

The coroner's court and the psychiatrist

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Abstract In psychiatry we are perhaps fortunate that the death of our patients is not such a regular occurrence as for our colleagues in other specialties or in primary care. However, when death does occur it is more likely to result from some unnatural cause such as suicide. Consequently, the prospect of being involved in a coroner's inquest is a very real and anxiety-provoking possibility for many psychiatrists. This article considers the role of the coroner in England and Wales and the process of investigation of sudden and unexplained deaths, and offers some practical advice regarding such proceedings. It illustrates a number of issues that have been highlighted in coroners' verdicts and have implications for the process of clinical governance. It also considers possible changes to the coroner system that have been proposed recently in several high-profile reports.

Historical aspects

The origins of the role of coroner are obscure (Levine, 1995; Levine & Pike, 1999). In England the office may date back to Saxon times and the reign of Alfred the Great (Knight, 1999). There is evidence, though, that as early as the 7th century AD there were coroners in existence in China (Knapman, 1993). During the reign of Henry II, a time when many were dissatisfied with the corruption of the sheriffs, the other legal representative of the King was the *Seviens Regis Corinarius*. However, in September 1194, with Richard I on the throne, Article 20 of the Articles of the Eyre stated that each county should elect Keepers of the Pleas of the Crown, and the 'crownors' or 'coroners' officially came into being.

Since then the role of the coroner has changed considerably. In those early times the coroner was an important and feared official (perhaps that is still the case today!) who had a responsibility for keeping a record of revenues that were due to the king. These often arose from criminal proceedings – for example a levy known as the 'murdrum' was payable to the king by the community whenever a Norman was murdered – but the coroner played little part in the judicial process. Another source of revenue was the 'deodand', which was any item involved in a violent death that was forfeited to the king. Later, coroners were involved in negotiations with criminals who had taken sanctuary and they would offer fugitives the alternatives of surrender or exile. Similarly, they

would take the confession of a criminal who had 'turned approver' or decided to turn King's evidence.

Following the medieval period the coroner's power was in decline. By 1500 he was no longer involved in collecting revenues and began to be concerned with sudden death where there was a suspicion that the cause was either unnatural or violent. Whenever such a death occurred the coroner would summon a jury to make 'an inquisition'. After viewing the body, the jury decided on a verdict of homicide, suicide or misadventure. In the case of murder, the coroner would be involved in bringing the accused to trial, but this criminal aspect of the coroners' work has gradually diminished. The coroner was also obliged to hold an inquest whenever a prisoner died in jail to determine whether the prisoner had died 'by the ill usage of the gaoler'.

For the next 200 years there was little change, but an attempt to improve the status of the office in 1751 led to arguments that persisted for another century. A formal system of inquiry into deaths was established in the first half of the 19th century by the Birth and Death Registration Act and several other pieces of legislation. The first medically trained coroner was appointed in 1839 and recommendations from a select committee in 1860 resulted in the Coroners Act of 1887. This defined a structure of duties and rules and marked the beginning of the modern era.

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Latterly the practice and procedures relating to inquests and post-mortem examinations were regulated by the Coroners Rules 1953. A review of the coroner system by the Brodrick Committee between 1966 and 1971 made a number of recommendations (including that coroners should *not* be doctors), but did not result in any significant changes. With the current Coroners Rules being introduced in 1984 and the Coroners Act 1988 consolidating existing legislation, today the need for an inquest is well defined.

Although a 'Continental' system exists which only investigates deaths that have aroused the suspicions of the police, the coroner system was exported throughout the British Empire and has been adopted in many countries around the world.

The coroner today (Box 1)

According to the Coroner Review Group (2003) there are 123 coroners in England and Wales, who are appointed and paid by local authorities in each district. The coroner is an independent judicial official who holds office until retirement. Responsibility for the operation of the coroner system falls to the Home Office, which deals with issues of legislation, the Home Secretary, who sets fees, collects statistics and acts as an arbitrator, and the Lord Chancellor, who for the moment regulates practice and procedures and is the only person able to dismiss a coroner. Apart from the basic requirement of being medically or legally qualified for at least 5 years there is no obligatory training for coroners, although the Home Office provides some induction courses and two or three weekend courses a year.

