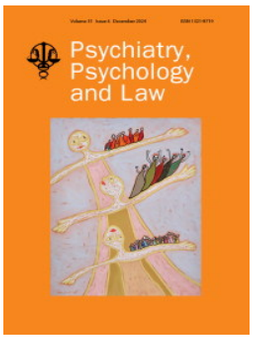

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A systematic review and critique of publicly available guidance for mental health practitioners called to a coroner's inquest

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Mental health practitioners may be called to an inquest after the unexpected death of a patient. Our review aimed to synthesise publicly available guidance written for practitioners working in mental health who are called to give evidence at a coroner's inquest. We conducted both a systematic database and web search. We conducted a quality appraisal and data synthesis using the Framework Method. We found limited guidance specifically for those working in mental health. Guidance gave advice on preparing effectively including how to give oral evidence and write witness statements. Support was often assumed to be given by the employing Trust. Only a minority of guidance suggested means of psychological support. We identified a set of practically applicable principles for healthcare practitioners attending inquests. Many recommendations were not backed by evidence and lacked stakeholder input.

Keywords: guidance; healthcare; unexpected death; staff wellbeing; suicide; mental health; practitioners; homicide

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Introduction

Coroners investigate unexpected death. Where necessary, the investigation culminates in an inquest: an inquisitorial process, fact-finding hearing, tasked with answering four specific questions in relation to the death: (1) who (2) when (3) where and (4) how. When a patient dies by suicide or there is a patient-perpetrated homicide, mental health practitioners involved in their care are commonly called to give evidence at the inquest as a factual witness. The inquest can be a difficult process for the those who attend including the immediately bereaved (1–4) and professionals involved in their care (5–7).

In the UK, approximately 1673 people under the care of mental health services die by suicide every year (8). Experiencing the suicide of a patient is an event that many mental health practitioners will experience (9,10). Patient-perpetrated homicide is less common, averaging 61 per annum over the past ten years (8), but also has significant impacts on relatives and practitioners (11). Research interest in the effect of patient suicide or patient-perpetrated homicide on healthcare practitioners is growing (12–16), as it is for the harm of such events on relatives (17–21).

Qualitative work and descriptive surveys focussed on health and social care professionals' response to suicide highlights the emotional effects of the experience and the tendency towards self-blame or feeling blamed by others (13, 22–24). Other reported harms

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include guilt, anxiety, self-doubt and, less commonly, mental health conditions such as post-traumatic stress disorder (PTSD) (14). Systematic review evidence shows that the risk of negative outcomes among practitioners is higher when they perceive themselves as responsible for the death of the patient (25).

A coroner's inquest is a critical aspect of the aftermath of patient suicide or patient-perpetrated homicide. Our systematic review of studies describing experiences of mental health practitioners called to attend a coroner's inquest (and other forms of investigations such as mandatory inquiries commissioned after a homicide) found that inquests could be experienced as stressful and anxiety-inducing, with practitioners often feeling blamed (6). This is despite the fact that by law, inquests are fact-finding proceedings and not intended to assign blame or (criminal or civil) liability.

The review findings suggested it was common for practitioners to feel under-supported, in terms of knowing what the coroner expected from them and what might happen during the inquiry process.

We found that consistent communication on what to expect can mitigate stress or feelings of professional isolation (6). Where practitioners felt they had been prepared for the investigatory processes, anxiety at the prospect of attending could be alleviated (13, 16, 26). Conversely, where witnesses felt underprepared or unsupported, the process was experienced as very stressful and even traumatic (14, 22). Given the reported gap in available support, we aimed to conduct a systematic review of publicly available guidance produced by professional bodies and other relevant stakeholders intended to assist mental health care practitioners in preparing to attend a coroner's inquest. Our original search for guidance specific to mental health practitioners returned minimal results so we broadened the search for this review to include all healthcare practitioners.

Woolf (27) defines four different methods behind the development of guidelines including informal consensus development; formal consensus development; evidence-based guideline development and explicit guideline development. This review included all types and has used the umbrella term 'guidance' to describe them. Our research objectives were to identify the guidance available, assess the quality, identify similarities and differences in the material produced, and consider the relevance of their content based on our recent synthesis of empirical evidence concerning mental health practitioners' experience of attending inquests (6).

Methods

This review was pre-registered on The International Prospective register of systematic reviews 'PROSPERO' (reference number: CRD42023400310).

Search strategy

We conducted a systematic search of both bibliographic databases and grey literature for relevant guidance documents. For the bibliographic databases, we used a combination of MeSH and free text terms, with search terms developed with input from a UCL librarian. The search was built around key search terms capturing three main concepts (1) 'healthcare practitioner' or 'healthcare clinician', (2) 'serious incident investigations, inquiries, coroner inquest' and (3) 'standards, guidelines or recommendations'. Search terms can be found in Appendix 1. Our original search strategy had been to identify guidance written specifically for practitioners working in mental health, but this returned limited results. Consequently, we broadened our search to guidance for all healthcare practitioners providing it could be relevant for those working in mental health.

We searched nine databases (Medline, Embase, PsycInfo, EBSCO CINAHL, Web of Science, Scopus, ProQuest, Lexis + UK, EBSCO Index to Legal Periodicals) and five registers (The Guidelines International Network library; The National Guideline

Clearinghouse; The National Technical Reports Library; NICE; CADTH's Grey Matters) with no date restrictions up until 22 January 2024.

We also searched the internet for potentially relevant guidance. The nature of web searching makes it difficult to outline a strategy that yields identical results given the fast-paced, changing nature of internet content, but we followed principles outlined by Briscoe et al. (28) with the aim of maximising the transparency and replicability of our approach. Searches were conducted using the Google advanced search function and the metasearch engine Dogpile. We used a combination of search terms ('coroner's inquest' OR 'coroner's investigation' OR 'coroner's court' OR 'coroner's inquiry') AND ('healthcare staff' OR 'healthcare personnel' OR 'healthcare practitioners') AND ('guidelines' OR 'advice' OR 'recommendation'). Results were screened up to a depth of ten pages per search.

Screening and selection

We collated the literature retrieved from bibliographic searches in Endnote X20 and duplicates were removed. MT initially screened all titles and abstracts, selecting potentially relevant articles. The full text articles of those selected were then screened. A second reviewer (ST) randomly screened 20% of titles and abstracts and 100% of those identified for full text screening. Potentially relevant material retrieved from web searches was collated using an Excel spreadsheet and duplicates were removed manually. Initial web search screening was completed by MT. A second reviewer (ST) screened a random 20% of the web search results and 100% of those deemed relevant by MT. Any disagreement on whether the guidance met inclusion criteria was resolved through discussion.

Inclusion criteria:

- Published, publicly available guidance for healthcare practitioners attending an inquest in England
- Guidance in a variety of formats, including web pages, journal articles, webinars, online pamphlets and training videos

Exclusion criteria:

- Material not publicly available
- Material relating to coronial systems outside of England and Wales
- Material produced by NHS Trusts intended for their employees only
- Material for witnesses that explicitly focused on healthcare practitioners working in specialties outside of mental health (e.g. guidance for surgeons)
- 'Information overviews' that did not include explicit guidance
- Excluded formats: books, unpublished material. We also excluded multiple formats of the same guidance (for instance a video delivering the same content as a webpage)

We have excluded Trust-issued guidance on the basis it could include advice specific to that Trust. Certain formats (unpublished materials, books) are excluded because we want to consider guidance that is easily accessible for healthcare practitioners to give a 'true representation' of what is available. Distinguishing guidance from information overviews was at the discretion of the research team and we acknowledge the difficulty of delineating between the two. We excluded literature which contained only background information within the document with no advice for someone being called as a witness. As our themes make evident, many of our documents did contain background sections but always contained some direct advice for healthcare practitioners.

Data extraction and quality appraisal

Key characteristics, agreed by the research team, were extracted from the included literature and materials by one researcher (MT) into Microsoft Excel. One researcher (MT) then conducted a quality appraisal of the selected

articles and materials using an amended version of the Appraisal of Guidelines for Research and Evaluation II framework (AGREE-II) (29). The 23 items in AGREE II are grouped into the same six domains as in the original AGREE instrument. These domains are 'scope and purpose'; 'stakeholder involvement'; 'rigour of development'; 'clarity of presentation'; 'applicability' and 'editorial independence'. We scored documents on every domain apart from 'applicability'. We made adjustments to each domain to ensure that every question was relevant to our study aims. Information on the AGREE-II tool and the amendments made can be found in Appendix 2.

We calculated individual domain scores for each item as well as an overall score out of 100. A second reviewer (ST) then randomly selected a sub-sample of the included articles and materials (25%) for quality assessment to validate the quality appraisal process. Any differences in scores between the two reviewers were resolved through discussion.

Synthesis

We used the Framework Method (30) to analyse our data. The Framework Method organises data into a matrix with rows of cases (pieces of guidance) and columns (codes). In our initial analysis of the data we identified codes inductively (as opposed to priori-determined categories) and then coded all the data into this coding framework. We then produced frequency counts for the identified themes as represented across guidance. The data were then re-reviewed based on the coding framework and further amendments made on the basis of team discussions (HK and JB) (31). Analysis of the guidance content was facilitated using NVivo 14 (32).

Results

Summary findings

We retrieved 3104 records from our database search. After removing 474 duplicate records, we screened 2630 records at title and abstract level. Of these, seven records were subjected to full text review, two of which met our inclusion criteria. The web search generated 302 records. After removal of 14 duplicates, 288 were assessed of which 33 met our inclusion criteria. We therefore included a total of 35 pieces of guidance in our systematic review. A PRISMA flowchart is shown in Figure 1.

There were 21 pieces of guidance defining themselves as based on best practice ($n = 16$) or author experience ($n = 5$). Other types of guidance included 'learning resources' ($n = 7$), 'advice' (opinion) pieces ($n = 6$), and 'consensus statement' ($n = 1$). Guidance consisted of documents ($n = 15$), journal papers ($n = 7$), web pages (articles) ($n = 5$), online videos ($n = 5$), webinars ($n = 2$) and one combined article and video resource ($n = 1$). Table 1 shows the summary characteristics of included studies.

