of the Legal Services Department may attend in addition to support the member of staff and represent the Trust. Should it have been deemed appropriate, the Trust Solicitor will attend to represent the Trust and provide support to the staff involved.

Unless there are exceptional circumstances which have been agreed by the coroner, staff must attend the inquest when requested. In circumstances where staff experience difficulties in complying with this request staff should contact their line manager or the Legal Services Department for advice. **Staff should not contact the Coroner's Office directly**.

You should attend in uniform unless advised otherwise by the Legal Services Department and for non-operational staff you should attend in smart clothes. Should you require any additional support throughout the process, please contact the Legal Services department who would be happy to advise.

**The inquest**

There are no 'sides' in an inquest and there is no 'prosecution' or 'defence'. It is a process which is designed for the coroner to find out the facts and not apportion blame. The coroner does not award damages or determine civil liability. If the family wish to make a claim for clinical negligence and damages, they must initiate a separate process. The Coroner's Court is an open court and members of the public and journalists often attend.

The coroner determines who is an 'interested person' ("IP") to the inquest e.g., the family of the deceased, the NHS Trust or GP who provided healthcare. An interested person is entitled to see the statements and documents, to ask the witnesses questions and to make legal submissions as to the conclusions. In some cases, such as an investigation into a death in custody or where there is a particular public interest, the coroner will sit with a jury, who will then decide the conclusions.

Following the passing of the Coroners & Justice Act 2009, it is a criminal offence to:

- do anything that is intended, or is likely, to have the effect of distorting, altering, or preventing any evidence or document that is given for the purposes of a coroner's investigation.

- intentionally suppress, conceal, alter, or destroy a relevant document. A document is relevant if it is likely that a coroner conducting an investigation would, if aware of its existence, wish to be provided with it.

Therefore, if you are asked to provide a statement for an inquest, you should carefully consider all the information which might be relevant for the coroner to discharge their duty.

**Giving evidence**

Every witness called to a coroner's inquest gives evidence 'on oath'. Before the inquest starts, the coroner's Officer will ask you whether you prefer to swear upon a religious book or whether you prefer to 'affirm' (where you promise to tell the truth without reference to religion). When you

are called to the witness box you will be asked to take the oath or affirm by reading from a card out loud. Lying on oath is a criminal offence as is known as perjury, with a maximum penalty of seven years imprisonment.

Giving evidence at an inquest is not a test of memory. You are allowed to take any documents into the witness box which might be helpful to you. In particular, you should take a copy of your statement; the coroner will have a copy and will normally ask you questions based upon your statement. Sometimes s/he will ask you to read from your statement. Your statement will help you to give accurate information to the court, as it should contain all the relevant dates and times of your involvement.

The coroner will begin by asking you to explain your name, position, and qualifications. You should address the coroner as 'Sir' or 'Ma'am'. You will then be asked questions about your direct involvement in the care of the deceased.

After that, the other interested persons can ask you questions e.g., the family (or their lawyer if they are legally represented). Lastly, the lawyer representing the Trust will be able to ask you questions. When you have finished giving evidence the coroner will tell you that you have completed and will give you the opportunity to leave the inquest at that point or remain for the duration of the proceedings.

At the end of the inquest the coroner (or jury where there is one) comes to a conclusion at the end of the inquest. This includes the legal 'determination' which states the answer to the four questions identified above. The coroner or jury also makes 'findings' to allow the cause of death to be registered. When recording this the coroner or jury may use one of the following terms:

- Accident or misadventure
- Alcohol/drug related
- Industrial disease
- Lawful killing
- Unlawful killing
- Natural causes
- Open
- Road traffic collision
- Stillbirth
- Suicide

The coroner or jury may also make a brief 'narrative' conclusion setting out the facts surrounding the death in more detail and explaining the reasons for this decision if a short form conclusion isn't appropriate.

**Tips for attending an inquest**

Here are some tips for attending an inquest:

1. Prepare a thorough, open, and honest statement, which includes details of all aspects of the deceased's care. Include your decision making, and where applicable, acts and omissions.

