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Advocacy for doctors at inquests: sit still and say nothing?

Introduction

1. It's a pleasure to speak to you today about coronial advocacy. It is always a privilege to appear in the coronial jurisdiction because of the gravity of the subject matter, and because of the kaleidoscope of personalities to be found at the Bar table, each with their own interest to protect and their own idiosyncrasies.

2. The focus of this paper is upon doctors, as they are who I usually represent, but it can be generalised to other professionals who have a sufficient interest in the potential findings of an inquest to require representation.

Inquests: a defensive and reactive role?

3. Here are two quotes from two very accomplished barristers about how to approach coronial advocacy when representing professionals who may be at risk of adverse comment at an inquest.

4. The first, slightly edited, is from a very capable senior counsel who regularly appears in the Coroner's court:

   "Your task is to protect your client from any unfairness, and to assist them in responding to criticism. Many experienced advocates say very little and ask very few questions when they appear at inquests."

5. Chester Porter, when he spoke on the subject, said simply:

   "Many good advocates say very little at inquiries."

6. Indeed, this is the first piece of advice your colleagues are likely to give you with respect to representing professionals at inquests, and it may well be the only piece of advice you are given.

7. This advice has the advantage of being rather easy to remember, easy to follow, and relatively safe. It will also largely keep you out of trouble, if you are able to follow it.

8. There will be times when it is absolutely the right approach.

Focused advocacy, not purely defensive advocacy

9. However, is your role always purely a defensive and reactive one? I want to suggest to you that there is a more creative side to coronial advocacy.

10. A good coronial advocate is not necessarily a silent advocate but a focused advocate, who has adapted their advocacy to suit the forum in which they appear.

11. As with all advocacy, everything you do must be for a forensic purpose, and every action you take must be directed towards the theory of the case you develop, but ultimately, your role need not be purely defensive.

12. As in all advocacy, there is a story you want to tell and often that story is a positive one.

13. The inquest is an opportunity. In many cases, it is an opportunity for your doctor to explain what she did on her terms.

14. In many cases it is an opportunity for families and health practitioners alike to come to some sort of understanding, reconciliation and acceptance of what has happened.

The structure of this paper

15. In this paper, I will go through each aspect of the inquest, from preparation to appearance, and consider how an active, not merely passive, approach can be taken to the inquest.

16. I will provide short case studies to demonstrate the approach I am suggesting.

17. I will discuss each of the following:

    i. The initial working-up of the brief;

    ii. Pre-hearing conferences with your doctor, a critical step which I will deal with at length

    iii. Pre-hearing conferences with your expert and other experts;

    iv. Talking with other counsel prior to the hearing;

    v. General principles with respect to questioning witnesses other than your own at the hearing;

    vi. Particular principles applicable to questioning of unfavourable witnesses;

    vii. Particular principles applicable to questioning experts at inquests;

    viii. Dealing with other advocates at the hearing;

    ix. Closing submissions.

(i) The initial working-up of the brief: the first opportunity to develop a case theory

18. Successful inquest advocacy begins with a good working knowledge of the brief. Sometimes the brief will be very large, and will arrive very late. Some of it will be peripheral, or of little relevance to your doctor. You may not have time to grapple with it all.

19. In large inquests, I create a "working brief". This brief will contain the statements of those giving evidence only. Though significant evidence at an inquest will be in written form only, the beating heart of the inquest is the evidence given by those witnesses the coroner considers significant enough to hear from in person.

20. As you work through the brief, you are developing a working case theory; what is the narrative which best suits your witness, does the weight of evidence support it, whose evidence is inconsistent with that narrative, and what problems need to be addressed?

(ii) Pre-hearing conferences with your doctor: the critical step of preparing your doctor to give evidence

21. Having formed a working theory of the case, the next step is a conference with your doctor. This is a critical step if not *the* critical step, so I will take some time over it. I will discuss five areas you should cover in conference. They are:

    1.) Making your doctor familiar with the coronial process, and comfortable with you;

    2.) Discussing tone, manner, and method of answering questions;

3.) Considering how expansive your doctor can afford to be when giving evidence;

4.) Considering and discussing the possibility of "pleading the fifth", as Chester Porter puts it;

5.) Exploring gaps and contradictions in the evidence and considering whether to put on a further statement.