The guidance was either for any area of healthcare ($n = 29$) or specific to mental health ($n = 6$).

Guidance tended to be aimed at professionals ($n = 31$) although some was written for healthcare providers ($n = 4$), three of which were specific to mental health providers ($n = 3$). Most guidance was aimed at clinicians generally ($n = 23$). However, we also found guidance more specifically aimed, including at nurse clinicians ($n = 3$), trainee doctors ($n = 2$) and psychiatrists ($n = 3$). Despite our intention to identify guidance for people working in both clinical and non-clinical roles, we found no guidance aimed at people working outside clinical roles (for instance, there was no guidance for those in support roles within a multidisciplinary team). All guidance used the narrower definition of 'clinicians'. To preserve accuracy, we have reflected the terminology of the original authors in the results and discussion section, using 'clinicians' or 'clinical witnesses' rather than our original search term of 'healthcare practitioners' (Table 2).

Ten (29%) of the identified materials were issued by solicitors, seven (20%) by clinicians, six (17%) by third-party indemnity companies, five by NHS England (14%), four (11%) by professional bodies (e.g. Royal College of

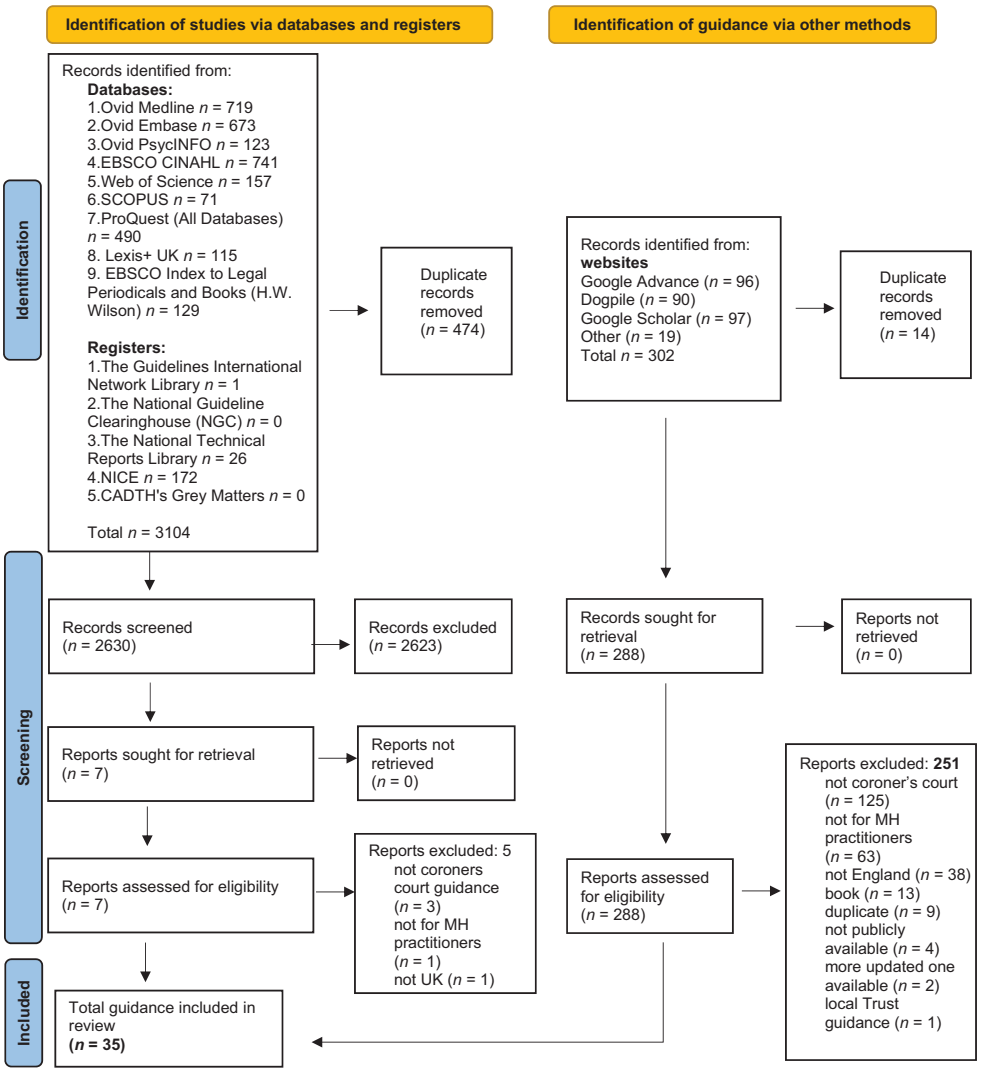

Figure 1. PRISMA flowchart. *Source*: Page et al. 2021 (33).

Psychiatrists), one (3%) by NHS Resolution (an independently run body of the Department of Health and Social Care providing advice on resolving concerns fairly) and two (6%) by multiple stakeholders. One of these represented a collaboration between a barrister, coroner, indemnity professional, psychiatrist and academic (68) and the other a collaboration between academics, the University of Plymouth, the Coroners' Courts Support Service (a voluntary sector organisation), NHS England West and Enable Law (67) (Table 3).

We found broad areas of common coverage across guidance, including background information on the inquest procedure, advice on communicating well and support. The information covered by each piece of guidance is summarised in Table 4.

Quality appraisal

Our quality appraisal using the AGREE-II tool found that the maximum 'total' score achieved was 66.5% (where 100% is maximum) and

Table 1. Summary characteristics of included guidance ($n = 35$).

First author	Guidance	Intended audience	Who issued by	Type of guidance	Guidance format
Academy of Royal Medical Colleges (34)	Acting as an expert or professional witness: guidance for healthcare professionals	Clinicians	Professional body	Consensus statement | best practice	Document (pdf)
Anonymous (35)	How to prepare for Coroner's Court	Nurses	Clinician	Advice | opinion piece	Web page / article
Browne Jacobson (36)	Writing statements for an inquest	Clinicians	Solicitor	Guidance | best practice	Document (pdf)
Browne Jacobson (37)	Shared insights: supporting clinicians through investigations, complaints, claims and inquests	Clinicians	Solicitor	Guidance | experience	Document (pdf)
Browne Jacobson (38)	Inquest guide for clinical witnesses	Clinicians	Solicitor	Guidance | best practice	Document (pdf)
Browne Jacobson (39)	Shared insights: mental health patients: learning from incidents and inquests	Healthcare providers (mental health)	Solicitor	Guidance | experience	Document (pdf)
Browne Jacobson (40)	Giving evidence remotely at a coroner's inquest for clinical witnesses	Clinicians	Solicitor	Learning resource	Online video
Calthorpe and Choong (41)	The coroner's court and the psychiatrist	Psychiatrists	Clinician (psychiatrist)	Advice | opinion piece	Journal paper
Fletcher and Ramsay (42)	Attending coroner's court: a practical guide	Clinicians	Clinician (general)	Learning resource	Journal paper
George et al. (43)	Providing effective evidence for the coroner	Clinicians	Clinician (obstetrician)	Advice | opinion piece	Journal paper
General Medical Council (44)	Providing witness statements or expert evidence as part of legal proceedings	Clinicians	Professional body	Guidance | best practice	Document (pdf)

(*Continued*)

Table 1. (*Continued*).

First author	Guidance	Intended audience	Who issued by	Type of guidance	Guidance format
Hill Dickinson (45)	Attending an inquest – a guide to witnesses	Clinicians	Solicitor	Guidance | best practice	Web page / article
Hussain (46)	Under the spotlight: supportive guidelines to maintain psychological wellbeing for staff involved in patient–coroner investigations	Clinicians	Clinician (psychologist)	Advice | opinion piece	Web page / article
Jones (47)	HM Coroner's Court: think inside the box	Clinicians	Solicitor	Advice | opinion piece	Journal paper
MDDUS (48)	Coroner's inquest	Clinicians	Third-party indemnity	Guidance | best practice	Document (pdf)
MDDUS (49)	Coroner's inquests	Clinicians	Third-party indemnity	Guidance | best practice	Document (pdf)
The Medical Defence Union (50)	Writing a report for the coroner	Clinicians	Third-party indemnity	Guidance | best practice	Document (pdf)
The Medical Defence Union (51)	Attending a coroner's inquest	Clinicians	Third-party indemnity	Learning resource	Online video
The Medical Defence Union (52)	Avoiding criticisms at the coroner's inquest	Clinicians	Third-party indemnity	Learning resource	Webinar
The Medical Defence Union (53)	Understanding coroners' investigations	Clinicians	Third-party indemnity	Learning resource	Webinar
Mills & Reeve (54)	Attending the Coroner's Court as a witness and how to give evidence	Clinicians	Solicitor	Guidance | best practice	Document (pdf)
Mills & Reeve (55)	Writing a statement for the coroner	Clinicians	Solicitor	Guidance | best practice	Document (pdf)

(*Continued*)

Table 1. (*Continued*).

First author	Guidance	Intended audience	Who issued by	Type of guidance	Guidance format
Mills & Reeve (56)	Health and care inquests	Clinicians	Solicitor	Learning resource	Online video
NHS England (57)	Mental health-related homicide – information for MH providers	Healthcare providers (mental health)	NHS England	Guidance | best practice	Document (pdf)
NHS Health Education England (58)	Medico-legal training programme	Clinicians	NHS England	Learning resource	Online video
NHS Health Education England (59)	Supporting doctors in training attending a coroner's inquest	Trainee clinicians (all)	NHS England	Guidance | best practice	Web page / article
NHS Health Education England (60)	Coroners' inquests – writing a statement	Clinicians	NHS England	Guidance | best practice	Document (pdf)
NHS Health Education England (61)	Coroner's inquest – a guide for trainees	Trainee clinicians (all)	NHS England	Guidance | best practice	Document (pdf)
NHS Resolution (62)	Inquests: a guide for health providers. Supporting staff to prepare for an inquest	Healthcare providers (all)	NHS Resolution	Guidance | best practice	Document (pdf) + online videos
Peel (63)	Understanding the nurse's role as a professional witness	Nurses	Clinician (nurse)	Advice | opinion piece	Journal paper
Royal College of Psychiatrists (64)	Supporting mental health staff following the death of a patient by suicide: A prevention and postvention framework	Healthcare providers (mental health)	Professional body	Guidance | best practice	Document (pdf)
Royal College of Nursing (65)	Advice guides for witness	Nurses Psychiatrists	Professional body	Guidance | best practice	Web page / article Journal paper

(*Continued*)

Table 1. (*Continued*).