2. Consider going to see the court on a day before the inquest starts so that you can get used to the surroundings. This can be arranged through the Legal Services Department.

3. On the day you are called, arrive in good time.

4. It is a good idea to dress very smartly or in uniform unless informed otherwise - this provides a professional reflection of yourself and the Trust.

5. Make sure you are familiar with the medical records so that you can easily find your notes and key documents e.g., ePR and CAD incident log. As a professional in court, you will be expected to know the details of the care you provided.

6. When giving evidence, speak slowly and clearly and address your answer to the coroner. The coroner will usually make notes; try to make sure that you pause to let the coroner keep up with you.

7. Think carefully about the question you are being asked and answer that specific question. If the coroner wants further information, they will ask you another question.

8. If you do not know the answer to the question, you must say so. The coroner should only expect you to give factual evidence about what you did, or what happened while you were present. Do not suggest ‘what might have happened’ or speculate. Remember, you are giving evidence on oath - the evidence you give must be accurate.

9. Be honest and try not to be defensive.

10. Be sympathetic and helpful: remember that the family of the deceased may have been waiting a long time to ask their questions, and they may not be used to asking questions in court.

For more information, or to discuss another inquest related matter, please contact the Coroners Section of the Legal Services Department at yas.coroner@nhs.net.

**Appendix E – GUIDANCE: Giving Evidence at Non-Coronial Courts**

## GUIDANCE: Giving evidence at non-coronial courts

As referenced within the Courts and Evidence Policy, requests for attendance regarding criminal matters being heard at magistrates and crown court will most likely be sent to individual's home addresses. This is due to how the Criminal Justice system operates in regard to Witness Care, which are operated by local police forces. Should a request be received by an individual at home, the request must be referred to their line manager and the Legal Services Department for advice and guidance. For any matters relating to an incident where a YAS member of staff (or the organisation itself) is the victim of a crime, then all enquiries would need to be made to the Security Team.

### Before you arrive

You can arrange with the Witness Service or Witness Care Unit to visit the court in advance of the trial. Please ensure that you wear your uniform or attend in smart clothes.

Ensure you take the following with you:

- Any information you have about the case – please contact the Legal Services Department who will endeavour to provide you with the ePR and CAD incident log of the incident. If you have provided a police statement this will be available at the court.
- The letter asking you to attend court if you receive one.
- Something to read or do – you may have to wait some time to be called.
- Money to cover costs on the day, such as car parking or refreshments.

If you have particular needs, possibly arising out of a disability or religious observance, please let someone know in advance of the day you are due to attend by contacting the Witness Care Unit or by calling the Witness Service - please see contact details provided within the correspondence, for further information.

It is important to inform the Witness Care Unit if you have any difficulties attending on the date you have been asked to attend. Please ensure that you have confirmed in advance with the Witness Care Unit that you will be attending on the date and at the time specified.

Please let the Witness Care Unit, know preferably in advance of the trial if you have any commitments during the day which cannot be changed, for example, children at school who need to be collected.

### On arrival

You should arrive at the court at the time notified to you, which is usually 30 minutes before the trial or hearing is due to start. If you anticipate any difficulties with getting to the court on time on the day, please notify the Legal Services Department or the Witness Care Unit immediately. It is important that the court knows of any possible delay otherwise it may think that you are not coming.

Unless special arrangements have been made for you, when you arrive at court, please report straight to the reception point. If you have asked for support from the Witness Service, you will be introduced to their representative who will take you to a waiting area.

**Before you give evidence**

Arrangements can be made for you to see where you will be giving evidence. Generally, this is done at a pre-trial visit, although this may occasionally be possible on the day. Please ask the Court Usher or the Witness Service representative.

You will usually give evidence in a courtroom unless special arrangements have been agreed in advance. It might be a while since you have seen the written or video statement which you made to the police. You should be given the chance to see it again before you give evidence. If not, then please ask a member of the court staff.

Oath taking procedures will be explained to you and you will be asked whether you want to swear to tell the truth on the holy book of your religion or whether you wish to make an affirmation, which is a non-religious way of swearing to tell the truth. If you are a witness in a youth court, you will promise to tell the truth or affirm. You will be asked about other rituals and practices you may want to observe before giving evidence.

