Mersey Care NHS
NHS Trust

Guidance Document on

SAG1 Support / Information available to staff following their involvement in Complaints, Claims, Incidents and Inquests

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Written By
Director of Patient Safety

(Complaints, Incidents & Legal Management)

CONTENTS

Introduction

The support of staff following their involvement in a serious adverse incident, inquest, complaint or claim is of primary importance to the Trust. It is recognised that staff can be upset and disturbed by some of the incidents that occur within the Trust. Timely and effective intervention by Managers and other Professionals can help to ensure that staff maintain their mental and physical well being.

This document covers all staff within the Trust and all incidents, though it is recognised that most support will be required when staff have been involved in Serious and Untoward Incidents. Agency and contracted staff should come under this policy at least from an initial perspective, though long term support and guidance may be delivered by their employer. Bank staff will fully come under these arrangements.

Responsibilities

The following staffs have specific roles in supporting staff -:

- **Line Manager**

  The Line Manager has the responsibility of ensuring that their Team / Ward Managers are fully committed and aware of the procedures outlined in this document and are able to offer initial support and guidance to staff.

- **Team Managers / Ward Managers**

  Team Managers / Ward Managers are responsible for ensuring that their staff receive initial support / guidance following an incident which may include physical health checks. They will also work with the staff member involved to monitor their reaction over an extended period. It is recognised that delayed reactions to incidents can take place particularly where learning and investigation processes are involved i.e. Coroner's Inquests, Litigation, Internal and External Review processes.

- **Inquests Manager**

  There is an identified member of staff who is responsible for ensuring that the Trust undertakes its responsibilities by providing information to the Coroner and National Health Service Litigation Authority (NHSLA) regarding claims. To do this, they will: -

  - Ensure staff are fully aware of the information they have to provide and why.

  - Ensure staff are aware of the timescales that are involved.

- Ensure staff involved are kept informed as to the progress of the claim.

- Liaise directly with staff and ensure that they understand the role of the Coroner / claim process and how they will be supported during any appearance at an Inquest / claim.

- Prepare staff for their appearance at an Inquest and hold a post Inquest Feedback session.

- Engage the Legal Team as is necessary to ensure that staff know and understand that they have legal rights and responsibilities.

- Provide leaflets on the role of the Coroner and potential outcomes of an Inquest.

- Any concerns they have about a staff member's well-being, refer to their Line Manager / Team Leader.

- Triage **all** requests from the Coroners' Officers / claimant's solicitors for statements from staff – arrangements have been made with the Trust's three associated Coroners, that they will not approach any member of staff directly.

- An information leaflet (see Appendix B) is available and given to all staff who are required to give / prepare evidence for a Coroners Inquest. This information is also available on all Ward and Team areas as well as on the Trust's website.

- Provide guidance on statement writing.

o **Staff Counselling Support**

- Provide professional and timely advice and interventions to Managers and staff on what interventions should be undertaken to support staff. This should include guidance on how staff should be helped/supported in the workplace following a serious adverse incident.

- Offer individual assessment sessions for staff who have been involved in an adverse incident, in accordance with national guidance. This may involve a follow-up session, or ongoing counselling.

- To provide a confidential, impartial counselling service to any staff who have been adversely affected by an incident, claim or complaint.

- **Occupational Health Staff**

  - Provide guidance regarding the health impact of an incident on staff to managers and direct how and when it is best to support the staff member returning to work.

  - Advise regarding the appropriateness and ability of staff providing evidence in court and the effect on the individual's mental and psychical health.

  - Provide information that can be used to share with the court regarding a staff member's ability to be involved in court proceedings

- **Complaints Lead**

When a complaint is received about a member of staff, the Complaints Lead should ensure the Line Manager / Team Leader is aware and can provide guidance on how to manage the situation. The Complaints Lead should ensure that the member of staff understands the process for receiving complaints and that the focus is on understanding what happened, learning, improving practice and not a laying blame. The Complaints Lead will ensure that the staff member receives feedback on the outcome as soon as possible. They will also refer any concerns regarding the staff member's well-being to the Line Manager.

- **Lead Reviewer**

When an adverse incident review takes place, staff are usually asked to prepare statements, attend interviews. The Lead Reviewer will ensure that: -

  - The staff member is given guidance as to what areas of information the review team will require from them in a timely manner, allowing time for staff to gain support from colleagues and/or Unions.