First author	Guidance	Intended audience	Who issued by	Type of guidance	Guidance format
St. John-Smith et al. (66)	Coping with a coroner's inquest: a psychiatrist guide		Clinician (psychiatrists)	Guidance | experience	
University of Plymouth et al. (67)	Inquests: top tips and advice for the medical witness	Clinicians	Multiple stakeholders	Guidance | experience	Online video
Van Dellen et al. (68)	What the psychiatrist needs to know about the Coroner's Court in England and Wales	Psychiatrists	Multiple stakeholders	Guidance | experience	Journal paper

the median score was 27.8%. Owing to the low median score and the fact that only four records achieved a total score of over 50%, we decided not to rate individual material in qualitative terms (e.g. as 'high', 'medium' or 'low' quality). The quality scores were highest for domain four, 'clarity and presentation' (median score 75%) and domain 1, 'scope and purpose' (median score 66.7%). Domain 2, 'stakeholder involvement', scored lower (median score 38.9%), and domains 3, 'rigour and development' and 5, 'editorial independence', both scored lowest (median score 0.0%). Most material was well presented with a clearly defined rationale and identifiable recommendations. However, most did not report any stakeholder consultation process, evidence of methodological rigour or explicit coverage of issues such as conflicts of interest and funding (editorial independence). Individual domain scores can be found in Table 5.

Only eight of the 35 guidance documents had undergone peer review (27 had not) and seven had undergone some form of stakeholder consultation (28 did not clarify whether this had occurred).

One of our quality assessment metrics considered whether there was an explicit link between recommendations and supporting evidence. Twenty-four guidance documents had no supporting references, and five had limited referencing (although with little clarity as to how the references related to recommendations). Only six guidance documents scored five or above on a one-to-seven-point scale (capturing whether there were robust links between a portion of their recommendations and an underlying evidence base). No material was based on a clearly detailed empirical evidence base which, given the absence of research done on the experiences of healthcare practitioners attending inquests, is unsurprising.

Thematic analysis

Our Framework Method (30) established four descriptive themes: (1) knowledge and

Table 2. Target audience of identified guidance ($n = 35$).

Area of health	Intended audience	*n*	%
Healthcare (professionals)	Clinicians (any healthcare discipline)	23	66
Healthcare (professionals)	Nurse clinicians	3	9
Healthcare (professionals)	Trainee doctors	2	6
Healthcare (providers)	NHS providers of healthcare services	1	3
Total for healthcare professionals or providers		29	82
Mental health (providers)	NHS providers of mental health services	3	9
Mental health (professionals)	Psychiatrists	3	9
Total for mental health professionals or providers		6	18

Table 3. Provenance of guidance ($n = 35$).

Who issued by	*n*	%
Solicitor	10	29
Clinician	7	20
Third-party indemnity companies	6	17
NHS England	5	14
Professional bodies	4	11
Multiple stakeholders	2	6
NHS Resolution	1	3

preparation, (2) giving evidence, (3) bereaved families and (4) support. Each of these themes also included sub-themes (as shown in Table 6) alongside the frequency that each featured across the included guidance.

Knowledge and preparation

The first theme 'knowledge and preparation' captured information provided about the coroner remit; the form that inquests can take; potential outcomes and advice for people preparing to participate in an inquest.

> Knowledge and preparation are the key components to successfully negotiating these highly complex situations.
>
> Van Dellen et al. (68), multiple stakeholders

Information on the coroner remit

Twenty-five pieces of guidance explained that an inquest is held after an unexpected death and is tasked with asking four questions in relation to the death: who, when, where and how? Twenty-one explained that the task of the inquest is inquisitorial rather than adversarial and therefore distinct from other courts of law:

> An inquest is a fact-finding inquiry to establish who has died, and how, when and where the death occurred. It is not the Coroner's role to apportion blame and the Coroner's Conclusion will not name any individual or organisation as being negligent or criminally liable for the death.
>
> Browne Jacobson (38), solicitor

Seven described the role of the coroner as conducting actions on behalf of the state. Five described the inquest's potential ability to assist with the mourning process.

> The inquest can help the family by assisting with the grieving process.
>
> Anonymous (35), clinician

Table 4. Summary of information included in each guidance ($n = 35$).

		Knowledge and preparation			Giving evidence			Bereaved families			Support	
Author	Source type	coroner remit	types of inquest	outcomes of inquest	preparing effectively	writing statements	communicating well	family perspective	answering family questions	expressing condolences	Practical support	Psychological support
Academy of Royal Medical Colleges (34)	Professional body	Y	N	N	Y	Y	Y	N	N	N	N	N
Anonymous (35)	Clinician	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
Browne Jacobson (36)	Solicitor	Y	N	N	Y	Y	Y	N	N	N	Y	N
Browne Jacobson (37)	Solicitor	N	N	N	N	N	N	N	N	Y	N	Y
Browne Jacobson (38)	Solicitor	Y	Y	Y	Y	N	Y	Y	Y	Y	N	N
Browne Jacobson (39)	Solicitor	Y	N	N	Y	Y	N	Y	Y	N	Y	Y
Browne Jacobson (40)	Solicitor	N	N	N	Y	N	Y	Y	Y	Y	N	N
Calthorpe and Choong (41)	Clinician	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N
Fletcher and Ramsay (42)	Clinician	Y	Y	Y	Y	Y	Y	N	Y	N	Y	N
George et al. (43)	Clinician	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N
General Medical Council (44)	Professional body	N	N	N	Y	Y	N	N	N	N	N	N
Hill Dickinson (45)	Solicitor	Y	Y	Y	Y	N	Y	N	N	N	N	N
Hussain (46)	Clinician	Y	N	Y	N	N	N	N	N	N	Y	Y
Jones (47)	Solicitor	Y	Y	Y	Y	Y	Y	N	Y	N	N	N
MDDUS (48)	Third-party indemnity	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N
MDDUS (49)	Third-party indemnity	Y	Y	Y	Y	Y	Y	N	N	N	Y	N
The Medical Defence Union (50)	Third-party indemnity	N	N	N	N	Y	Y	N	N	N	N	N
The Medical Defence Union (51)	Third-party indemnity	Y	Y	Y	Y	N	Y	N	Y	N	Y	N
The Medical Defence Union (52)	Third-party indemnity	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N
The Medical Defence Union (53)	Third-party indemnity	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N
Mills & Reeve (54)	Solicitor	Y	Y	N	Y	Y	Y	Y	Y	N	N	N
Mills & Reeve (55)	Solicitor	Y	N	N	Y	Y	Y	N	N	N	N	N
Mills & Reeve (56)	Solicitor	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N
NHS England (57)	NHS England	N	N	N	N	N	N	Y	N	Y	N	Y
	NHS England	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

(*Continued*)

Table 4. (*Continued*).

		Knowledge and preparation			Giving evidence			Bereaved families			Support	
Author	Source type	coroner remit	types of inquest	outcomes of inquest	preparing effectively	writing statements	communicating well	family perspective	answering family questions	expressing condolences	Practical support	Psychological support
NHS Health Education England (58)												
NHS Health Education England (59)	NHS England	Y	Y	N	N	N	N	N	N	N	Y	Y
NHS Health Education England (60)	NHS England	Y	Y	N	Y	Y	Y	N	N	Y	Y	N
NHS Health Education England (61)	NHS England	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
NHS Resolution (62)	NHS Resolution	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N
Peel (63)	Clinician (nurse)	Y	Y	N	Y	Y	Y	N	N	N	Y	N
Royal College of Psychiatrists (64)	Professional body	N	N	N	N	N	N	N	N	N	Y	Y
Royal College of Nursing (65)	Professional body	N	N	N	Y	Y	Y	N	Y	N	Y	N
St. John-Smith et al. (66)	Clinician	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N
University of Plymouth et al. (67)	Multiple stakeholders	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Van Dellen et al. (68)	Multiple stakeholders	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N

Table 5. Quality scores.

Author	Scope and purpose (1) (%)	Stakeholder involvement (2) (%)	Rigour and development (3) (%)	Clarity and presentation (4) (%)	Editorial independence (5) (%)	Total (%)
Academy of Royal Medical Colleges (34)	67	56	29	75	0	42
Anonymous (35)	67	39	0	67	0	26
Browne Jacobson (36)	50	44	0	100	0	32
Browne Jacobson (37)	67	50	0	50	0	26
Browne Jacobson (38)	67	50	0	100	0	35
Browne Jacobson (39)	17	61	0	100	0	33
Browne Jacobson (40)	17	22	0	17	0	10
Calthorpe and Choong (41)	67	44	8	83	0	33
Fletcher and Ramsay (42)	67	17	4	100	50	36
George et al. (43)	67	44	33	100	50	53
General Medical Council (44)	67	44	25	100	0	42
Hill Dickinson (45)	50	17	0	100	0	25
Hussain (46)	83	56	17	75	0	39
Jones (47)	50	22	0	83	0	24
MDDUS (48)	17	17	0	100	0	22
MDDUS (49)	17	17	0	58	0	15
The Medical Defence Union (50)	67	22	0	100	0	28
The Medical Defence Union (51)	17	28	0	83	17	25
The Medical Defence Union (52)	50	22	0	75	0	22
The Medical Defence Union (53)	67	22	0	67	0	22
Mills & Reeve (54)	67	22	0	58	0	21
Mills & Reeve (55)	33	22	0	75	0	21
Mills & Reeve (56)	50	44	0	42	0	22
NHS England (57)	67	56	21	92	0	42
NHS Health Education England (58)	50	44	8	67	0	29
NHS Health Education England (59)	67	39	0	50	0	24
NHS Health Education England (60)	33	28	0	75	0	22
NHS Health Education England (61)	67	39	0	58	0	25

(*Continued*)

Table 5. (*Continued*).

