Free Members' Webinar: Coroners preventing future deaths reports - improving learning for mental health services		
Question Details		
	Question	**Answer**
1	what is generally classed as misadventure	For MoJ statistical purposes, there is no difference between accident and misadventure. However, if any logical distinction exists, then misadventure may be when someone deliberately undertakes a task, which then goes wrong and cases death.
2	17% of reported deaths last year led into an inquest, how many of those involved NHS services? and is there any medical specialty more likely to be involved in coroners inquest among others?	This data is not available
3	A question on the process for publishing PFD responses on the Chief Coroner's website - does the Coroner who had issued a PFD have a duty to publish all the responses received by those to whom the PFD was addressed? Can the Coroner choose to not publish some of the responses?	See Chief Coroner's Guidance No. 5. A Senior Coroner must send a copy of a PFD report to the Chief Coroner, who must publish it, unless the redaction policy applies.
4	Are all the contents of a PFD available to the public? Can information be withheld and if so, what sort of information?	In the main, Yes. Subject to the reaction policy, e.g. contact details, suicide methodology.
5	Hi, I just want to know .NHS is also arranging lecture with Lawayers about death report etc?	Noted
6	Hoe far can professionals prevent suicides? What lessons can be learnt on risk management from Coroners view?	This is too wide a topic for this Q&A
7	Can we raise to the cornoer for the lawyer to use better language and tone before I answer the questions?	This should be for your lawyer to raise.
8	Very informative talk by the first speaker, thanks. I have in the last few years given evidence at the Coroner's request as an independent expert witness. It felt a little adversarial as there were lawyers representing each side and giving evidence felt a little like other Courts. is this becoming the new practice in Coroner's Courts - it doesn't sound like it from your talk. Can you possibly elaborate a little on this please?	The lawyers Regulators' Toolkit is meant to recalibrate the tone of Inquests - they are fact finding inquisitorial hearings.
9	I have found that the major challenges colleagues who have gone to an inquest report, is usually with the lawyers and how they made them feel during the process. This has kept me wondering really the reason behind having lawyers present in such a setting since it is a fact finding activity? And who do the lawyers represent in the court?	Inevitably organisations need to be represented by lawyers.
10	A large number of EDs have multiple mental health patients in for days (often up to 7). The ED is certainly not a conductive environment. What plans, if any, are in place to create additional mental health capacity? It's unfair to continue to put pressure on acute Trusts.	As a Judge, I cannot comment.
11	Thank you Rachel; excellent as always. Is it a sensible response to the "low risk paradox" just being advised not to use risk stratification?	The advice is to move to dynamic clincial formulation. Work is being done on the structure for this.
12	I sympathize with your experience and many of us have lost patients to suicide. I disagree with your statement that suicide risk is completely unpredictable. We are trained and have skills to assess suicide and although cannot always predict we do generally prevent many suicides. A study in the US some years ago showed that close working between all agencies concerned reduced very signficantly local suicide rates to almost none>	I can only speak from my experience here- in that I have not ever seen any evidence of indiivdual suicide being predictable. There is good evidence for public health intervnetions reducing suicide rates e.g reduction in access to means. I am sure we do reduced the chance of suicide in our work with patients but who cannto be deteremined. To talk about suicide and to put feeligns into words reduces the risk of action.
13	Will the transition to the PSIRF framework help with critical reports?	Yet to be determined.
14	Thank you to both speakers - informative and clear - Limited experience of attending Coroner's Court, but have to echo that the Coroner did set the scene and tone.	Noted.
15	Dear Derek I have submitted a medical report following the death of one of my patients by suicide. I received a request from the corner's office to identify the unavailabity dates for the next 9 months to attend the hearing . Why it's too long , it's distressing fro all parties including families to wait all this time . Thanks	Noted. But as a Judge, I cannot comment on individual cases.
16	Why are deaths by suicide treated differently to death by other reasons example cardiac related	Section 1 The Coroners and Justice Act 2009 - the Coroner investigates deaths, which are unnatural, violent, in state detention or the cause of death is not known. A cardiac related death is natural and would not necessarily come under the coroner's jurisdiction.
17	In an increasingly litigious society, how can we avoid falling into the trap of defensive practice while also ensuring that we are covered legally? I know that robust documentation can be a crucial element; however, in practice, it's only sometimes feasible to maintain that level of thoroughness, given ongoing time constraints and an increasingly demanding workplace culture. Also, sometimes we have to make judgement calls in real-time, often under a growing sense of urgency, and realistically, it can be challenging to manage the ongoing pressures. Even more so in psychiatry, where we rarely have access to quantitative investigations (we can't just check some bloods or review a scan), and we need to rely on our experience and expertise rather than concrete results that could support our findings. It's one thing to say that someone is "clinically stable" and back that with a set of data, and it's an entirely different thing to say that someone is "not suicidal" without having anything to support your impression	Noted.
18	Comment. I think it is admirable that clinicians like Dr Gibbons can harness and use their own personal responses to adverse outcomes to help others ! Thank you.	Thank you
19	How should one cope knowing that there are systemic issues which contribute to patient deaths rather than an individual person/s contributing to death? Things don't change despite escalating issues	I am not sure that we 'know' that systemic issues contributed to the death- however we may know that there are significant systemic issues affecting patient care. How to deal with this is a very broad question that deserves a more thoughtful response than I can give at this time.
20	Eleni with respect I hope you don't appear as an expert witness in any Inquest I attend; the whole point of Rachel's carefully considered comments is that it is a self delusion that we can assess suicide risk in the way you indicate.	Not requiring an answer

21	would you comment on any common themes /lessons observed in inpatient suicides?	This is too wide a topic for this Q&A
22	To what extent are PFD letters and recommendations pursued / monitored; and if an organisation does not act on PDF is there any repercussions? Does anyone check on actions?	There is no formal follow up power or sunction by a Senior Coroner or the Chief Coroner. The NHS do look at thematic issues as do some charities and academics.
23	Are there statistics on the effect of suicide or coroner's inquest on practitioners	No
24	Do GPs/Primary care have a role in preventing suicides as 80% present to them in the year before suicide. Again any informations that can assist from the Coroner?	This is too wide a topic for this Q&A
25	link of podcast please?	https://www.ficm.ac.uk/podcast-the-coroner-%E2%80%93-part-1