The court ushers will provide you with regular updates on the progress of the case and explain the reasons for any delay, where possible. If you are likely to have to wait a long time, the court will consider letting you leave court to return at a later time.

**Giving your evidence**

A court usher or a member of the Witness Service will take you to the courtroom when it is your time to give evidence.

In the courtroom, you will be asked by the Court Usher to take the oath or affirm in accordance with the procedures already explained.

**After you have given your evidence**

When you have finished giving your evidence you will be thanked for attending and will be told whether you are allowed to leave. If you wish to stay and watch the rest of the case, this will be arranged if the court agrees.

Appendix F – Medical Reviews of Coronial Caseload SOP

## 1.0 Introduction

This Standard Operating Procedure ("SOP") outlines the process for medical reviews of coroner cases by the Consultant Practitioners as part of the wider coronial workstream which is administered, coordinated, and managed by the Legal Services Department of Yorkshire Ambulance Service NHS Trust ("YAS").

The purpose of a medical review is to ensure appropriate escalation of cases of concern at an early stage, enabling appropriate management and prompt identification of risks and subsequent learning.

This SOP shall be reviewed annually by the Clinical Governance Group and any relevant changes made and version control updated.

For further information on the coronial workstream, please see the Courts & Evidence Policy, available on Pulse

## 2.0 Background

All coroner cases require two reviews, one from a legal perspective and the other from a medical perspective. Medical reviews will be conducted by the Consultant Practitioner for each ICB area, as follows:

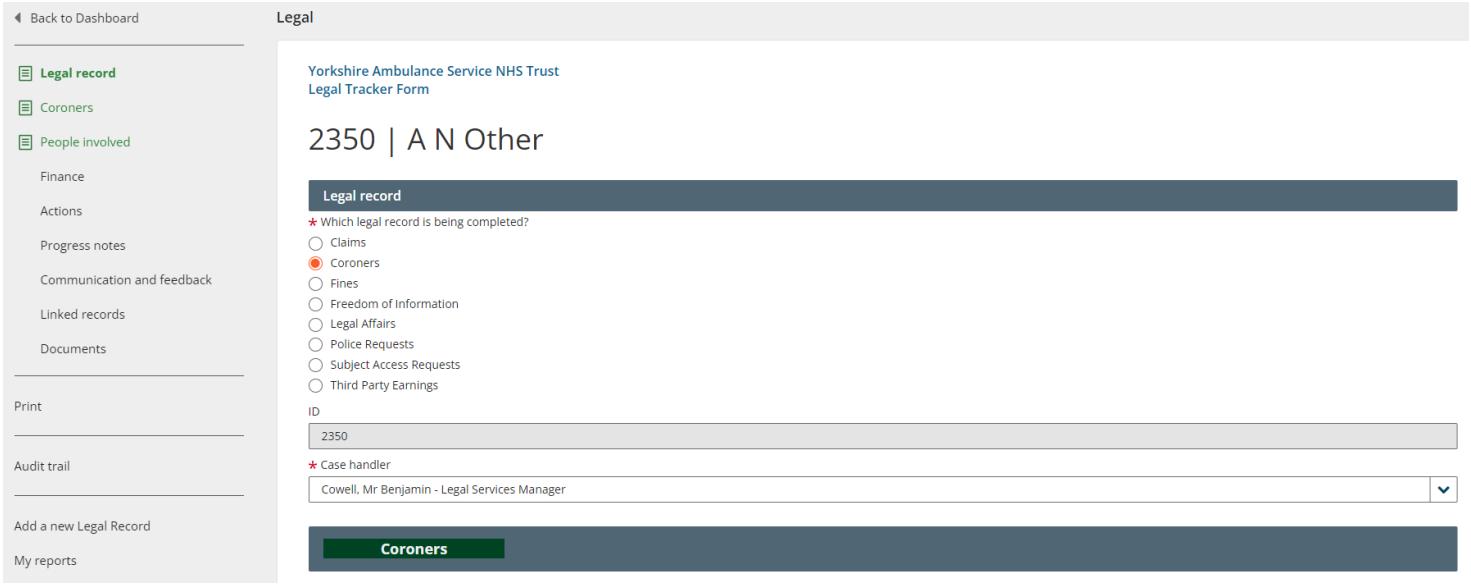
- West Yorkshire
- South Yorkshire
- Humber & North Yorkshire
- Remote Clinical Triage (for EOC and IUC dominant cases)