  - Conduct interviews in a professional and supportive manner.

  - Ensure staff know that the review is being conducted as part of a learning and safety culture as opposed to the apportioning of blame.

  - Keep staff / Managers up to date on review progress.

  - Provide feedback regarding the report as soon as possible (see page 10).

Involvement with the Police and/ or Court Proceedings

It is not unusual for staff to be asked to provide witness statements for the police or the Coroners Court. The Trust has a legal management Team that will be actively involved in providing guidance and management of this process.

When the Police request an interview with staff as part of an investigation, or to act as a witness, the Line Manager / Team Manager will ensure that they are accompanied to any Police interview / Court appearance. This will ensure that staff member can receive support and also where appropriate the police investigation is kept within agreed legal process. The attendance of Line Managers/Team leaders will ensure that they are fully aware of the actions being taken by the police and allow them to ensure that staff have full legal representation / advice.

The Trust's Legal Adviser will meet with staff on request or referral by the Line manager to discuss: -

- The role of the witness
- The role of the Court
- Professional's likely to be present
- Style of the hearing and role of the Judiciary
- Layout of the Court
- Why the person has been asked to attend

If required the Legal Adviser will take the individual to an empty court and explain the environment. The Legal Adviser will discuss techniques regarding answering adversarial questions but will not interfere with the legal process. The Legal Adviser can attend the court with the individual to provide enhanced support, though this would not be in his/her role as legal advocate(see Appendix C).

Actions to be Taken

- **Immediately following an incident**

When an incident has occurred, it is the responsibility of the senior member of staff in charge of the shift / period of duty to: -

- Ensure all staff are present and safe.
- Undertake a review of the staff's need for physical health care such as a review by their GP / A&E Department. The senior Practitioner will encourage and guide the staff member to attend for a physical health care check. Where necessary, an ambulance will be called

or transport arranged. Where a staff member has been involved in a violent incident, it is essential that a physical assessment is undertaken as it will be required if a prosecution of the perpetrator is undertaken.

- The senior Practitioner will allow time for staff to discuss the incident either in a group or individually. This will be done in a supportive and friendly manner and not as part of any formal investigation or review process.

- During a serious incident, the Line Manager / Bronze on Call Manager will attend to ensure that any formal processes are undertaken i.e.: -
  - Provision of statements
  - Planning for a Reflective Practice Review
  - Informing staff of the next steps

- In the case of a violent incident, Team Leader / Manager will discuss with staff whether they wish to prosecute the perpetrator. If they do, then they will be supported to contact the Police and provide a statement.

  If they are not able to make this decision initially, then: -

  - Team Leader / Manager will discuss this issue with them when they are next on duty.

  - They will also receive a letter from the Local Security Management Specialist, confirming the offer of support if they wish to prosecute and the Trust's general support on prosecuting people who have committed violent crime.

  - The Multi Disciplinary Team / ACT Team will discuss the incident / case and complete police clinical referral form to identify ability of the service user to be interviewed.

  The reason for asking individuals if they wish to prosecute initially is that the Criminal Justice System request that a referral for investigation is made as soon as possible after any incident.

o **24 hours after the incident**

Following a serious incident, the Team Manager should formally meet with the Team / Individual to: -

- Clarify the staff member's thoughts, feelings and well-being.

- Provide information on the next steps regarding investigation / Police involvement.

- Ensure the staff member is aware of what systems / services are available i.e. Staff Support Services (Counselling). External support can be provided if it is not available from within the Trust.

- Agree with the staff member the interventions they require and who can provide these.

- If the staff member is not on duty, then the Team Leader / Manager should contact the individual via the telephone/email/text with the aim of checking how they are and providing any information required. When the staff member returns to work a formal review meeting should take place to clarify the needs of the individual member of staff.

Ongoing Recognition

Team Leaders / Managers and staff need to recognise that the psychological effects of being involved in an incident and the associated procedures can be ongoing in some cases for several years. It is important that via the use of regular clinical supervision and extra supportive sessions, the staff member is kept up to date with how procedures such as inquests are being managed. The staff member should be encouraged to share their concerns and fears. If the Team Leaders / Managers cannot answer their questions and/or reduce their anxieties, specialists in the Trust or external to it should be asked to become involved and provide guidance including: -

- Legal Adviser
- Claims Manager
- Local Security Management Specialist

Where a change of work base or practice is either requested or thought to be appropriate, this should be undertaken in conjunction with the individual member of staff and in a supportive and learning approach.