In a survey of coroners by the Home Office (Tarling, 1998) the vast majority (98%) were male with an average age of 58 years (range 39–75 years). The majority of coroners were part-time, but there were 23 full-time posts in the busiest districts. The number of medically qualified coroners was small (15%), a situation reflected among deputies and

assistant deputies, who are appointed by the coroner to assist them.

In addition to the deputies, every coroner has on average three coroner's officers. They are usually employed by the police and are serving or retired police officers. An increasing number of civilians are found in this position. Their roles vary, but they do much of the detailed investigation and preparation for inquests as well as liaison with bereaved families.

The coroner's duties are defined by Levine & Pike (1999) as follows:

- to investigate all deaths where the cause is unknown or there is reason to believe that the cause was violent or unnatural;
- to decide whether a post-mortem examination is required and to instruct an appropriate medical practitioner to undertake it if necessary;
- to hold an inquest, with or without a jury, where there is reason to suspect that the deceased has died a violent, unnatural or sudden death of unknown cause or has died in prison or in any circumstances that require an inquest according to other Acts of Parliament (although deaths in psychiatric hospitals are not subject to a mandatory inquest, the Home Office has asked that all deaths in legal custody, including those of patients detained under the Mental Health Act, be investigated as if they were deaths in prison);
- to pay the relevant fees to witnesses and jurors;
- to notify the Registrar of Deaths of the findings of the inquest or that no inquest needed to be held;
- to keep a register of all the deaths reported and retain documents in connection with inquests and post-mortems;
- to make annual returns to the Home Office in connection with the inquests held and the deaths investigated;
- to appoint a deputy coroner and an assistant deputy coroner if needed.

Box 1 The coroner

- An independent judicial officer
- Responsible only to the Crown
- Usually a lawyer, some are medically qualified
- Funded by the local authority
- Responsible for investigating the cause and circumstances of sudden, violent or unnatural death

The inquest

Purpose (Box 2)

The inquest, held in the coroner's court (Box 3), has a very limited remit. It is intended to establish certain facts: namely, the identity of the deceased and how, when and where they met their death. The proceedings and evidence must be directed solely at this purpose and no comments from the coroner, jury or any verdict can determine either blame or criminal or civil liability.

Box 2 Purpose of the inquest

- To provide independent scrutiny of the events surrounding a death
- To establish the facts
- To allow properly interested persons an opportunity to question witnesses
- To draw attention to circumstances that might lead to further deaths

The inquest is not a trial, there are no parties or sides and it should not be confrontational. The process, unlike the mainstream judicial system, is inquisitorial rather than adversarial and concerned entirely with fact finding, not with fault finding. It is very important that the family of the deceased are aware of this, otherwise there can be considerable frustration or anger if it is perceived that no blame has been apportioned or there has been some form of cover-up.

The coroner's role is 'central and dominant' (Levine & Pike, 1999) in the inquest process, although he or she may be supported on the bench by a deputy or by an 'assessor' who has specialist knowledge appropriate to a complex technical case. The coroner's main task, as was stated in the Jamieson case (*R v. HM Coroner for North Humberside and Scunthorpe*, 1995), is to ensure that the relevant facts are 'fully, fairly and fearlessly investigated' to establish the course of events and resolve any ambiguity in the evidence if it exists. The coroner must also strike a balance between excessive investigation of a case and what is sufficient for the purpose of the inquest.

Although the coroner usually sits alone there are certain situations that require a jury. The coroner has a degree of discretion to call a jury in any case that is in the public interest, but a jury must be called if the death occurred in prison; in police custody; by accident, poisoning or any disease that requires other government departments to be notified; or when circumstances exist that might

affect the health and safety of the public if they were allowed to continue.

According to Home Office figures, a jury sat in only 3% of inquests in 2000, so it is an infrequent occurrence. A jury is made up of a maximum of 11 jurors and a minimum of 7, who qualify for jury service if they are aged between 18 and 64, are registered on the electoral roll and have lived in the UK for at least 5 years after the age of 13. The main exclusions are persons who have served prison sentences. Certain groups, including Members of Parliament, the armed forces, doctors and some other professions, are excused jury service. The duty of the jury is to return a verdict based on the evidence presented – if there is any doubt an open verdict is returned. The coroner must accept any unanimous verdict even if it seems 'perverse', but is also able to accept a majority verdict.