## 3.0 Review Process

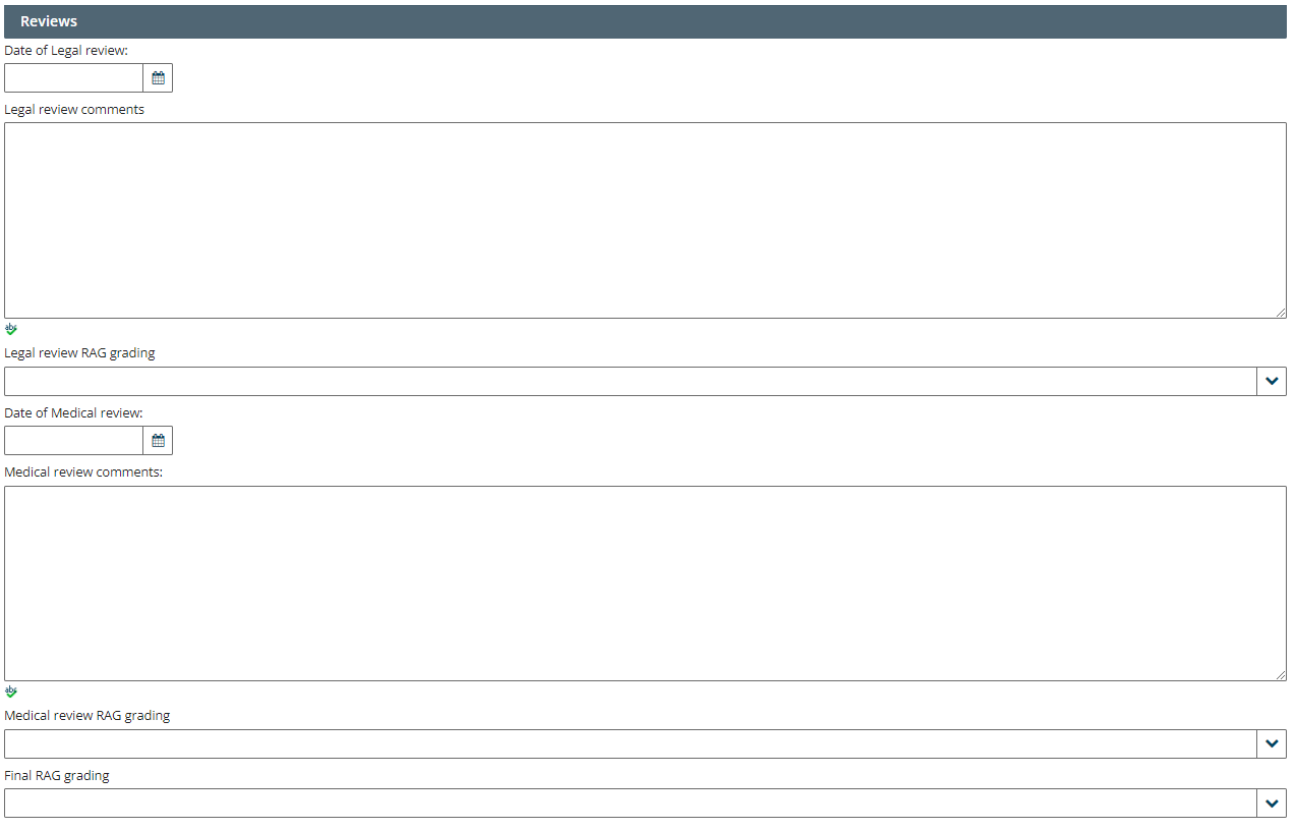
As of 1 April 2020, all coroner cases are recorded on the DATIX Cloud IQ ("DCIQ") record management system. The DCIQ system can be accessed at: https://yas.gateway.prod-uk.datixcloudiq.co.uk.