Author	Scope and purpose (1) (%)	Stakeholder involvement (2) (%)	Rigour and development (3) (%)	Clarity and presentation (4) (%)	Editorial independence (5) (%)	Total (%)
NHS Resolution (62)	83	50	17	75	0	38
Peel (63)	50	39	50	75	50	51
Royal College of Psychiatrists (64)	100	78	50	83	0	58
Royal College of Nursing (65)	33	33	0	17	17	17
St. John-Smith et al. (66)	33	39	46	75	50	49
University of Plymouth et al. (67)	100	72	0	75	58	49
Van Dellen et al. (68)	83	67	33	92	100	67

Information on different forms of inquests

The inquest remit and the role of witnesses can change depending on the complexity of the sudden death and whether there was state involvement. Clinical witnesses can, alongside family, be 'interested persons' (IP), which gives them additional rights and suggests a more direct involvement in the death.[1] IP was mentioned in 19 pieces of guidance. A comprehensive explanation of the rights of a person with IP status, such as the one below, featured in 11 pieces of guidance.

> The coroner can designate any witness as an interested person (IP), a specific legal status which gives rights such as to be legally represented at the hearing, to ask questions of other witnesses and to obtain disclosure of documents. Essentially, an IP will play a more active role in the inquest proceedings, as opposed to a factual witness.
>
> MDDUS (49) third-party indemnity

Occasionally a jury will sit at an inquest. This was mentioned by 17 guidelines with ten providing a detailed explanation of when this might occur.

> A small number of cases each year are heard and decided by a jury. Most often this is because the person died while they were detained or in custody or they died due to an accident at work and the cause of death was not natural.
>
> Browne Jacobson (38), solicitor

Article 2 inquests are enhanced inquests held in cases where the state or 'its agents' have 'failed to protect the deceased against a human threat or other risk' or where there has been a death in custody. The investigatory remit is widened to consider the surrounding circumstances of the death.[2] Only one piece of

[1] https://www.legislation.gov.uk/ukpga/2009/25/section/47.

[2] https://www.cps.gov.uk/legal-guidance/coroners see 'Article 2 inquests' for a full explanation.

Table 6. Themes and sub-themes with frequency of coverage.

Theme	Sub themes	Included in pieces of guidance (*N*) (%)
Knowledge and preparation	1.1 Information on the coroner remit	28 (80%)
	1.2 Information on the form of inquests	23 (66%)
	1.3 Information on potential outcomes from the inquest	20 (57%)
	1.4 Advice on preparing effectively	29 (83%)
Giving evidence	2.1 Advice on written statements	25 (71%)
	2.2 Advice on communicating effectively	28 (80%)
Bereaved families	3.1 Awareness of family perspective	17 (49%)
	3.2 What to do when questions posed by the family veer outside the expected remit	20 (57%)
	3.3 Expressing condolences	11 (31%)
Support	4.1 Practical support	24 (69%)
	4.2 Psychological support	8 (23%)

guidance (68), written for psychiatrists called as witnesses, gave an explanation of some of the considerations around Article 2 inquests.

> Circumstances [for article 2] include: the patient's vulnerability, assumption of control over the patient by the hospital and whether the nature of the risk was exceptional … However, there is no general duty to prevent everyone from taking their own life.
>
> Van Dellen et al. (68), multiple stakeholders

Article 2 and jury inquests are comparatively rare which may provide one explanation for the paucity of coverage. However, they are more common in inquests involving mental health services, since the person may have been under the direct care of a statutory service at the time of their death (e.g. a suicide occurring in an inpatient mental health unit). Most of the guidance referred to Article 2 inquests only briefly. The exception was those produced by third-party indemnity companies, perhaps owing to the increased likelihood of needing legal representation in these situations:

> Do not delay in seeking advice on any inquest you are asked to attend, especially where there may be criticism of your care. Preparation is key and can avoid adverse consequences.
>
> MDDUS (48), third-party indemnity

Information on potential outcomes from the inquest

Fourteen pieces of guidance outlined the range of conclusions that might arise at the end of an inquest, including short-form conclusions (such as lawful/unlawful killing, suicide, accident, misadventure, open conclusion), the circumstances when a narrative verdict may be used and what a conclusion of neglect means.

> Narrative conclusions:- The use of narrative conclusion(s) is increasingly common. The coroner will often choose this form of conclusion to make the sequence of events clearer for the family and can also use the narrative where shortcomings of care have occurred.
>
> NHS England (61)

Fourteen pieces of guidance highlighted that one of the roles of coroners was to issue a Prevention of Future Deaths Report (PFD) or Regulation 28 Report in circumstances when they felt there was a risk that a similar incident

could happen, and changes needed to be made to prevent recurrence. PFD reports are addressed to an organisation or person who the Coroner believes has the power to take action.

> The Coroner has a legal duty to send a PFD Report if they have heard evidence which gives rise to a concern that there is a risk of deaths occurring in the future.
>
> Browne Jacobson (38), solicitor

Eleven pieces of guidance mentioned the possibility of witnesses facing clinical negligence claims or referral to the General Medical Council (GMC). Five of the six pieces of guidance issued by third-party indemnity firms mentioned the possibility of GMC referral which reflects the fact these are situations where external advice or legal representation may be required.

> If you are criticised, seek advice before contacting the GMC. If you are in any doubt if you have been criticised, seek advice. Even when it doesn't meet the threshold, it may be tactically advantageous to self-refer.
>
> MDU (52), third-party indemnity

It is notable that only a third of guidance mentioned the possibility of clinical negligence claims or referrals, despite the fact, although rare, such a situation could arise and would likely mean that clinician's would need specific guidance and support.

Advice on preparing adequately for the inquest

An explicit definition of the role of a witness featured in 18 pieces of guidance with differences between an expert and factual witness outlined. Most guidance focused on the role of factual witnesses, it being the most likely capacity in which a clinician is called.

> As a professional witness, the psychiatrist will have seen the deceased as a patient and will give professional evidence without acting as an expert witness, who is called specifically to use their expertise to interpret and comment on the facts of a case.
>
> Calthorpe & Choong (41), clinician

Guidance suggested that the role of a factual witness is to provide evidence to assist the coroner and their investigation.

> Statements can be taken from any person who is felt able to assist in the enquiry
>
> Jones (47), solicitor

Guidance from professional bodies such as the GMC and the Association of Medical Research Charities (AOMRC) focused on the professional duty for a clinician acting as a witness:

> Healthcare professionals should be able to describe and explain the range or spectrum of clinical/professional opinion on the issue in question.
>
> AMRC (34), professional body

In preparing to be a witness, all source-types emphasised the importance of the witness familiarising themselves with key documents related to the inquiry ($n = 22$).

> Be prepared. Familiarise yourself with your statement, the medical records, investigation report and any other relevant documents in advance of the inquest including relevant local and national policies and guidance.
>
> Browne Jacobson (38) solicitor

Familiarisation may involve reminding oneself of the case given that inquests are frequently delayed. Witnesses may well have moved organisation since or forgotten clinical aspects of the patient's case.

> Quite a long delay [between] being asked to prepare a report and the inquest actually taking place. During that time, there is an opportunity for things to change … Some courts are running with delays of a couple of years
>
> MDU (53), third-party indemnity

Six pieces of guidance spoke of effective record-keeping to assist with explaining the clinical decisions taken. Clinicians were advised to be aware of inconsistency across medical records which may need explanation at the inquest.

> Better to be aware of any criticisms or inaccuracies in any of the documents that the coroner is looking at so that you are not taken by surprise.
>
> MDU (52), third-party indemnity

Eleven pieces of guidance suggested documenting one's own learning from the incident. This could include showing evidence of changes to clinical practice that had been implemented since the incident. Examples given of documenting learning included an audit of the event, doing relevant Continuous Professional Development (CPD) training and a significant event analysis.

> Doing a significant event analysis is an opportunity to provide reassurance to the coroner. The clinicians involved have reflected and if appropriate, have taken remedial action.
>
> MDU (52), third-party indemnity

It was suggested in this guidance that a thorough report could reduce the chance that witnesses would have to attend the court in person whilst also providing assurance to the coroner and bereaved that the risk of a repeat incident was reduced.

Some guidance covered what are considered central parts of the inquest procedure such as the requirement to take the oath or affirmation ($n = 21$) and the order in which witnesses are questioned ($n = 19$).

> The coroner usually starts by asking questions of the witness. The family (or their lawyer) will usually be given an opportunity to ask you questions next, followed by other 'interested persons'.
>
> Mills & Reeve (54), solicitor

Fifteen pieces of guidance covered other logistical considerations such as appropriate dress, planning journey times, redeeming expenses and planning where to park. These were most commonly covered by clinicians who were writing guidance based on their own experience of attending an inquest.

> Witnesses should dress conservatively and attend the coroner's court promptly.
>
> Calthorpe & Choong (41), clinician

Giving evidence

The second theme captured the advice given for those submitting evidence. It is sub-divided into two sub-themes: advice on writing witness statements and communicating effectively in court.

Writing statements

Witness statements were described as key pieces of evidence that may be required for multiple reasons.

> Clinicians can be requested to write a statement for various reasons:
>
> To detail your own direct involvement with the patient.
>
> To provide an overview of the care and treatment.
>
> To address family concerns
>
> To summarise any organisational learning that has taken place following the individual's death.
>
> Browne Jacobson (36), solicitor

Nineteen pieces of guidance explained the purpose of the witness statement, often with different emphases, which may reflect

differences in authors' perspectives. One guideline produced by a law firm described the purpose of the statement as helping the coroner in their investigation.

> The primary thing the coroner wants from the witness is assistance … to understand what happened.
>
> Mills & Reeve (56), solicitor

Material produced by the University of Plymouth in collaboration with, amongst others, the Coroners' Courts Support Service (a charity assisting families through inquests), highlighted the additional value of helping families understand what has happened.