(1) Making your doctor familiar with the coronial process, and comfortable with you

22. Take some time to outline the process when your doctor gives evidence. It is easy to forget that even highly experienced and obviously capable professionals may not have given evidence in any court, let alone the coroner's court.

23. Further, even for a very experienced doctor who has experienced many deaths, there are no doubt complex feelings where a patient has died unexpectedly, and anxiety, whether acknowledged or not, about being asked to answer questions about that death in an unfamiliar environment.

24. You can provide a great deal of assistance and reassurance in carefully outlining what will happen when they give their evidence. Your doctor will also benefit from being told what you are there to do while she is giving evidence, and that you will intervene to protect her where it is necessary to do so.

25. Feedback confirms the value of this support. I remember one very capable surgeon writing to me afterwards and thanking my instructing solicitor and me *"particularly for your explanation of the legal process"*.

(2) Discussing tone, manner, and method of answering questions

26. With all doctors, basic feedback on their manner and tone when answering questions should be given in conference. The advocacy rules do not allow "coaching" of witnesses, but this is not a prohibition on advice about the manner in which questions are answered, it is a prohibition on attempting to influence the substance of the evidence given.

27. Similarly, it is not coaching to present a witness with evidence which appears to contradict their account and asking them whether they have an explanation or want to change their evidence, in the light of the apparent contradiction.

28. With respect to the manner and tone of giving evidence, the advice will depend upon any weaknesses observed in their manner in conference.

29. In general, doctors should be encouraged to maintain eye contact with the advocate questioning them.

30. They should be told that they should avoid anticipating questions which have not yet been asked, that they should focus on answering the question they are asked, that their tone should be warm, firm, and patient, and that reasonable concessions should be made.

(3) Considering how expansive your doctor can afford to be when giving evidence

31. To turn to the theme of this paper, it is also a good opportunity to explore how expansive your doctor can afford to be in explaining what she did, why she did it, and her own assessment of what was going on for the patient at the time.

32. Highly respected and obviously accomplished doctors are as likely to be involved in deaths which go to inquests as any other doctor.

33. If you have a doctor in that category, there is an excellent chance that their evidence will make a powerful contribution to everybody's understanding of the health-care provided, a contribution beneficial both to the doctor's reputation, and the family.

Case study No 1: the power of a good witness

34. An inquest I appeared in last year demonstrated this point very strongly. The inquest involved the death of a young man who attended hospital in a distressed state, was prescribed medication, left the hospital, and died from an overdose of the medication prescribed.

35. My doctor was a psychiatrist, and the more senior of two doctors who assessed the young man, prescribed the medication, and allowed him to leave the hospital.

36. At the inquest, the doctor spoke powerfully and movingly of the predicament the young man was in, about the choices which the healthcare team faced, and the reason for the decisions which they made.

37. He was able to convey his very sophisticated expert knowledge in a clear, considerate, and powerful way.

38. That evidence allowed the young man's family, who asked me to thank the doctor concerned, the comfort of knowing that their son's last contact with health services, and possibly his last meaningful contact, was one which involved a high degree of care, concern, and compassion.

39. Equally I am sure that it provided a degree of satisfaction to both my doctor and the more junior (and rather more anxious) doctor involved in the young man's care that the coroner observed:

"It is....clear from the written and oral evidence that [the doctors involved] were very caring, thoughtful and considerate and showed an impressive degree of commitment in their care of Mark."

40. You will generally have a gut feeling about whether you have a doctor who can be trusted in this way.

41. If your gut feeling is that your doctor is not one who is likely to impress when giving evidence, your advice will be listen very carefully to each question, to ask that it be repeated if they do not understand it, and to answer each question in as simple a way as possible.

(4) Considering and discussing (if necessary) the possibility of "pleading the fifth"

42. In an appropriate case, you should advise your doctor about their right to object to answering questions on the basis that they may be subject to civil penalty[1].

43. Chester Porter QC has suggested that a professional person should not lightly take such action, and that it would quickly become known amongst his profession and damage his reputation.