If the procedures for concluding an incident go on for a prolonged period, then staff may move roles, apply to other Trusts or retire. The responsibility of the Trust to keep them informed of events such as litigation, inquest findings etc do not stop when they move role or leave the organisation. It is essential that individuals are kept involved and aware of all the proceedings, as it affects them, this will usually be undertaken by the Trust's Claims / Inquest Manager who will be their identified link.

Where staff continue to feel responsible for incidents, despite evidence to the contrary, professional advice should be sought from Staff Counsellors, Occupational Health Specialist. A formal letter from a senior Manager to the staff member can be helpful if it clearly identifies where the deficits were found to be.

- **Distress as a direct result of the incident / legal activities**

Where staff are psychologically disturbed by an incident and there are complicating factors such as an ongoing court case, coroners inquest etc then the following actions should be considered: -

- Planning Meeting involving all key stakeholders: -
    - Staff member/s
    - Line Manager
    - Claim / Inquest Lead
    - Legal Representative
    - Staff Side
    - HR Representative

  This meeting will be conducted with the aim of identifying a plan of how to support the member of staff through the legal processes.

  A referral to the Occupational Health Department must be made at the earliest possible time. They should be asked to provide an assessment of the staff member's suitability to give evidence and the potential effects on their wellbeing if they do.

  The court (Crown, Magistrate, Coroners) should be kept informed and asked to offer alternative arrangements for the staff member to be able to share their evidence: -

  - Giving evidence in camera
  - Statement read out in court.

- Continued explanation regarding the processes should be given via the agreed person (usually the Line Manager) to the staff member.

- All suggestions / guidance by the Occupational Health Service should be undertaken in a timely manner, and may include referral for psychiatric / psychological intervention.

Staff may make an Employer Liability Claim against the Trust in accordance with their statutory rights. It is essential that they understand that this will not affect the support and guidance they will receive from their managers or colleagues. This information and process will be kept separate from their need for information and support. It is important that they are aware that the NHS Litigation Authority will be the lead agency dealing with any claim and make decisions regarding the trusts liability.

Communication

It is essential that staff are kept informed of all the activities / actions that will be taken following an incident having occurred. They must be given a key contact (usually their line manager). Delays often do occur and the directions of investigations change often due to the views and actions of external agencies

such as the Coroner / Police and Health and Safety Executive etc. It is the responsibilities of the Trust to ensure that staff are aware of the changeable nature of the post incident process and to keep them up to date with any information available.

Being aware of what is happening is often seen as the single most important issue by staff who can complain of being in avoid which creates anxieties for them.

An information pamphlet has been prepared for staff (see appendix 1) and this should be given to staffs who have been involved in an incident, it also should be regularly available in wards and team bases to inform staff proactively.

It is important that Trust managers ensure that external agencies and contractors receive communication about any proceedings that involve them. Also that their contact details are shared with agencies such as the Coroner's office so that communication can take place. It is also important that when Trust managers are disseminating learning from incidents or planning learning events that external partners such as contractors/provider agencies are actively encouraged to be involved. This will also allow their staff to achieve full closure.

Individual Feedback following Incident Reviews

It is essential that following each serious adverse incident, staff are provided with the findings of the Review Panel as soon after the report has been validated as possible. The staff should be asked if they wish to attend on their own, with other involved colleagues or with a friend or staff side. This process is not part of any disciplinary / HR process which should have been undertaken previously where HR actions are being taken, advice should be sought from the HR manager as to how the report should be disseminated. The Trust will always try and ensure that staff have a full copy of the anonomised report. The will be given time after the initial sharing of it to ask further questions and seek clarification.

Learning Oxford Model/ Dare to Share Events

These are events which focus on sharing the learning from an incident, complaint or claim with as many service staff as possible. The event is carefully controlled by a systematic and managed approach. They do though cover difficult and emotional topics.

It is usual to invite staff who were involved in an incident or the care of the individual service user. The Line Manager in association with the Director of Patient Safety will consider how the staff's emotions are most appropriately managed and what support is required. The Staff Support Services will be asked for advice and guidance where appropriate. Individual staff will be approached when they have had either specific involvement or have been negatively affected by the incident. They will be informed of what will happen and given the option to attend or not.