> If the family go away understanding in simple terms what has happened, you have eminently discharged your duties.
>
> University of Plymouth et al. (67), multiple stakeholders

Third-party indemnity bodies, coming from the perspective of protecting the clinician, described the witness statement as an opportunity for detailing the clinician's own involvement.

> Provide a clear chronological account of your role in the sequence of events.
>
> MDU (53), third-party indemnity

One piece of guidance, written by stakeholders from the legal and medical professions, suggested a well-written witness statement can meet all these objectives.

> The production of a comprehensive, clear and concise report can have several positive outcomes. It can help the coroner in their understanding of events; give closure to the family by answering questions they have; and provide some catharsis for the clinician … and if problems or errors are identified, it allows time to address and remediate these before the inquest.
>
> Van Dellen et al. (68), multiple stakeholders

Nineteen pieces of guidance gave advice on what should be included in witness statements. All emphasised the importance of writing a fact-based rather than opinion-based account – advice that also held for when answering questions verbally in court.

> Only include relevant facts; your opinion is only necessary if specifically asked for. You are entitled to explain why you took a particular decision and its basis, as a witness of fact.
>
> Van Dellen et al. (68), multiple stakeholders

It was common for guidance to propose a chronology of events as an underlying structure for a statement.

> Draft a detailed chronology from the medical records. This will help you to ensure the facts are clear and can be presented in a logical order and it will help ensure that factual accuracy is maintained.
>
> NHS England (60)

Three pieces of guidance considered the specific requirements for psychiatrists called as witnesses. There is a potential tension that those working in mental health must additionally address – namely, which elements of the patient's history to include that may not be amongst the immediate causes of death, but may help piece together the circumstances in which the person died or committed homicide, that is, additional information that might assist the inquiry process.

> The issue of content is subject to some debate, as a full psychiatric report may contain a great deal of often intimate information which, although not strictly relating to the death, may have relevance to diagnosis.
>
> Calthorpe & Choong (41), clinician

Sixteen pieces of guidance gave advice on communicating effectively. The most

consistent advice was to write and speak concisely, clearly and in plain English ($n = 15$).

> It should be clear and understandable by an educated lay person, without medical jargon or abbreviations.
>
> Calthorpe & Choong (41), clinician

Communication (written and spoken) in clear English reflected an underlying sentiment of inclusivity. Inclusivity holds for both what is communicated and how it is done given that different stakeholders present at an inquest may have varying levels of medical expertise or knowledge of the case.

> Speak slowly, sharing the story of what happened logically from beginning to end in plain English. Explain medical terminology to assist the court and help those attending to understand.
>
> Browne Jacobson (38), solicitor

Clarity and accuracy reflect the underlying duty of honesty. Fourteen pieces of guidance describe the witness as the responsible owner of the statement's content and to regard everything they write as a reflection of their own professional integrity.

> No one can tell you what to include or take out of your statement. This is your document and you should include all of the information that informed you and/or whether and how you were involved that you consider relevant and you would wish the Coroner to be aware.
>
> NHS England (61)

A final piece of advice ($n = 11$) in relation to statement writing was for statements to be checked by a colleague, the Trust legal department or in the case of bodies offering representation for clinicians, themselves.

> Before submitting your statement to the coroner, organise for your trust legal service and/or medical defence organisation to review it
>
> George et al. (43), clinician

Communicating in court

Similar to the advice on written statements, regarding the purpose of oral statements, there were some differences in emphasis across guidance but not to the point of mutual exclusivity.

Some guidance ($n = 11$) focuses solely on assisting the court as the witness's prime objective.

> Mindset – witnesses are there to help the Coroner – try and answer the Coroner's questions to the best of your ability.
>
> Browne Jacobson (39), solicitor

Others ($n = 6$) highlighted the additional importance of helping families:

> In effect, the coroner is listening in to the story that you are giving to the family. Assume that you have an excellent bedside manner. You will have no doubt honed it over the years, but make sure the family goes away understanding what has happened.
>
> University of Plymouth et al. (67), multiple stakeholders

Advice on answering questions in court included ensuring the clinician answered the question they were being asked, answering succinctly and avoiding any temptation to fill silences ($n = 14$).

> The most common mistake witnesses make, is not listening to the question being put to them.
>
> Jones (47), solicitor

> Answer the question as directly as possible. If the witness does not answer the question, the witness looks like they

> are evading the question. The risk is that the credibility of a witness is damaged.
>
> NHS Resolution (62)

> Once you have answered a question, stop talking and don't feel obliged to fill a silence.
>
> MDDUS (48) third-party indemnity

Advice on appropriate mannerisms was provided in 17 pieces of guidance and included suggestions such as speaking clearly, considerately and professionally to ensure inclusivity as well as to show respect for the family members.

> Muddled thinking, speaking or shuffling of papers never gives a good impression. The witness must concentrate and take time to speak clearly and slowly.
>
> NHS England (59)

One difference between written statements and giving evidence orally is that the latter demands witnesses to respond dynamically to what is occurring in the moment. Seven pieces of guidance suggested the witness use eye contact and non-verbal feedback such as watching for when the coroner had finished writing to help pace answers and gauge the impact of what they are saying.

> In giving your answers watch the panel/judge/coroner's pen if he or she is taking notes. You should provide him or her with the opportunity to note what you are saying before you carry on.
>
> Royal College of Nursing (65), professional body

Bereaved families

Treatment, and awareness, of bereaved families was the fourth theme, with three subthemes: awareness of the family perspective; what to do when questions posed by the family veer outside the expected remit; and expressing condolences.

Awareness of the family perspective

Twelve pieces of guidance suggested that clinicians be aware of the family's perspective during an inquest. Families may be carrying an information deficit in what has happened to their loved one and in their medical knowledge as well as managing the difficulty of hearing information relating to the death for the first time.

> Don't assume the reader has any knowledge of the case. Several people may have to read the report apart from the coroner and they may not have access to or be able to interpret the medical records.
>
> MDU (50), third-party indemnity

Remembering the perspective of the family was most frequently mentioned in the guidance given in material collaborated on by the University of Plymouth and the Coroners' Courts Support Service and in material written by clinicians.

> I think when a doctor attends an inquest it's really important for them to have a really good understanding of where bereaved families are at when they attend … Put yourself in the shoes of a bereaved family member.
>
> University of Plymouth et al. (67), multiple stakeholders

Consistent with the advice given on communicating effectively, some guidance indicated that the most appropriate way to demonstrate compassion and recognition of loss was through respectful conduct in front of the family ($n = 10$).

> Be aware that the family and press will be present. This is a solemn day and you must behave professionally and respectfully at all times.

> Browne Jacobson (38), solicitor

Seven pieces of guidance specifically mentioned that family and witnesses may have to share space outside the courtroom and to adjust conduct accordingly.

> It can add to everyone's stress if you have to wait for long in the same room as anxious, grieving or angry relatives. You could ask for a separate waiting room.
>
> St. John-Smith et al. (66), clinician

What to do when questions posed by the family veer outside the expected remit

A common area for authors, especially in guidance written by clinicians, was to offer advice on answering questions put to them by the family or their representatives ($n = 20$). Often the authors acknowledged the possibility that questioning by family members or representatives might veer outside the statutory remit of the inquest, such as implying the clinician is to blame. Such guidance often suggested there could be a question asked outside the witnesses realm of professional expertise or questions which are not pertinent to answering the central four questions of who, when where and how. Finally, there was a warning given for instances when families or their representatives stray beyond an inquisitorial remit into a more adversarial one, potentially leaving the witness on the defensive.

> It is perfectly normal in many circumstances when decisions and reasons for taking decisions are challenged that a person can feel very defensive. The (task) is for the person to get over that threat, however difficult.
>
> Mills & Reeve (56), solicitor

Most guidance advised that anyone taking the witness stand at an inquest should maintain their composure, but there was less agreement on what the witness should expect to happen in instances when questioning did veer outside the expected remit. Some guidance demonstrated an implicit faith in the system, suggesting that they could either rely on the coroner to intervene pre-emptively – or be a source of recourse in the event this happened.

> If you think the question unfair or the manner of questioning inappropriately aggressive, raise the matter with the coroner.
>
> Van Dellen et al. (68), multiple stakeholders

One training course suggested the coroner might permit family members some latitude in their questioning and advised clinicians to be prepared. Another piece of guidance intimated that an adversarial experience was possible, even likely.

> Although the other party's legal representative may seek to provoke you, they are only doing their job and therefore you should remain as calm as possible and avoid offering any defensive, emotional or sarcastic reply.
>
> Royal College of Nursing (65), professional body

Answering questions from family members or their legal representatives appeared to be one area where the reality of the inquiry could be experienced as more adversarial than what is implied by the theoretical premise of an inquisitorial process. In these instances, the risk is that questioning goes beyond the fact-finding remit towards implications of blame or liability.

Expressing condolences

Advice on communicating directly with family members and the appropriateness of extending condolences was covered in 11 pieces of guidance. The advice differed. Some guidance advocated a pragmatic approach, which involves assessing the situation before deciding whether the family would value an apology.

> Each situation and relationship is different and the right approach will vary from case to case.
>
> Browne Jacobson (38), solicitor

In other guidance, condolences were described as unanimously positive for families.

> Approach them after the inquest and say that you're sorry for their loss, because I think sometimes that's all somebody wants, is to hear somebody else say that they're sorry that somebody has died. You're not admitting guilt.
>
> University of Plymouth et al. (67), multiple stakeholders

Guidance issued by the NHS addressed this in the context of a witnesses' professional duty:

> You may express your condolences to the family of the deceased if you wish, but this is not mandatory.
>
> NHS England (60)

Similarly, in the guidance issued by the NHS on conduct after homicides occurring in mental health settings, saying sorry was considered part of the Provider's duty.

> The Mental Health Provider(s) should send condolences to the family within seven days of becoming aware of the death.
>
> NHS England (57)

Support

Our fourth theme captures support for clinicians attending an inquest. It was rare for guidance to offer suggestions of psychological support. When it was given, it was often in the form of signposting either to the employing organisation or listed third-party resources.