The Legal Services Coordinator – Coroners within the Legal Services Department will undertake a legal review of the case and then shall apply an initial legal risk rating – Green, Amber, or Red. Once completed, the 'Coroners Status' within the record will be changed to state: 'Need to complete medical review – [ICB area].' This will then trigger an e-mail alert which will provide the Consultant Practitioner with a link to the record in question.

On accessing the file through the link, the Consultant Practitioner will be met with the record within DCIQ and will look like this:




Click on the ‘Coroners’ tab and the screen will change, and scroll down to the section headed ‘Reviews’ and the following will be seen:

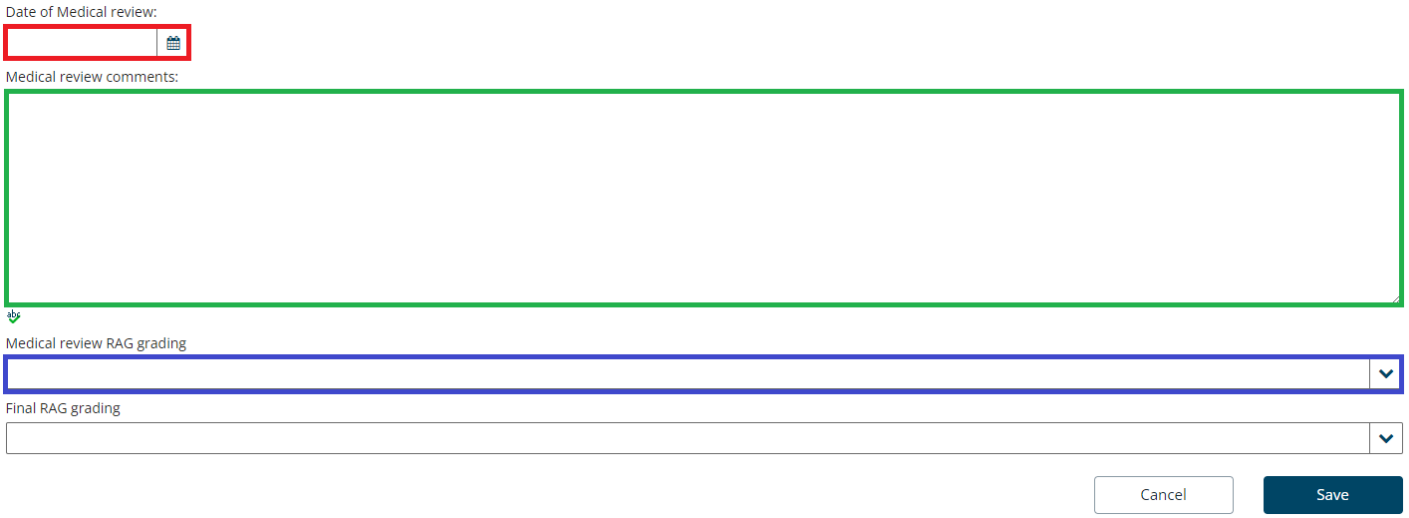



All pertinent information collated to date will be found in the ‘Documents’ section, which will include:

- Copy of the computer aided dispatch (“CAD”) sequence of events
- Copy of the electronic patient record (“ePR”)
- Copy of the recognition of life extinct (“ROLE”)
- Statement(s) of attending ambulance personnel

A copy of the risk matrix can be found at Appendix A. This should be considered to ensure consistent application of gradings across ICBs.

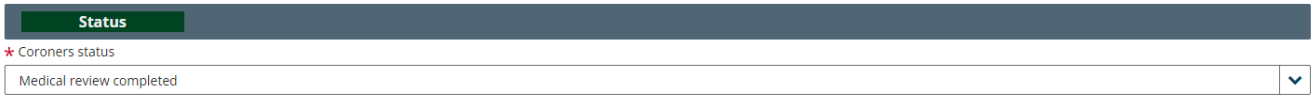
Once the review is complete, the date of the review and the comments from the Consultant Practitioner should be added as shown below:




- Date of when the review took place (shown in red)
- Comments following the review, incorporating any concerns, comments, areas of good practice etc. (shown in green)
- The medical review RAG grading – a drop down list of 'Green – Low Risk,' 'Amber – Medium Risk,' and 'Red – High Risk' (shown in blue).