The presentation of the incident is anonymous and all recognised data is removed. During the session, staff are encouraged to be aware of each other's needs and be respectful of their colleague's feelings. These sessions are always facilitated after all investigations have been completed i.e. inquest etc. Any individual accountability will have been managed in accordance with trust policy and procedure.

Human Rights

It is envisaged that the use of this policy will enhance the way the trust ensures that the Human Rights of its staff are maintained. It is important that when using this policy, managers and other specialist staff identified within the policy consider the human rights of the individual and ensure they are maintained at all times. They can obtain help and guidance from the Ethnicity and Diversity Team if they are in any doubt .

APPENDIX A

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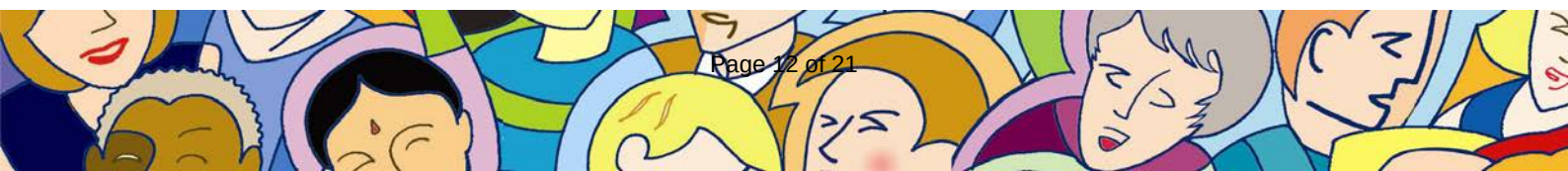
WHAT HAPPENS AFTER AN ADVERSE INCIDENT OCCURS

Steve Morgan
Director of Patient Safety
(Complaints, Incidents & Legal Management)

Margaret Smith
Staff Support



1. THE PURPOSE OF THIS LEAFLET

This leaflet is for staff and managers. Its purpose is to help you to be clear about what may happen to you following the incident you have been involved in over the next weeks and months and how you can access support.

2. ADVICE / GUIDANCE FOR STAFF

2.1 Support for you immediately after the incident

2.1.1 The first contact after an incident will depend on: -

- What precisely happened and
- Whether as a member of staff you are personally involved in the incident.

If you are involved in the incident yourself, you will have needed to: -

- Ensure that the area and the people including yourself are safe.
- Report the incident to your senior manager for further guidance and direction.
- Within 24 hours the incident must be reported centrally to ensure that all appropriate systems are activated and any urgent remedial action is taken.

We recognise that it is important that having been through a traumatic and untoward event, that you feel that you can access as much support as you need at this stage.

If you are not personally involved but you have personal involvements with people involved in a traumatic incident for example, a patient's suicide, then: -

- You can expect that your Line manager or team leader will provide you with information about the incident as far as this is known at that time.

When your manager meets with you following the incident you can expect: -

- The offer of some support from them for you and anyone else involved
- To be able to talk about how you are coping and how you are affected.
- At this stage, you can also expect your manager will check out with you whether you would like some additional support e.g. untoward incident debriefing advice for Staff / HR referral to Occupational Health.

We see it as essential to provide you with your own support during this difficult period.

2.2 The Incident Review process

2.2.1 In parallel with this the Line Manager will be organising a review of the incident and this will depend on information that they get from the incident form once it is completed where the incident will be classified from A to D.

- If the incident is graded B or C then your local team leader may review with you and other members of the team what happened using the Reflective Practice Model which include issues such as “were the policies followed”, “was the care plan up to date” “did the service user have a care co-ordinator”? This process will take the form of a meeting which brings together all those involved in the care of an individual. It will be conducted with the aim of learning from the incident.
- If the incident was classed as A or in some cases of B, then it will automatically be dealt with through Root Cause Analysis where two reviewers - one from the directorate and one from another directorate will lead the process of the review.
- The review itself should commence within a maximum of 10 days following the incident but the process may take sometime and must be completed within 45 working days of the incident. The review will include the list of recommendations following the incident.

2.2.2 At the end of 45 working days, the Line manager will receive the report and: -

- If there is agreement, they will start the process of implementing the recommendations.
- Urgent issues identified as part of the review should be actioned and implemented straightaway.
- The primary purpose of the review is to learn what happened rather than to blame anyone. Although staff may have to accept responsibility for an aspect of what occurred.
- It you are concerned about your involvement in the incident, you should consider: -
  i. Discussing in supervision.
  ii. Addressing with your line Manager.
- Following the completion of the document, if you feel it is overly blaming, this can be discussed directly with Steve Morgan, Director of Patient Safety (Complaints, Incidents & Legal Management) on 0151 287 2873.