Practical support

We found three common suggestions regarding practical support. Firstly, 15 pieces of guidance highlighted instance when legal representation might need to be considered, for instance, when the employing organisation could not offer representation or the clinician was an IP. It was most common for either clinicians writing from their own experience or third-party indemnity companies to cover independent representation.

> It is important to also note that you may find yourself in a direct conflict of interest with your employer and will therefore need to seek out your own legal representative.
>
> Anonymous (35), clinician

Secondly, seven pieces of guidance advised attending an inquest in advance of their own:

> Attendance at an inquest can be stressful. We recommend that all psychiatrists sit in on one, as it can be a very informative experience.
>
> St. John-Smith et al. (66), clinician

Finally, four pieces of guidance suggested taking a colleague or equivalent to support them during the inquest.

> It is normal to be nervous – consider bringing a friend or colleague for support.
>
> MDDUS (48), third-party indemnity

It was common for guidance to signpost clinicians to their organisation's legal department for support, with 13 pieces of guidance suggesting these departments as the key point of contact and information source. Legal departments were described as the coordinator in preparing witnesses for the inquest and the source of advice on writing witness statements, giving oral evidence and legal representation. Advice issued by NHS England clearly sets out the role of Trusts, suggesting a standard level of support which those called as witnesses can expect.

> In the Trust/provider, the governance/ complaints/legal services departments will be coordinating statements and be aware of the date of the inquest. They are familiar with the process and can give appropriate advice. It will be normal practice to have a Trust pre-inquest preparatory meeting to go over statements and give advice on giving evidence and the inquisitorial process. They also frequently offer post inquest debriefing.
>
> NHS England (61)

Psychological support

Most guidance had an overarching focus on how clinicians can assist families, coroners and the investigatory process. It was relatively rare for guidance to give psychological advice or provide third-party resources for the clinicians themselves. This is notable given the near unanimous acknowledgement across the body of guidance that the coroner's inquest could be a source of stress and anxiety for clinicians. We found one piece of guidance (46) offering detailed psychological support directly to the readership. This was written by a clinical psychologist who worked with staff who attend inquests. The guidance was based on her own observations that staff are often underprepared both emotionally and practically for the investigation and that resources available to staff vary. Advice given included strategies for maintaining psychological health, including practical suggestions such as contacting the coroner's office for clarity of information, ascertaining what support is available through your employer and when in the process to write your witness statement. The author suggested that the clinical witness thought about the decisions they took in the context of clinical practice rather than the now-known outcome of suicide.

> Avoid following any chain of thought that starts with I should have/I could have/if only I had.
>
> Hussain (46), clinician

We identified two more documents which directly addressed clinical witnesses own psychological support. In both instances, guidance was non-specific, akin to basic principles of self-care. Unlike the source above, these documents did not consider the specific challenges of an inquest experience.

> Take care of yourself and ensure you have time off after to reflect and de stress.
>
> Anonymous (35), clinicians

> Do ask for any help, support, advice which you feel you need or take up what may be offered.
>
> NHS England (58)

There was greater discussion of psychological support in pieces of guidance written for organisations. One common message was for organisations to be aware of the negative impact inquests can have on individuals.

> It is important to understand and recognise that healthcare workers may suffer from an acute stress reaction.
>
> Browne Jacobson (37), solicitor

The precise form of support may be secondary to fostering a cultural recognition that staff need supporting.

> There is no ideal form of support that suits everyone, and clinicians and non-clinicians can vary in what they want and need. However, most individuals will likely value knowing there is support available if and when they want to access it.
>
> RCPsych (64), professional body

Five pieces of guidance included suggestions of how organisations can support employees. Again, as with advice given direct to clinicians, suggestions were often generic rather than specific to the inquest experience. Suggestions included ensuring that staff are supported by senior colleagues, offering additional supervision or mentoring, and assistance from occupational health services. One

specific suggestion in literature issued by the Royal College of Psychiatrists (RCPsych; 64) was for training on the coronial process and report writing with input from other stakeholders such as solicitors. Ensuring the clinical witness had protected time to prepare for the inquest was another:

> It is vital that clinicians are able to prepare thoroughly for the inquest and have appropriate supervision, support, and protected time to ensure that the coronial process is not frustrated.
>
> RCPsych (64), professional body

Four pieces of guidance suggested formal support interventions. Suggestions in these guidance documents included, firstly, buddy systems, where colleagues with prior inquest experience support those preparing to attend.

> The 'buddy' can give collegiate support and information, helping to guide the clinician through the processes that follow the event.
>
> RCPsych (64), professional body

Secondly, peer to peer mentoring schemes were mentioned, and thirdly, a pastoral suicide lead who would have responsibility for overseeing the pastoral care of clinicians in relation to the wider event of patient suicide and as part of that, ensuring they were well supported through formal processes.

> Leading, overseeing, supervising the organisational response in the pastoral care of clinicians experiencing loss of patients to suicide … supporting staff and families through the formal processes that follow.
>
> RCPsych (64), professional body

In the case of buddy systems and pastoral suicide leads, these are initiatives that had been piloted in some organisations but without any accompanying study to evaluate their feasibility or acceptability as forms of support.

Discussion

Main findings

On average, 1673 people under the care of mental health services die by suicide every year. There are other unexpected deaths where mental health services may be involved, including death by misadventure or homicide which increase that number. In each of those instances, people working in mental health will be called as a witness to the inquest which follows. It is concerning that despite the commonality of the experience, there is such limited specific guidance for those working in mental health.

We identified 35 pieces of guidance from eight types of source (clinicians, solicitors, NHS etc.). The overall quality of guidance was low owing to a lack of methodological rigour, an absence of underlying evidence and, often, limited levels of stakeholder consultation. We determined four descriptive themes which describe the collective body of guidance. We found similarity in content and thus consistency across authors in what is considered most important for clinicians called as witnesses. It is worth noting that the empirical research done on the experience of being called as a witness is minimal which provides one explanation why guidance did not tend to consider an underlying evidence base. We consider the relevance of the guidance identified given the understanding we do have, below.

Summary of findings and comment on quality

We retrieved 35 pieces of guidance from eight source-types. Most guidance ($n = 23$) was aimed at all healthcare clinicians, and we found only three pieces specifically for professionals working in mental health services, which had been our initial area of interest. Additionally, we hoped that by using the word 'practitioner' we would find guidance aimed at those in support roles within healthcare. We found no guidance for this subset of

professionals; guidance was aimed at those in clinical role's only.

The quality of the guidance was low. Whilst guidance scored well in relation to scope and purpose and clarity of presentation, few pieces of guidance scored highly in the domains of developmental rigour, stakeholder consultation or editorial independence. Rather than being based on empirical evidence, most ($n = 20$) material was what authors deemed best practice based on professional expertise in the case of law firms and third-party indemnity companies or by virtue of perspective in the case of NHS-sponsored documents. Of the 'best practice' material, two had demonstrable evidence backing the recommendations made, two had some evidence to back recommendations and 16 cited none.

Current evidence suggests clinicians working in mental health generally feel ill-informed and underprepared going into an inquest (13), including on practical matters that are covered in this guidance. This may suggest that despite the 'reliability' of content across existing guidance, addressing these practicalities does not go far enough in making the experience more tolerable. Additionally, or alternatively, accessing guidance may be an issue. Our own experience locating guidance found it to be time-consuming and difficult. There was no central repository of information for healthcare witnesses who may be under considerable stress and need clear, accessible, information. This is addressable and a recently launched website (https://voicing-loss.icpr.org.uk/) goes some way to doing so.

Similarities and differences

Most guidance covered the fact-finding and inquisitorial nature of the coroner's remit; the role of a witness; and how to communicate effectively. Within these topics, advice across the guidance was generally consistent, such as the emphasis on clarity, avoiding medical jargon and staying with the facts as opposed to expressing an opinion. There were also areas that were commonly omitted. For instance, it was rare for guidance to provide much discussion on different types of inquest or on what the clinician could do for support.

We found no instances where advice in one guideline directly contradicted another. Differences lay either in points of emphasis or in the choice of what was included. We identified differences in the described purpose of the coroner investigation. Some guidance described coroners acting on behalf of the state, others described additional functions of coroners as an investigator for the family or facilitators of the mourning process. The differences in interpretation echo a wider ambiguity surrounding the purpose of the coroner's inquest (7, 69–71). We identified differences in advice given in relation to questioning of witnesses by family or their representatives and questioning which veers outside the formal remit of the inquest. Third-party indemnity companies, solicitors and clinicians commonly discussed the tension inherent in that situation. Advice centred on finding the balance between protecting oneself whilst simultaneously remaining a composed witness. Other authors did not acknowledge the challenge and simply suggested remaining measured, clear and polite in responding. All authors recognised the need to remain sensitive to the needs and expectations of the bereaved.

Different points of emphasis between the guidance materials often reflected authorship. Organisations offering legal representation, including law firms and third-party indemnity companies, focused their guidance on ensuring the clinician (as a professional) was protected legally. Professional bodies, such as the GMC, focused on the mental health practitioners as a professional with accompanying moral obligations associated with meeting the demands of their role. The Coroners' Courts Support Service was predominately interested in assisting families and the tone and content of their guidance reflected this.

Some authors considered the clinician's own personal and professional wellbeing, but most restricted their focus to the role of the witness and the objective of assisting the inquisitorial process. By staying resolutely in the territory of the witness's 'role', a lot of the material omitted consideration of how the theory of the inquest might differ from the reality and what the clinician might need to do to prepare for that (5, 6). By restricting the focus to the objective of being an effective witness, most pieces of guidance become applicable to most types of witness. By the same token, this limited focus prevents consideration of how the experience might differ for witnesses from differing professional backgrounds operating in different organisational contexts. It also does not allow for the reality that different types of witnesses might know the deceased and their families in varied capacities. This might influence the clinician's wider experience of the inquest or, perhaps more practically, shape how they relate to families during the inquest. Every situational variable cannot reasonably be accounted for, particularly in guidelines which, by definition, demand precision. Nevertheless, some consideration of where differences exist across types of witnesses may be valuable. We consider this in light of other literature below.