44. However, my personal view is that this risk is overstated, for three reasons. First, the coroner understands that the intention is not to avoid answering the questions asked, but to allow the coroner to grant a certificate[2] which will provide a degree of protection for the doctor[3], and

[1] *Coroners Act* 2009 (NSW), s. 61.
[2] *Coroners Act* 2009 (NSW), s. 61 (3).

allow her to answer the questions candidly and directly. Coroners will generally let you, as advocate, take the objection on your doctor's behalf.

45. Second, and critically, the fact that the doctor has objected to the evidence cannot be published without the express consent of the Coroner[4]. In the interests of obtaining candid and direct evidence, the Coroner will as a general rule not only withhold that consent, but will often, upon application, make an order prohibiting publication of the evidence given over objection[5], where a certificate has been granted.

46. Third, the doctors for whom this approach is appropriate are not the type to whom the reputation of their peers is critical, or whose closest colleagues are sufficiently well connected that they will become aware of the fact.

47. Often, a global objection is taken. However, there is authority which suggests that this approach does not reflect the wording of section 61, which allows objection to be taken to "particular evidence" or "particular matters"[6].

48. For that reason, you should attempt to define the specific areas of evidence (ie, "the particular matters") with respect to which the objection is taken prior to those areas being explored in questioning, allowing the coroner to grant a certificate which is confined to evidence on those topics only.

49. You will need to be alert to the possibility that further objection will need to be taken as the questioning of your doctor moves to problematic areas which fall outside the "matters" with respect to which objection has already been taken.

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[3] *Coroners Act* 2009 (NSW), s. 61 (7).
[4] Coroners Act 2009 (NSW), s. 76 (c).
[5] Coroners Act 2009 (NSW), s. 74 (1) (b).
[6] *Rich v Attorney General of New South Wales & Ors* [2013] NSWCA 419, at [14] – [15]

(5) Exploring gaps and contradictions in the evidence, and considering whether to put on a further statement

50. It is important to tackle difficulties in the evidence head-on, as your doctor needs to be prepared to deal with them at the inquest.

51. In some cases, it may be appropriate to put on a further statement, particularly if the earlier statement (which may have been prepared before advice was obtained from the doctor's insurer) creates a bad impression, is inaccurate or misleading.

52. Your doctor's statement will be the only impression the coroner and counsel assisting have of your doctor until she is called. Their own tentative theories of the case will be influenced by this statement as well. Counsel assisting will have your doctor's written statement as the starting point for their questioning of her, and the questioning might not allow the evidence which should have been given to come out easily or coherently.

53. Your opportunity to bring that more positive evidence will come at the very end of her evidence, after an impression of your doctor has been well and truly set.

54. In some cases, the provision of a more comprehensive statement may even lead to the Coroner determining that your doctor need not be called as a witness, and remove the risk of adverse findings against her.

55. In other cases, where there is simply more helpful detail which the doctor can usefully provide, it is as well to allow it to come out naturally in oral evidence, where it will have the greatest impact.

Conclusion on the subject of doctor's evidence

56. Much more could be said on the subject of doctors' evidence, but in the end, if your doctor's evidence comes across as ordered and professional, and their manner is warm and compassionate, it is far more likely that their provision of care to the deceased will be considered in the same light.

(iii) Pre-hearing conference with your expert and other experts

57. You may also have an expert who is giving evidence. I'll confine myself to one observation. If you had to do some research to understand what they say in their report, then so will others. Don't be afraid to ask your expert to explain something in very simple terms, and don't be afraid to question them until you have a full understanding of what they are saying.

58. An expert is a very valuable resource for assessing your doctor's strengths and weaknesses, and they are a significant resource for preparing cross-examination of other experts.

59. Remember also that there is no property in a witness, and counsel assisting will be quite happy to facilitate a conference or conversation with any experts qualified by the coroner.

(iv) Talking with other counsel

60. Another important element of pre-hearing preparation is talking with other advocates. Often there will be other doctors and nurses represented, and conversations with them will both allow you to understand how their approach might affect your doctor, and to offer a different way of looking at the evidence.

61. Incidentally, it will also confirm what I say about the centrality of a working theme or case theory: most advocates will, at some point in the conversation, say *"This is really about X, Y, or Z, isn't it?"*, to which you will usually offer a fairly non-committal response.