2.2.3 If there is a Police investigation or court hearing,

- In some circumstances the review may not be able to take place or be completed until after the official legal process has been completed.
- If as part of the post incident process, there is a court hearing, you are entitled to access as much support as you need through your Line manager which might include personal support or it may include legal

advice, direction and help prior to the hearing, possibly even including a private visit to the court so you feel comfortable about what you are doing.

- You should never be asked for a statement directly from a Coroner's Officer, it should always come via the Trust's Claims / Inquest Manager. She will provide you with support and guidance as to your role, timescale etc. She will also liaise with your Line Manager to ensure that they are aware of the situation and can provide extra support.
- If you are contacted by the Police or other agencies for a statement, then you should contact your Line / Line Manager immediately. You should expect them to either proffer guidance and/or obtain this from the Trust's Legal Adviser. You should not be expected to attend any Court procedures or Police statement without being accompanied by a member of Trust staff.

2.2.4 Once the review has been completed,

- The reviewers should meet with staff involved and the line Manager to talk them through the outcomes and the recommendations to encourage local learning to take place.
- If you are involved in an inquest, we would also like to stress that you are entitled to support if you are involved in this process or have concerns about what may be said. This can be accessed through your Line manager but will normally be directly provided by the Claims / Inquest manager. The incident support service will also be available.
- There are coroner's inquest leaflets available as part of the Trust guidance to let you know what happens under those circumstances. Available from Claims / Inquest Manager on 0151 471 2361.

3. INDEPENDENT INQUIRIES

Homicides - it is statutory obligation on the part of the Strategic Health Authority / Primary Care Trust to initiate an external inquiry when a service user has been involved in a homicide. There are different levels of independent investigation which range from a full re-investigation with external specialists through to a table top review of the information available. The Trust will keep staff informed of what type of review will be used and how they may be involved.

This process can take up to two or more years after the incident happened to commence. The document they produce will generally be distributed more widely than the internal review.

4. SUPPORT

The Staff Support Service offers support to all staff who work for Mersey Care NHS Trust. These services offer a chance for staff to talk through things that are on their mind with a counsellor, who will be non-judgemental and impartial. This service is provided to help staff with both personal and work issues.

All staff can access the Central Staff Support Services at Switch House on 0151 330 8103. From this central service, staff will then be directed to sessions based at venues closer to home or work.

Other Support can be gained from a variety of sources some are listed below;

Team Leader / Ward Manager
Line Manager
Occupational Health
Chaplaincy Department
Unions
The Trust Legal Advisor
Claims and Inquest Managers
Director of Patient Safety for adverse incident management
Your work colleagues

The purpose of the Inquest is to determine as far as possible the identity of the deceased and where, when and how he or she came to die. An Inquest does not apportion blame.

The Conclusion of the Inquest

At the end of the Inquest HM Coroner will conclude as follows:

1 Name of the deceased.
2 Cause of Death.
3 Time, place and circumstances of the death.
4 Conclusion (commonly referred to as verdict).
5 Registration particulars.

The Verdict

The Verdict can be one of the following:

1 Natural Causes.
2 Industrial Disease.
3 Want of attention at birth.
4 Dependence on drugs/non-dependant abuse of drugs.
5 Killed himself/herself.
6 Accident/Misadventure.
7 Execution of sentence of death.
8 Lawful killing.
9 Unlawful killing.
10 Open Verdict.
11 Stillbirth.

Self-neglect/neglect and system neglect may also be attached.

Feedback

If staff are not called to attend the Inquest, the Claims & Legal Manager will provide feedback to the staff who have provided statements and to the Service Manager.

If staff are required to attend and give evidence the Claims & Legal Manager will also offer a Post Inquest Review.

Contact Details

Legal Management Team – 29-30 Parkbourn, Magull Site.

Christine Winters, Claims & Legal Manager - (Tel: 0151 471 2361).
Sarah Cain, Secure Services Administrator (Tel: 0151 471 2626)
Barry Judge, Legal Advisor – (Tel: 0151 473 2799)

Steve Morgan Assistant Chief Executive, CAB (Tel: 0151 473 2874)

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INQUESTS AND THE CORONER'S COURT – PREPARING FOR AN INQUEST

It is the Trust's aim that all staff involved in this process feels fully aware and supported.