Process

Typically an inquest is opened within a few days of the death. The venue is usually within the area of the coroner's jurisdiction and may be established court facilities, municipal offices, a room within a hospital or a police station. The coroner notifies all interested parties of the date, time and venue. These include the spouse, a near relative or a representative of the deceased and anyone who is entitled to examine the witnesses. The coroner has no obligation to notify the family that they can seek legal representation, but may do so. There is no legal right for the public or press to be informed of the inquest, but in practice the local media are usually notified on an informal basis. The proceedings are held in public unless there are grounds of national security and only under exceptional circumstances are witnesses allowed anonymity.

At the first hearing, only limited evidence usually concerning the identity of the deceased is heard and in most cases an adjournment follows to allow preparations for the full hearing. The procedure at the resumed hearing can vary, but the general aim is to create an informal atmosphere while maintaining the dignity of the court. The coroner's officer acts both as clerk and usher, seating the family in the front rows and the visitors behind. Those in court stand when the coroner enters, he or she bows and all sit. The jury, if present, is sworn in before the coroner explains to its members the function of the court and warns them against discussing the case outside the court or being influenced by the media. The coroner introduces himself or herself to the court and takes the details of any legal representatives. Any relevant documents are circulated and the inquest begins with the examination of the witnesses, who are chosen by the coroner to address

Box 3 The coroner's court

- Conducts inquests into unnatural deaths
- Inquests are held in public and attended by the press
- The system is inquisitorial not adversarial
- The coroner's remit is limited to establishing the facts: who, when, where and how
- Inquests do not consider blame or guilt

the factual issues. The order of witnesses is chosen to allow a narrative of events leading up to the death to develop.

Witnesses are examined initially by the coroner. If the witnesses have legal representatives these may ask questions after the coroner. Certain other people are entitled to examine the witnesses, including a parent, child, spouse or representative of the deceased, any beneficiary of an insurance policy, the insurer and the police. The jury can question witnesses and recall a witness if necessary. The line of questioning should not be confrontational or accusatory and again the questions must be solely aimed at establishing who has died and when, where and by what means. The coroner must take notes of the evidence presented and this may involve tape recording and transcription.

The process can be interrupted at any time, for a variety of reasons. These can include an application for adjournment, the inclusion of other witnesses, for a jury to be summoned or to visit a scene connected with the case. When all the evidence has been heard interested parties may also make submissions about possible verdicts or points of law, which may then be included in the summing-up. However, these submissions are not allowed to challenge the facts in evidence or lead the jury, so the potential for solicitors or others to influence the outcome of the proceedings is very limited.

At the conclusion of proceedings the coroner sums up the evidence, before the verdict is announced in open court.

When a jury is present, the coroner provides it with all the exhibits and documents that have been put before the court and sums up the essential points of the evidence. The coroner also gives directions on the requirements for each verdict under consideration, explains the standard of proof necessary, directs the jury as to the law and guides it to the verdict suggested by the evidence. However, the verdict is ultimately the jury's decision and there should be no pressure on it to arrive at any particular verdict. After deliberation, the verdict is announced to the court.

Following the verdict, the inquest is closed by the coroner.

The findings of the inquest are recorded in a formal document called the inquisition. This includes the caption, giving the particulars of the inquest, an attestation signed by the coroner and the jury, and details of the facts found, including:

- the name of the deceased
- the injury or disease causing the death
- the time, place and circumstances in which the injury was sustained
- the conclusion of the jury/coroner as to the death – commonly referred to as the verdict.

Verdicts

A number of verdicts are suggested in the documentation of the inquisition. These are so-called short-form verdicts and represent the conclusions of the coroner or the jury. They include natural causes, death from dependence on drugs/non-dependent misuse of drugs, suicide, including where appropriate, 'whilst the balance of his/her mind was disturbed', accident or misadventure and an open verdict. There is also death from industrial disease, lawful and unlawful killing and a number of others relating to pregnancy and birth. However, there is no legal ruling that a verdict has to be given in any of these terms.