Once these have been completed, click 'Save.'

It is important that the 'Coroner status' is then changed to read **'Medical review completed'** on the main screen, as shown below:




This will then 'return' the record to the correct status within the coronial workstream for further work for the Legal Services Department.

## 4.0 Impact of green, amber, and red medical review grading

As mentioned previously, all cases will have two reviews (legal and medical) and will be processed with the higher of the two (should there be a difference).
Any case with an amber or red grading would most likely be taken to the Incident Review Group for discussion and escalation.

Any review can change during the 'life' of a case and can be upgraded or downgraded accordingly.

## 5.0 Appendices

### Appendix A – Risk matrix

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

| Key to managing risk scores | | |
|---|---|---|
| Risk score of 1 - 6 | Low | Managed at a local team/departmental level. Local management to determine and develop risk treatment plans or to manage through routine procedures; and consider including on the risk register. This level of risk may be short-lived or aggregated into a higher risk. |
| Risk score of 8 – 12 | Moderate | **Consider implications for Risk Register.** Managed at local team/departmental level, unless escalated to Directorate or Trust/Subject specific group. Where there is a severity score of 4 or 5 alone, this may be considered for escalation to the Risk & Assurance Group regardless of the likelihood score. |
| Risk score of 15 – 25 | High | **Consider implications for Risk Register.** Managed at local team/departmental level and/or Directorate or Trust/Subject specific group depending on management control, treatment plan, or wider strategic implications for the Trust. Risk Leads consider escalation and review at Risk and Assurance Group (RAG) where consideration is given to escalating the risk into the Corporate Risk Report and/or Board Assurance Framework (BAF). |

### Risk scoring = Consequence x Likelihood (C x L)

| | **Likelihood score** | | | | |
|---|---|---|---|---|---|
| **Severity score** | **1** | **2** | **3** | **4** | **5** |
| | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| **5 Catastrophic** | 5 | 10 | 15 | 20 | 25 |
| **4 Major** | 4 | 8 | 12 | 16 | 20 |
| **3 Moderate** | 3 | 6 | 9 | 12 | 15 |
| **2 Minor** | 2 | 4 | 6 | 8 | 10 |
| **1 Negligible** | 1 | 2 | 3 | 4 | 5 |

### Consequence Score (C) Guidance

Choose the most appropriate risk descriptor for the identified risk from the left-hand side of the table, then work along the columns in the same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

| | **Risk Consequence score and examples of descriptors** | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| **Risk Descriptors** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Safety**<br><br>Harm to patients/staff and/or public (including physical and/or psychological harm) | Minor injury not requiring first aid or no apparent injury | Minor injury or illness, requiring minor intervention<br><br>1-2 people affected<br><br>No long-term consequences. | Moderate injury which impacts on an individual or a small number of people<br><br>Some degree of harm up to a year.<br><br>RIDDOR/MHRA/agency reportable incident | Major injury leading to long-term incapacity/disability<br><br>Serious mismanagement of care with long-term effects<br><br>16-50 people affected | Death /life threatening harm<br><br>Multiple permanent injuries or irreversible health effects<br><br>More than 50 people affected |
| **Staff**<br><br>Competence and training, poor staff attendance for mandatory/key training | Insignificant effect on delivery of service objectives due to failure to maintain professional development or status | Minor error due to a lack of appropriate skills, knowledge, and competence to undertake duties. | Moderate error due to limited skills, knowledge & competence to undertake duties | Major effect on delivery of service objectives due to failure to maintain professional development or status | Significant effect on delivery of service objectives due to failure to maintain professional development or status |