All deaths that are sudden, appear accidental or suspicious e.g road crashes, industrial accidents, suicide, death whilst in custody etc., are reported to the Coroner. Not all deaths that are reported proceed to Inquest.

Supporting Staff

All staff required to provide a statement and/or attend Court to give evidence will be fully supported throughout the process by the Claims & Legal Manager or a member of the Legal Management Team.

Support can also be provided by the following:

- Line Manager / Service Manager
- Legal Advisers via the Claims & Legal Manager.

General support can be provided via:

- The Buddy Service
- Relevant staff support service.

The Trust aims to provide preparation by a legal adviser 48 hours before the scheduled Inquest when necessary. The preparation will take place in a private area due to confidentiality and the professionalism of the organisation and the individuals involved.

The Request from H.M Coroner

If a request from H.M Coroner to provide a statement is received directly by staff then the Claims and Legal Manager should be advised immediately. This ensures that the Trust is aware of whom the Coroner requests statements from and which staff members may be called to give evidence to enable support to be provided. The member of staff being requested to provide the statement should also ensure that their Line Manager is informed.

Supervision/guidance on writing the statement will be provided by the Line Manager and/or the Claims & Legal Manager.

Preparing a Statement

Statements being prepared for the Coroner should include the following:

- Heading – The Report For HM Coroner for the Inquest into the death of (Patient's Name and Date of Birth).
- Full name of author.
- Address of author – as c/o Trust.
- Job Title.
- Professional qualifications.
- Summary of duties/responsibility of author.
- Summary of involvement/overview of patient's care and treatment.
- Sensitive phrases – (e.g. condolences to family).
- All paragraphs should be numbered.

Do not include – Statements such as "suicide", that is for the Coroner to decide.

If you have written a statement it is important to remember that you will usually be asked to read it out in an open court. It is important that you are objective about the information written.

Do not identify family members or other non-professionals by name within the report.

Where a patient made it clear before death that he/she did not want certain information to be shared with a particular person or group of people (e.g family) this should be brought to the Coroner's attention. Such information should be included in an addendum to the report.

Once prepared the statement will be reviewed by the Service Manager for factual accuracy and clinical appropriateness. The report is then to be sent to the Claims & Legal Manager who will check regarding legal criteria. The Claims & Legal Manager may send some statements to the Trust's Solicitors for advice/guidance should this be necessary.

The Claims & Legal Manager will send all the reports to the Coroner.

Before the Inquest

The Claims & Legal Manager will be liaising with the Coroner's Officer from the time the request for the report has been received to access any relevant information such as:

- Date of Inquest
- Cause of Death
- Family issues / concerns
- Staff attendance.

This information will be shared with the Co-ordinating Manager / Service Manager.

Attending Court and Giving Evidence

The Trust recognises that staff called to give evidence at a formal Hearing or Court may not have been involved in this process before and that you may feel concerned and anxious.

An Inquest is heard in public. Attending a Coroner's Court is a formal process and therefore dress code and manner must be appropriate. The Claims & Legal Manager will attend Inquests where staff are called, to give guidance and support, if the Trust's Solicitors have been instructed they will also attend. Staff may also choose to take their Line Manager, representative or friend. The Service Manager or representative may also attend where appropriate. In certain circumstances the Claims & Legal Manager will attend an Inquest even thought staff from the Trust are not required to attend.

Evidence is given on oath or affirmation. The Coroner decides in what order the witnesses are called. Consultants are usually asked to read out their statement/report. The Coroner will usually take other witnesses through the statements.

When giving evidence:

- Take your statement into the witness box.
- You will then be sworn in.
- Evidence should be within your professional area of expertise.
- It is acceptable to say that you do not know the answer or cannot remember, if that is the case.
- Hearsay evidence is admissible.
- You can be released at the end of giving evidence with the Coroner's permission.

You can be asked questions at the Inquest from the following:

- The Coroner.
- The family through a nominated family member or legal representative.
- The legal representative for any interested party.
- If the Inquest concerns a detained patient, a Mental Health Commissioner.
- Where there is a jury, the Jurors.
- The legal representative for the witness has an opportunity to ask questions last.