In choosing the verdict the coroner or jury should try to avoid as far as possible any unnecessary stigma to the memory of the deceased. This applies particularly to a verdict of suicide, where evidence is required 'beyond reasonable doubt' that the deceased intended to take their own life. The verdict of death from dependence on drugs is often returned, in spite of potential stigma, to highlight the dangers of drug misuse.

The verdict of 'neglect' or 'lack of care' is entirely different from a finding of civil negligence, nor does it relate to any issue of breach of a duty of care, both of which have to be decided in a civil court. For psychiatrists, in cases where a patient takes their own life, suicide has to be the verdict and a verdict of neglect is said to be inappropriate except in the rare circumstances of gross neglect by a professional directly connected with the suicide. Although prohibited from commenting on liability or blame, the coroner does have the power to recommend action that should be taken to prevent deaths occurring under similar circumstances.

Statistics

The following statistics are taken from Allen (2002). In 2001 there were 532 500 deaths in England and Wales. Of those, 322 200 (61%) were certified by doctors without being referred to the coroner, and 201 262 (38%) were reported to coroners, who arranged post-mortem examinations in 121 100 cases and subsequent inquests in 25 800 cases. Although there is considerable local variation, this equates to 23% of all deaths being subject to post-mortem examination and nearly 5% resulting in inquests. Coroners notified the registrar that no inquest or post-mortem was required in 78 974 cases (15%).

From the 25 800 inquests, 42% returned a verdict of accident/misadventure, 17% natural causes and a verdict of industrial disease was recorded in 11% of cases. Of interest to psychiatrists, 14% were

suicide, 11% had open verdicts and 3% were drug-related. Unlawful killing figured in 192 cases (0.7%) and lawful killing in 2 (0.01%). The 'lack of care' qualification was included in the verdict of 43 cases (0.17% of inquests).

Practical issues

Reports (Box 4)

If a report is requested by the coroner there is a legal obligation to provide one. Ideally, the report should be prepared at the earliest opportunity so that events are still fresh in the mind, although often there is a considerable delay. Under those circumstances good note-keeping is essential. The report should be an honest, chronological account of the involvement in the case. It should be clear and understandable by an educated lay person, without medical jargon or abbreviations. The author should write in the first person and not comment on behalf of others. 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. Chambers (1985) suggests that the precise content of the report remains a question for the judgement of the individual clinician. Matters of fact and opinion, however, should be separated. The report itself should be carefully reviewed before submission and any areas of concern discussed with a legal adviser.

Preparation

In order to alleviate some of the anxiety surrounding the inquest, preparation is crucial. It may be possible to attend a talk by the local coroner and this is a feature of the induction to some health care trusts. For first-hand experience it is recommended that professionals visit the coroner's court, which is open to the public. When an inquest is to be held a

pre-hearing meeting within the trust can be useful to provide support to those involved, to anticipate relevant issues and, where necessary, to raise positive points and consider explanations.

Immediately before an inquest, particularly if there has been a long adjournment, it is important to review the medical notes and read through the report, making sure that they will be available on the day. Witnesses should dress conservatively and attend the coroner's court promptly. Medical witnesses who fail to attend are liable to be fined, unless they can demonstrate a suitable excuse.

Giving evidence

Psychiatrists appearing as witnesses fall into one of three groups: ordinary witness, professional witness and expert witness. An ordinary witness uses no medical expertise and merely provides facts as a member of the public. 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. Regardless, the psychiatrist's duty is to the court and they should be impartial.

Usually witnesses stand in the witness box and are obliged to swear an oath. They can refer to their statement while giving evidence or may be asked to read it aloud. During the examination the coroner is addressed as 'Sir' or 'Madam'. It is important to be clear and concise and to explain any technical terms, answering questions honestly and frankly. If there is any uncertainty about questions it is important to ask for clarification and to answer only the question posed. The coroner should ensure that questions do not suggest blame, but if it appears that an issue of competence is being questioned the doctor can ask for an adjournment and seek legal advice. Witnesses do not have to answer any questions that might incriminate them.

Fees and allowances are payable to witnesses by the coroner and a claim form should be provided.