| | | | | | |
|---|---|---|---|---|---|
| **Statutory duty/ inspections** | No or minimal impact or breech of guidance/ statutory duty | Breech of statutory legislation<br><br>Reduced performance rating if unresolved | Single breech in statutory duty<br><br>Challenging external recommendations/ improvement notice | Enforcement action<br><br>Multiple breeches in statutory duty<br><br>Critical report | Multiple breeches in statutory duty<br><br>Prosecution<br><br>Severely critical report, zero performance rating |
| **Service/business interruption** | Loss of ability to provide services (interruption of >1 hour) | Loss of ability to provide services (interruption of >8 hours) | Loss of ability to provide services (interruption of >1 day) | Loss of ability to provide services (interruption of >1 week) | Permanent loss of service or facility |
| **Business programmes/ projects** | Temporary defects causing minor short-term consequences to time and quality | Poor project performance shortfall in area(s) of minor importance | Poor project performance shortfall in area(s) of secondary importance | Poor performance in area(s) of critical or primary purpose | Significant failure of the project to meet its critical or primary purpose |
| **Financial loss/Contracting** | Small loss of budget (£0 - £5,000) | Medium financial loss (£5,000 - £10,000) | High financial loss (£10,000 - £50,000) | Major financial loss (£50,000 - £100,000)<br><br>Purchasers failing to pay on time | Huge financial loss (£100,000 +), loss of contract / payment by results<br><br>Unrecoverable financial loss by end of financial year |
| **Information governance risks** | Minimal or no loss of records containing person identifiable data.<br><br>Only a single individual affected. | Loss/compromised security of one record *(electronic or paper)* containing person identifiable data. | Loss/ compromised security of 2-100 records *(electronic or paper)* containing confidential/ person identifiable data. | Loss/ compromised security of 101+ records *(electronic or paper)* containing person identifiable data. | Serious breach with potential for ID theft compromised security of an application / system / facility holding person identifiable data *(electronic or paper).* |
| **Adverse publicity/ reputation/Public confidence** | Rumours<br><br>No public/political concern | Local media area interest – short-term reduction in public confidence | Extended local/regional media interest.<br><br>Regional public/political concern. | Regional/national media interest with less than 1 day service well below reasonable public expectation | National media interest with more than 1 day service well below reasonable public expectation. |
| **Litigation** | Likely repudiation at pre-action stage. | Damages valued at less than £10,000<br><br>Minor concerns relating to care highlighted, no systemic issues identified<br><br>Allegations not substantiated and claim likely to be successfully defended and discontinued at pre-action stage. | Civil action / Criminal prosecution / Prohibition notice- proceedings issued<br><br>Likelihood of success at trial >50%<br><br>Damages valued between £10,000 and £100,000<br><br>Concerns relating to treatment/care/systemic issues identified which are not likely to have impacted on the outcome<br><br>Low level risk of reputational damage. | Civil action / Criminal prosecution/Prohibition notice – proceedings issued<br><br>Likelihood of success at trial <50%<br><br>Damages between £100,000 and £1 million<br><br>Major concerns as to treatment/care/systemic issues which are likely to have impacted on the outcome<br><br>Reputational damage (local level)<br><br>Raises individual employee failings and/or Trust policy concerns | Civil action/Criminal prosecution/Prohibition notice – indefensible<br><br>Damages >£1 million<br><br>Catastrophic / significant systemic issues/concerns which have significantly contributed to the outcome<br><br>Damage due to never event<br><br>Reputational damage (national level) |
| **Coroner's requests / inquests** | No issues or concerns identified<br><br>No identified risk of criminal or civil litigation<br><br>No identified risk of reputational damage | Minor concerns identified unrelated to management of patient<br><br>No identified risk of criminal or civil litigation | Concerns relating to treatment/care/systemic issues which are not likely to have impacted on the outcome<br><br>Does not raise significant individual or Trust policy failings | Significant concerns to treatment/care/systemic issues which are likely to have impacted on the outcome<br><br>Consideration given to legal representation at Inquest<br><br>YAS has Interested Person Status | Catastrophic / significant issues/concerns which are likely to have significantly contributed to the outcome<br><br>High likelihood of a Coroner's Prevention of Future Death |