Findings in the context of the wider literature

When assessing the relevance of current guidance, the empirical research on mental health practitioners' experiences of attending inquests suggests that the prospect of attending an inquest can be anxiety-inducing, with people often feeling underprepared and unsupported on a practical and emotional level (13, 14, 16, 22, 26). Some practical difficulties associated with feeling underprepared were addressed in the guidance located for this review. Information such as how to write a witness statement and how to answer questions in court may help mental health practitioners feel better prepared. It may be that simply better knowledge of, and access to, very practical guidance is sufficiently psychologically containing for those anxious about attending. Conversely, it may be constructive for guidance to include discussion of thornier issues such as when to seek legal representation or further discussion around differences between inquisitorial and adversarial processes. For instance, in the case of inquisitorial inquests, it is the coroner who leads the questioning, whereas in mainstream adversarial court settings, it falls to opposing parties. It is when inquests depart from their remit that they risk becoming adversarial.

The findings of this paper can be compared to a recent study by the Institute for Crime & Justice Policy Research (ICPR) at Birkbeck in partnership with the Centre for Death and Society at the University of Bath.[3] The original study examined, through interviews, the experience of the coronial process for family members. Amongst the study output is good practice guidance for coronial professionals. These materials cover the themes of (1) improving information given to families on the purpose of the inquest, (2) better signposting to support resources and (3) better information about the structure and format an inquest will take. A further area covered was interactions during the inquest, ensuring these were based on principles of compassion, inclusion and sensitivity. This included expressing condolences, being attentive to non-verbal communication, avoiding belittling questioning, clear direct communication, plain language, and conduct in keeping with the gravity of the situation at hand. There are clear similarities in the content of advice direct for coronial professionals and our own, not least the importance of acknowledging, through conduct, one's respect as well as the importance of sensitive interaction, which starts with clear and direct communication. Understanding the similarities as well as the differences in stakeholder experience may yield insight into how

[3] https://voicing-loss.icpr.org.uk/

improvements focused on one stakeholder group may have benefits for the inquest process at large.

We note that the resource dedicated to psychological support in identified guidance is limited. Guidance issued by the RCPsych (64) made suggestions for formal support interventions, although these were not clearly linked to an empirical evidence base. A report by the Healthcare Safety Investigation Branch (72) on staff support after major events found limited evidence relating to either the implementation or impact of proposed models for staff support. Suggestions of how best to support staff, in this literature and more widely, lack evidence and tend to consist of consensus opinion. A common assumption across most of this guidance was that the employing Trust can offer general practical support and advice. Across guidance for staff wellbeing more widely, including National Institute for Health and Care Excellence (NICE) guidelines (73) and more specific guidelines on organisation conduct after a serious event (64, 72), the 'context' of support delivery is considered key. On the understanding that clinicians often do not feel supported, there may be a void between what much of this guidance assumes is available to the clinician, via employing organisations, and the reality.

We assessed guidance using the AGREE-II tool, a widely used standard for assessing the methodological quality of clinical guidelines. We acknowledge that most guidance included did not purport to be based on empirical understanding or be clinical in orientation. Therefore, to score guidance using these metrics is arguably 'unfair'. However, the domains in the AGREE-II tool are a useful way to consider which areas of guidance are most in need of addressing and we argue that guidance should, where possible, be based on a systematic distillation of evidence, even if, ultimately, available evidence is of 'low' quality (6). This paper has highlighted both a paucity of guidance based on empirical evidence and the absence of high-quality empirical evidence on which to base guidance. Both of these areas need addressing.

A recent review on non-clinical postvention guidance after a colleague's suicide (74) found guidance promoted individualised approaches and failed to consider that staff experiences are specific to the contexts and cultures in which they occur. Guidance did not consider the organisational perspective or issues of professional identity – two factors in need of consideration for delivery of postvention support (74). A similar critique may be applied here: the guidance identified in this review failed to consider the specific challenges that may be faced by people working in mental health, partly because the intended audience tended to be broader and partly because, with the exception of material written by clinicians themselves, guidance failed to draw on the lived experiences of the people it aims to support.

Recommendations made by NICE for writing good practice guidelines state that underpinning evidence and methods used to derive the guidance should be detailed (75). Causer et al. observed that the evidence-based standard in guidelines for treatments and interventions does not appear to be mirrored in guidelines for staff wellbeing (74, 76). A similar situation is evident here: few authors documented their process of constructing the guidance and there was limited evidence that output was supported by empirical understanding.

Strengths and limitations of this review and critique

To our knowledge, this is the first review of existing guidance for mental health practitioner's called to attend a coroner's inquest. Existing guidance tends to be based on best practice or personal experience and is not, nor does it purport to be, based on empirical evidence. In the absence of an evidence base, much of this guidance is tantamount to opinion. We have proceeded with a rigorous, transparent selection, screening and data extraction

process which should be replicable for future research as the area develops. The limitations include that we were unable to complete the search in the exact terms that we intended – we had intended to search for guidance specifically for mental health practitioners which included non-clinical roles for mental health practitioners (such as support workers). Owing to a lack of 'hits', we broadened our search to 'healthcare practitioners' and subsequently found that existing guidance does not distinguish between different areas of health but is for those in clinical roles only. In addition to this departure from our intended search terms, this has presented challenges with terminology when writing the paper. Further limitations include that we confined our searches to guidance written specifically for the English coronial system despite the similarity of coronial systems across much of the Commonwealth. In doing this, we risked omitting guidance that may exist in geographies such as New Zealand and Australia where higher quality empirical research has been conducted on the coronial system. Instead, we only included guidance which considered the workings of the UK healthcare system. A final limitation is the challenge of being exhaustive in our literature and web searching. We acknowledge that search results are dynamic and subject to quick change.

Future research and recommendations

This review has highlighted only limited guidance for those working in mental health who are called to inquests. This is concerning. Additionally, most guidance on attending inquests is not supported by empirical research findings but instead represents expert and non-expert opinion. Guidance supported by empirical research is needed. Guidance produced should be specific to different areas of health specialism – mental health being one example – and consider unique factors for professionals working in those areas. Further empirical work on the experiences for mental health practitioners of attending inquests, including the factors that make the experience more or less difficult, is required before meaningful guidance can be produced. Methodologically, guidance on staff wellbeing, should aspire to replicate the quality found in more traditional guidelines, adopting a rigorous and openly detailed process in formulation. When considering inquests specifically, a thorough stakeholder consultation process is particularly important given the number of interested parties attending an inquest.

Conclusion

Our intention was to identify guidance which assisted and supported mental health practitioners attending inquests. We found only three pieces to that effect. We located guidance which, for the large part, gave generic advice on how clinicians can fulfil the role of a witness. There was an absence of guidance for non-clinical healthcare practitioners who may be called to the inquest. The material offered some, again generic, practical guidance which might help alleviate clinician anxiety such as how to write statements and answer questions in court.

Practical guidance on how clinicians can assist the inquest is one facet of the experience but not the only one. We did not find much guidance which considered support needs of these types of witness. This omission might be due to the unmet assumption that one's employing organisation plays a central role in preparation and providing direct support. More research is needed about what kind of support is useful for which kinds of mental health practitioner as well as who is tasked with delivering it.

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Ethical standards

Declaration of interest

Millie Tamworth declares no conflict of interest
Professor Jo Billings declares no conflict of interest
Sahra Tekin declares no conflict of interest
Professor Alexandra Pitman declares no conflict of interest
Professor Jessica Jacobson declares no conflict of interest
Professor Helen Killaspy declares no conflict of interest

Ethical approval

This article does not contain any studies with human participants or animals performed by any of the authors.

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Appendix 1. Search terms

Database: Ovid MEDLINE(R) ALL <1946 to January 22, 2024>

Search Strategy:

1. exp Health Personnel/ (625088)
2. ((health or medical) adj2 (personnel or staff or practitioner* or consultant* or trainee* or professional* or counsel*)).ti,ab. (180490)
3. (clinician* or therapist* or social work* or psychiatrist* or psychologist*).ti,ab. (414124)
4. 1 or 2 or 3 (1139099)
5. medical errors/ or near miss, healthcare/ (18146)
6. "Root Cause Analysis"/ (435)
7. "Cause of Death"/ (54061)
8. serious investigation*.ti,ab. (58)
9. serious untoward incident*.ti,ab. (16)
10. patient safety event*.ti,ab. (451)
11. patient safety incident*.ti,ab. (667)
12. (safety adj2 inquir*).ti,ab. (30)
13. (incident* adj2 inquir*).ti,ab. (12)
14. (coron* adj2 (inquest* or court* or inquir*)).ti,ab. (327)
15. "root cause analys?s".ti,ab. (1501)
16. or/5-15 (74484)
17. 4 and 16 (6471)
18. editorial/ or government publication/ (679915)
19. guideline adherence/ or peer review, health care/ (36600)
20. Clinical Protocols/ (30018)
21. consensus/ (22026)
22. exp consensus development conference/ (12676)
23. exp consensus development conferences as topic/ (3001)
24. Critical Pathways/ (7932)
25. exp guideline/ (38095)
26. exp Guidelines as Topic/ (173081)
27. Health Planning Guidelines/ (4165)
28. clinical decision rules/ (946)
29. (guideline or practice guideline or consensus development conference or consensus development conference, NIH).pt. (48009)
30. (position statement* or policy statement* or practice parameter* or best practice*).ti,ab,kf. (48865)
31. (standards or guideline or guidelines).ti,kf. (140395)
32. ((practice or treatment* or clinical) adj guideline*).ab. (55475)
33. (CPG or CPGs).ti. (6540)
34. consensus*.ti,kf. (36676)
35. consensus*.ab. /freq = 2 (36066)
36. ((critical or clinical or practice) adj2 (path or paths or pathway or pathways or protocol*)).ti,ab,kf. (27910)
37. recommendat*.ti,kf. or guideline recommendation*.ab. (61110)
38. (care adj2 (standard or path or paths or pathway or pathways or map or maps or plan or plans)).ti,ab,kf. (88706)
39. (algorithm* adj2 (screening or examination or test or tested or testing or assessment* or diagnosis or diagnoses or diagnosed or diagnosing)).ti,ab,kf. (10676)
40. (algorithm* adj2 (pharmacotherap* or chemotherap* or chemotreatment* or therap* or treatment* or intervention*)).ti,ab,kf. (13428)
41. (guideline* or standards or consensus* or recommendat*).au. (9)
42. (guideline* or standards or consensus* or recommendat*).ca. (1837)
43. or/18-42 (1293309)
44. 17 and 43 (766)
45. limit 44 to english language (719)