Talking with counsel assisting

62. The most important conversations you will have will usually be with counsel assisting. In talking with counsel assisting, you are able to take advantage of one of the special features of the coronial jurisdiction, which is that there is a colleague who has direct lines of communication with the bench.

63. This works both ways. In finding out how counsel assisting is approaching the matter, you have a pretty good understanding of the way that the coroner is approaching it.

64. Equally, it is your opportunity to plant a few seeds of your own, and thus influence the course of the inquest, and the thinking of the coroner. It is an opportunity to gently push your case theory, gently pointing to critical facts, or a favourable characterisation of what has occurred.

65. If you are able to establish a good rapport with counsel assisting, this two-way process can continue through the inquest.

(v) Questioning witnesses other than your own at the hearing

66. Let's turn to questioning of witnesses other than your own. In this area, focus is immensely important. Many issues will already have been fully explored, or will be explored by other advocates.

67. Your focus with all witnesses should be very much defined by your case theory, and confined to what will genuinely help you when it comes to closing submissions.

68. Coroners do not expect you to be a minimalist in questioning of witnesses, but they do expect focus and efficiency.

69. As you know, the rule in *Browne v Dunne* does not apply. Coroners do not expect you to ask questions which have been asked other parties, or to ask questions where the answer is obvious or unlikely to be helpful.

70. You have the choice of leading questions or open-ended questions. This gives you a great deal of flexibility when crafting your questions. As a starting point, you would tend towards more open-ended questions with those who are favourable to you (as their evidence will carry more weight if not directed), and more directed questions towards those who are unfavourable.

Case study No 2: questioning which reinforces the theory of the case

71. A good illustration of the "focus on case theory" approach to questioning of witnesses is a cross-examination of a registered nurse in an inquest in a country town.

72. In that case, a young man had hanged himself. A day or so before, he had presented at the local hospital after a suicide attempt. There was no-one qualified to assess him on site, so a community nurse at another hospital interviewed him by video-link, and recorded her observations.

73. Our doctor, a psychiatrist, was on-call in another town. He was the one who had to make a judgment, based on the information provided to him by the community nurse, as to whether or not the young man should be admitted, either voluntarily (if he would accept), or involuntarily.

74. One aspect of the case theory was obvious; he was reliant on the observations and expertise of the community nurse. The closing submission on this point was *"She was his eyes and ears"*.

75. Every question asked of the community nurse emphasised this advantage:

    "What did you observe about his body language during the interview?"

    "What did you notice about his voice?"

    And so on.

76. At the same time, in asking the community nurse to outline the observations which she made, I was supporting the community nurse's clinical judgment and skills, as our broader case theory was that no failure of assessment or judgment had been made when the decision not to detain the young man was made.

77. The phrase *"He was her eyes and ears"* found its way into the coroner's reasons.

(vi) Questioning unfavourable lay witnesses

78. The more challenging type of witness is one who is essentially unfavourable. Often, this will be family members.

79. They are a particular category of witness, and should be approached with respect and care.

80. The starting point is to look for what might be obtained from them which supports your case theory, and which is likely to be uncontroversial.

81. Next, you might be looking at minimising the damage of their evidence. Often witnesses' oral evidence will be significantly more damaging than that which is contained in their statements; the patient will have been more obviously sick, the entreaties for help will have been more insistent, and so on.

82. Given that their statement will have been made significantly closer to the date of the events they are recalling, it is usually relatively straight-forward to have them accept that what is in their statement is more likely to be a true reflection of events.

83. Some evidence you might feel you have to tackle head-on. Ask yourself what your submissions will be, and whether the question needs, as a matter of fairness, to be put, or whether it can just be a submission.

84. As a general rule, your submission should be that the family member has forgotten, or is mistaken in their recollection. It will rarely be advisable to suggest that they have lied.

85. An exception is where a family member is clearly obsessive, unreasonable, and vindictive. Grief is looked upon kindly in the coronial jurisdiction. Vindictiveness and dishonesty are not.

86. You will have to rely on a gut feeling, however, if you are confident, you can expose such a witness, and this will be greatly appreciated by the health practitioners who have no doubt been the subject of this witness's vindictiveness.

(vii) Questioning experts

87. Another special category of witness is the expert. I will offer just a few tips. First of all, one of the most useful forms of questions involves asking

an expert whether certain accepted facts are "consistent with" a certain scenario which suits your case theory.