| | | | | | |
|---|---|---|---|---|---|
| | Witness statements admitted under Rule 23<br><br>YAS not an Interested Person | No identified risk of reputational damage<br><br>YAS not an Interested Person. | Low level risk of civil litigation claim<br><br>Low level risk of reputational damage<br><br>Family and/or other Interested Persons legally represented | Concerns raised by Coroner/other Interested Persons<br><br>Potential for Prevention of Future Deaths report- issues addressed pre- inquest<br><br>Notification of civil claim- contemplated or actual<br><br>Reputational damage (local level)<br><br>Jury/Article 2 inquest<br><br>Family and/or other Interested Persons legally represented | report- issues not addressed pre-inquest<br><br>YAS has interested person status.<br><br>Raises issues of national importance<br><br>Potential to result in public national enquiry (i.e., London Bombings, Mid Staffordshire enquiry)<br><br>Potential for criminal prosecution or civil claim proceedings issued<br><br>Reputational damage (national level)<br><br>Jury/Article 2 inquest<br><br>Family and/or other Interested Persons legally represented. |
| **Complaint** | Minor injury not requiring first aid or no apparent injury<br><br>Misunderstanding of an element of the service which can be corrected<br><br>Local rapid resolution anticipated with no service change requirements | Minor injury or illness, requiring minor intervention<br><br>Single failure to meet internal standards with no consequence<br><br>Local resolution anticipated, local service change may be required | Moderate injury which impacts on a small number of people<br><br>Single failing resulting in loss of appointment or care<br><br>Resolution service wide with possible escalation of actions | Major injury leading to long-term incapacity/disability<br><br>Repeated failure to meet internal standards within organisation<br><br>Resolution service wide with possible escalation of actions | Death /life threatening harm<br><br>Unacceptable level or quality of treatment/service. Grossly substandard care<br><br>Resolution expected to be protracted, major trust wide service change may be required |
| **Safeguarding children & Adults at Risk**<br><br>*Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking, and modern-day slavery* | No issues or concerns identified clinically or with reputation<br><br>Progression to strategy meeting or multi-agency review unlikely<br><br>No media interest<br><br>Response to query responded to within 2 working days<br><br>No, or minimal impact or breech of guidance/statutory duty | Minor concerns over patient care<br><br>CDOP/Form B with uncomplicated information gathering<br><br>Minor delay in response to external agency request (more than 5 working days)<br><br>No allegations against Trust or employees<br><br>Short term service impact from brief investigation involving discussions Police, Social care, and HR | Moderate concerns about patient care, response times, clinical interventions<br><br>CDOP requiring moderately complex information gathering and analysis<br><br>Referral to LADO and Police. Disciplinary process commenced, suspension from front line duties<br><br>Possible media interest anticipated | Major concerns with patient care that could have affected outcome<br><br>Major injury leading to incapacity or disability<br><br>Repeated failure to reach internal standards<br><br>Regional media statement requested<br><br>Abuse enquiry becomes public enquiry | Incident leading to death or permanent disability<br><br>Healthcare did not take appropriate action/intervention to safeguard against abuse occurring<br><br>Abuse that resulted in (or was identified through) a SCR, DHR, LLR<br><br>Inquest requiring safeguarding information<br><br>Staff/ex-staff member is found guilty of abuse and convicted<br><br>Media interest highly likely |

## Likelihood Score (L) Guidance

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to determine the frequency.

| Likelihood score | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Descriptor** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| **Probability** | < 5%<br>1 in 100,000 chance | 6-20%<br>1 in 10,000 chance | 21-50%<br>1 in 1000 chance | 50-80%<br>1 in 100 chance | >81%<br>1 in 10 chance |
| | This will probably never happen/recur<br><br>Will only occur in exceptional circumstances | Unlikely to occur<br><br>Do not expect it to happen/recur but it is possible it may do so | Reasonable chance of occurring<br><br>Might happen or recur occasionally | Likely to occur<br><br>Will probably happen/recur but it is not a persisting issue | More likely to occur than not<br><br>Will undoubtedly happen/recur, possibly frequently |