Support for Trust staff attending Court as a witness

Going to court

Attending Court as a witness or as the victim of a crime can be a worrying experience, particularly if it is your first time, you have not given evidence before and you receive a summons to attend. Understandably, you do not know what to expect and this advice sheet provides details of the support the Trust will offer and other Services who are available to help you.

The Trust's commitment

Once you have received notification that you are required to attend Court please contact Barry Judge in the Trust Legal Management Team (0151 473 2799) or the Criminal Justice Liaison Team (0151 255 0040).

You will be provided with:

- information on Magistrate and Crown Court procedures including:

    1. when a jury is used
    2. the Magistrates and Judge's role
    3. the order with which you will answer questions from advocates
    4. when, if appropriate, special measures may be requested
    5. how to get access to and use of your statement (not in the witness box)
    6. if appropriate, access to the Trust's Solicitors if specialist advice and/or support is required i.e. to support a challenge to the witness summons if for example you have a holiday abroad booked

- someone, to discuss with, in confidence, any fears or questions you have although Trust staff cannot go through your evidence with you

- If you wish, support to visit a Court to observe a trial and have a look around a courtroom before you are called as a witness

- On the day you are giving evidence support at the Court (if appropriate, arrangements may be made so you can sit in a separate area to other witnesses, family etc)

- Contact details for the appropriate Court Witness Service (further details below)

- Contact details for the Witness Care Unit (further details below)

The Witness Service

The Witness Service helps witnesses, victims, their families and friends before, during and after a hearing. It is run by Victim Support, the national charity which helps people cope with crime. There is a Witness Service in every Crown Court centre and magistrates' court in England and Wales. The service is confidential and

free. Trained volunteers provide emotional support and practical information about court proceedings. The Witness Service will normally contact you in advance of the court hearing to offer its services.

The Witness Service can arrange for:

- Support at the Court if you do not wish to utilise the Trust's support
- a quiet place for you to wait before and during the hearing
- someone to accompany you into the courtroom when you give evidence
- practical help, for example with expense forms. If you are called as a witness, you can claim your expenses after the trial. These expenses may include travel to the court, essential childcare, or loss of earnings
- to put you in touch with people who can answer specific questions about your case (the Witness Service cannot discuss evidence or offer legal advice)
- a chance to talk over the case when it has ended and to get more help and information

The Witness Care Unit

The Witness Care Unit is a statutory agency and the single point of contact for victims and witnesses as their case progresses through the Criminal Justice System. The Witness Care Unit becomes responsible for a case once the defendant has been charged and appeared before the court for First Hearing. At this point, the case is allocated to a Witness Care Officer who will assist a victim/witness throughout the case.

The Witness Care Unit will make early contact with the victim/witness (after the first hearing), keeping them continually updated of every subsequent court hearing, and addressing their needs.

The Witness Care Unit has a number of obligations under The Code of Practice for Victims of Crime, an important one being they will keep victims updated throughout the life of a case. The Unit is also responsible under The Victim's Code for:

- assessing the needs of each victim who is required to attend court;
- providing information on the court process;
- advising the victim of the case outcome and giving an explanation of any sentence passed;
- keeping victims informed of any appeal to Crown Court or the Court of Appeal.

A victim's/witness's needs are continually assessed during their contact with the Witness Care Unit, and the Witness Care Officer will endeavour to meet these needs as best as possible through close liaison with Police Officers, the CPS, Witness Service and other voluntary agencies.

The Witness Care Unit has produced a very useful information leaflet called *Merseyside Witness Care Unit – Going the Extra Mile* which is available from the Unit (0151 777 1700) or the Trust Legal Team.

On a practical note you may find it useful to take the following

- a friend or relative in addition to any member of Trust staff you would like to support you. The important point is you don't have to attend court alone
- any information you have about the case (for example, the name of the police officer dealing with your case)
- the letter asking you to attend court, if you receive one
- something to read or do as you may have to wait a long time for the case to be called
- money to cover costs on the day, such as car parking or refreshments as you may have to wait a long time to give your evidence i.e. you will be asked to attend on a specific day but no time will be provided as to when you are required to give your evidence.

Further information

You may find it useful to refer to the *Witness in Court* leaflet, published by the Home Office. This leaflet may have been enclosed with the letter advising you of the date you have to attend court. If it was not and you would like a copy please contact the Trust Legal Management Team.