88. Most doctors will concede that particular facts are "consistent with" a number of scenarios.

89. Second, most experts recognise their ethical responsibility[7] is to give a fair and balanced opinion, properly supported by the literature. Their reputation and credibility is dependent upon appearing fair and reasonable.

90. For this reason, appropriate concessions will generally be made. If an expert appears not to be taking this approach, it is useful if you can think of a question where the reasonable answer appears clear and is helpful to you.

91. Even partisan experts will usually recognise the necessity of giving the reasonable answer. However, if they don't their credibility as independent experts is greatly compromised.

Case study 3

92. I had to employ this tactic in a hearing with respect to a doctor's competency held late last year. The Medical Board's forensic psychologist was calling into question the results of psychometric testing conducted by our doctor's expert.

93. The questioning was in the form of a dare:

"There are clear rules for the administering of these tests?"

[7] See, for instance, *Mustac v Medical Board of Western Australia* [2004] WASCA 156, at [129].

"Yes."

"You accept that these tests, if administered according to those rules, provide accurate results?"

"Yes".

"Do you accept that Dr X is a competent and qualified professional?"

"I have no reason to say that he is not."

"Do you say that Dr X did not administer the tests according to the rules?"

"I have no evidence to suggest that he did not."

(viii) Dealing with other advocates at the hearing

94. With respect to advocates generally, obviously the over-riding rule is do not pick a fight unless it is really necessary. However, object to questions which contain inaccurate premises damaging to your doctor (often a misquoting of the evidence already given).

95. Do not be afraid to object to such questions even when they are asked by counsel assisting.

Dealing with advocates appearing for families

96. I should say something about dealing with advocates appearing for families.

97. The coroner's court does, on the whole, avoid overt blame, and aim for some form of reconciliation and acceptance. That is what is satisfying for the coroner, and convenient for many of the parties.

98. Advocates representing families are often innocents, wandering into the jurisdiction equipped with nothing but some rather incendiary instructions from family members.

99. Well placed objections to allegations put without foundation, and questions which are not in proper form, as long as your interventions are sparing and timed for maximum effect, will earn the gratitude of counsel assisting and the other lawyers at the Bar table, as well as shut down a line of questioning which, through shear rambling haphazardness, may accidentally do some damage.

100. I say "shut down" the line of questioning, because faced with the challenge of asking a question in proper form, inexperienced advocates will often prefer to sit down.

(ix) Closing submissions

101. This leaves the topic of closing submissions. There is a fashion for these to be very low key and understated. There will be occasions when this is all that is needed.

102. However, my challenge to you is to consider going further. If your doctor provided a high level of care, say so, don't confine yourself to purely defensive statements. If you think that should be acknowledged in the decision, ask that it be acknowledged.

103. Very powerful submissions can be made when you tap into the intense feelings which are inevitably a part of the inquest. Very often, it is most effective to start with a short acknowledgement of the family members who have spoken or are present, and speak very directly to them, and in plain English.

104. I remember one particular inquest where a number of old people died. What was striking, as children and grandchildren spoke on the last day of the inquest about their parents and grandparents was how their tales told the story of post-second world war migration, and of the hard work and determination on which contemporary Australia was built.

105. That observation was worth making, and I made it. Equally, it was important to acknowledge the heroic efforts of members of the NSW Fire Service, so I did.

106. Do not use euphemisms. You are sorry that their brother, father, sister died. They didn't "pass". They haven't been "lost". They died. If there is something which struck you about the way they talked about their father, there is no harm in commenting on it.

107. Tone is critical in coronial advocacy, and you will find a receptive coroner if you can get that tone right.

108. Of course your submissions must be logical, structured, and deal with what needs to be dealt with in the evidence. But if they can tap into the beating heart of the inquest, they will be more powerful.

Conclusion

109. If there is one thing I would like you to take away from my talk with you today, it is that coronial advocacy can be a creative exercise, and not purely a defensive one.

110. You will all have your own ways of approaching that exercise, and often you may not have to say that much at the inquest, but the deeper your engagement with the inquest itself the more enjoyable you will find it, and

the more likely it will be a satisfactory and even a beneficial process for your doctor.

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