Database: Embase <1974 to 2024 January 22>

Search Strategy:

1. 1 exp *health care personnel/ (633104)
2. ((health or medical) adj2 (personnel or staff or practitioner* or consultant* or trainee* or professional* or counsel*)).ti,ab. (237630)
3. (clinician* or therapist* or social work* or psychiatrist* or psychologist*).ti,ab. (601460)

4. 1 or 2 or 3 (1382088)
5. *"cause of death"/ (13772)
6. "root cause analysis"/ (3072)
7. medical error/ or medical accident/ or "near miss (health care)"/ (21411)
8. therapeutic error/ (1914)
9. serious investigation*.ti,ab. (74)
10. serious untoward incident*.ti,ab. (61)
11. patient safety event*.ti,ab. (608)
12. patient safety incident*.ti,ab. (887)
13. (safety adj2 inquir*).ti,ab. (43)
14. (incident* adj2 inquir*).ti,ab. (18)
15. (coron* adj2 (inquest* or court* or inquir*)).ti,ab. (380)
16. "root cause analys?s".ti,ab. (3109)
17. or/5-16 (42119)
18. 4 and 17 (5616)
19. clinical pathway/ (10148)
20. clinical protocol/ (119286)
21. consensus/ (103925)
22. consensus development/ (28454)
23. practice guideline/ (571913)
24. health care planning/ (111452)
25. clinical decision rule/ (755)
26. (position statement* or policy statement* or practice parameter* or best practice*).ti,ab,kf. (70161)
27. (standards or guideline or guidelines).ti,kf. (191911)
28. ((practice or treatment* or clinical) adj guideline*).ab. (84747)
29. (CPG or CPGs).ti. (7871)
30. consensus*.ti,kf. (46027)
31. consensus*.ab. /freq = 2 (48129)
32. ((critical or clinical or practice) adj2 (path or paths or pathway or pathways or protocol*)).ti,ab,kf. (42965)
33. recommendat*.ti,kf. or guideline recommendation*.ab. (78504)
34. (care adj2 (standard or path or paths or pathway or pathways or map or maps or plan or plans)).ti,ab,kf. (158835)
35. (algorithm* adj2 (screening or examination or test or tested or testing or assessment* or diagnosis or diagnoses or diagnosed or diagnosing)).ti,ab,kf. (15151)
36. (algorithm* adj2 (pharmacotherap* or chemotherap* or chemotreatment* or therap* or treatment* or intervention*)).ti,ab,kf. (20311)
37. (guideline* or standards or consensus* or recommendat*).au. (27)
38. (guideline* or standards or consensus* or recommendat*).co. (2266)
39. or/19-38 (1337294)
40. 18 and 39 (705)
41. limit 40 to english language (673)

Database: APA PsycInfo <1806 to January Week 3 2024>
Search Strategy:

1. 1 exp social workers/ (15267)
2. 2 therapists/ or occupational therapists/ (15376)
3. 3 clinicians/ or counselors/ or exp health personnel/ or exp psychologists/ (242834)
4. ((health or medical) adj2 (personnel or staff or practitioner* or consultant* or trainee* or professional* or counsel*)).ti,ab. (74204)
5. (clinician* or therapist* or social work* or psychiatrist* or psychologist*).ti,ab. (350493)
6. 1 or 2 or 3 or 4 or 5 (559953)
7. exp causal analysis/ (7947)
8. *patient safety/ (2426)
9. accidents/ (3068)
10. *errors/ or error analysis/ (10006)
11. serious investigation*.ti,ab. (33)
12. serious untoward incident*.ti,ab. (11)
13. patient safety event*.ti,ab. (56)
14. patient safety incident*.ti,ab. (78)
15. (safety adj2 inquir*).ti,ab. (9)
16. (incident* adj2 inquir*).ti,ab. (12)
17. (coron* adj2 (inquest* or court* or inquir*)).ti,ab. (108)
18. "root cause analys?s".ti,ab. (157)
19. or/7-18 (23620)
20. 6 and 19 (2305)
21. treatment guidelines/ or best practices/ or clinical governance/ (16314)

22. professional standards/ or professional liability/ (9631)
23. (standards or guideline or guidelines).ti,hw. (28357)
24. ((practice or treatment* or clinical) adj guideline*).ab. (9498)
25. (CPG or CPGs).ti. (143)
26. consensus*.ti. (3776)
27. consensus*.ab. /freq = 2 (6024)
28. ((critical or clinical or practice) adj2 (path or paths or pathway or pathways or protocol*)).ti,ab. (2501)
29. recommendat*.ti. (8422)
30. guideline recommendation*.ab. (504)
31. (care adj2 (standard or path or paths or pathway or pathways or map or maps or plan or plans)).ti,ab. (10729)
32. (algorithm* adj2 (screening or examination or test or tested or testing or assessment* or diagnosis or diagnoses or diagnosed or diagnosing)).ti,ab. (804)
33. (algorithm* adj2 (pharmacotherap* or chemotherap* or chemotreatment* or therap* or treatment* or intervention*)).ti,ab. (856)
34. (guideline* or standards or consensus* or recommendat*).ca. (306)
35. or/21-34 (71548) process with giving labels with AQ … 36 20 and 35 (128)
36. limit 36 to english language (123)

Searches – 23 Jan 24

ProQuest All 67 databases (490 results)/ SCOPUS (71 results)/WoS (157 results)

((health OR medical) NEAR/2 (personnel OR staff OR practitioner* OR consultant* OR trainee* OR professional* OR counsel*)) OR (clinician* OR therapist* OR social work* OR psychiatrist* OR psychologist*)

AND

"serious investigation*" OR "serious untoward incident*" OR "patient safety event*" OR "patient safety incident*" OR "root cause analys?s" OR (safety NEAR/3 inquir*) OR (incident* NEAR/3 inquir*) OR (coron* NEAR/3 (inquest* OR court* OR inquir*))

AND

standards OR guideline* OR "CPG" OR "CPGs" OR consensus* OR recommendat* OR algorithm* OR pathway* OR protocol* OR advice OR "position statement*" OR "policy statement*" OR "practice parameter*" OR "best practice*"

English language limit

Guideline registries

1. The Guidelines International Network library (1 result – searched for: safety event) https://guidelines.ebmportal.com/?q=safety%20event&fv%5Bfield_collection_field_4%5D%5B2796%5D=2796
2. The National Guideline Clearinghouse (NGC) – 0 results
3. The National Technical Reports Library – 26 results – download PDF https://ntrl.ntis.gov/NTRL/dashboard/searchResults.xhtml
   Searched for:
   KW "coroner" OR "serious" OR "root cause analysis"
   AND
   KW "investigation" OR "inquest" OR "court" OR "event" OR "incident" OR "tribunal"
4. NICE – 172 results – download PDF
   (coroner investigation) or (coroner inquiry) or (coroner court) or (serious incident) or (serious investigation)
5. CADTH's Grey Matters – 0 results

Law databases

Lexis + UK – 115 results – searched for: advice for healthcare staff during coroner's investigation

Index to Legal Periodicals and Books (H.W. Wilson) – 129 results

(Sources for searching CPGs: https://www.ncbi.nlm.nih.gov/books/NBK209545/)

Appendix 2. Amended version of AGREE-II.

AGREE-II was designed to evaluate the methodological rigour and transparency with which a guideline was developed. However, not all 23 items within the original tool were applicable to the literature identified in this review. As stated in the user manual of AGREE-II, items may be skipped if deemed to be irrelevant. For instance, some of the criteria (1b; 1c; 3e, 4b) are more relevant to healthcare treatments and interventions rather than practitioner wellbeing. We excluded the applicability domain as this appeared concerned with implementation of guidelines within an institutional setting whereas our search was centred on identifying guidance for individual staff. We assessed material on 12 of the 23 items.

Points indicated with * are those that have been excluded from our quality appraisal.

1. **Domain 1: Scope and purpose**
   - a. The overall objective(s) of the guideline is (are) specifically described.
   - *b. The health question(s) covered by the guideline is (are) specifically described.
   - *c. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.
2. **Domain 2: Stakeholder involvement**
   - a. The guideline development group includes individuals from all relevant professional groups.
   - b. The views and preferences of the target population (patients, public, etc.) have been sought.
   - c. The target users of the guideline are clearly defined.
3. **Domain 3: Rigour of development**
   - a. Systematic methods were used to search for evidence.
   - *b. The criteria for selecting the evidence are clearly described.
   - *c. The strengths and limitations of the body of evidence are clearly described.
   - d. The methods for formulating the recommendations are clearly described.
   - *e. The health benefits, side effects, and risks have been considered in formulating the recommendations.
   - f. There is an explicit link between the recommendations and the supporting evidence.
   - g. The guideline has been externally reviewed by experts prior to its publication.
   - *h. A procedure for updating the guideline is provided.
4. **Domain 4: Clarity of presentation**
   - a. The recommendations are specific and unambiguous.
   - *b. The different options for management of the condition or health issue are clearly presented.
   - c. Key recommendations are easily identifiable.

*5. **Domain 5: Applicability**
   - a. The guideline describes facilitators and barriers to its application.
   - b. The guideline provides advice and/or tools on how the recommendations can be put into practice.
   - c. The potential resource implications of applying the recommendations have been considered.
   - d. The guideline presents monitoring and/or auditing criteria.

6. **Domain 6: Editorial independence**
   - a. The views of the funding body have not influenced the content of the guideline.
   - b. Competing interests of guideline development group members have been recorded and addressed.