Local experience

Although the inquest is a fact-finding exercise not intended to apportion blame, the coroner is able to comment on issues that have implications for the future safety of the public. Issues raised can have a considerable impact on trust policies and learning from the findings of inquests into patients' deaths is an important part of the process of clinical governance.

A number of areas have been highlighted recently in our locality that relate to psychiatric practice, and we briefly outline a few of these in the following

Box 4 Reports

Psychiatric reports written for the court:

- should include a record of personal involvement in the case
- should be full, clear and objective
- should present information in chronological order
- should be written in the first person

Legal advice should be sought if the writer is worried about the content of a report

sections. However, our experience in each of these areas is not isolated and reflects problems highlighted around the country in surveys such as the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Department of Health, 2001) and the investigation into the deaths of detained patients by the Mental Health Act Commission (Williams *et al*, 2001). Both reports find similar weaknesses in psychiatric practice and make similar recommendations to address these deficiencies.

Communication

With regard to emergency admissions, especially under the Mental Health Act, coroners have on occasions criticised the level of communication between community teams and ward staff, particularly concerning issues of risk. Similarly, they have commented that transferred patients should be accompanied by more detailed information to assist in this matter. Greater communication between hospital staff and family members and friends of the patients has been encouraged. As medical and nursing notes are separate, it has been suggested that nursing staff attend to the medical entries on a more regular basis, although this highlights the case for combined notes within a trust. Lastly, emphasis has been placed on the need for good-quality handover processes.

Nursing observation

As might be expected, several issues have been raised regarding nursing observations, including overall trust policies, environmental factors that contribute to problems with observation, and individual instances of problems in recording nursing checks.

Risk assessment

Some comments arising from local inquests highlight the importance of accurate risk assessments and of documentation, particularly of initial assessments, mental state examination and physical findings. The coroner has recommended the process of peer review and audit as ways to improve the practice of risk assessment, and clearly the use of appropriate assessment tools and care programme approach documentation can also be helpful.

The future

Despite its long history, concerns have been raised about the coroner system in a number of recent high-profile public inquiries. In particular, Dame Janet

Smith, in a report of the Shipman Inquiry, has criticised a variation of practice and standards in different districts arising from inadequacies of training, the lack of a leadership structure, variability in resources and the part-time nature of many services (Smith, 2003). This has led to a loss of confidence in the coroner system's ability to protect the public. The Home Office has also commented that current arrangements may not be sufficient to meet the demands of recent human rights legislation and a fundamental review by the independent Coroner Review Group (2003) highlights concerns similar to those of Smith.

According to this latter review, suggested reforms aimed at restoring public confidence include an entirely new unified national coroner service with 60 areas. A chief coroner with the status of a circuit judge supported by a deputy would provide leadership and set standards, and the role of part-time coroners would be reviewed, with a view to creating full-time posts in each locality with more formal job descriptions and mandatory training. These area coroners would all be legally qualified, receiving advice on medical aspects from a statutory medical assessor. Further support would come from expanded numbers of deputies and more specialised coroners' officers. The main aim of the changes is to provide a consistent full-time professional service that is sensitive to the needs of the bereaved.

In her report, Smith also makes suggestions for a new coroner service that would be similarly well-trained and cohesive and, not surprisingly given the origins of her inquiry, have procedures aimed at detecting homicide, medical error and neglect. Smith favours a regional structure with both a medical and a judicial coroner and, at district level, a medically qualified coroner supported by one or more deputies and a team of coroners investigators who would replace the coroner's officers.

Both reports acknowledge that currently the coroners' activities are severely limited by the need for a death to be reported to them, and therefore recommendations have been made to expand the coroners' jurisdiction in each system and make access to them easier, particularly for bereaved families.

However, with regard to public inquests, both reports consider whether it is necessary to hold as many as at present. It is felt that deaths in some current categories should not automatically require an inquest and, interestingly, this includes cases of suspected suicide where the circumstances of death could be determined in private. Public inquests in the future would still be held into the deaths of persons detained under mental health legislation and a degree of public interest in uncovering failings in organisations would also favour an inquest.

Smith is particularly keen that deaths arising from medical neglect or error are rigorously investigated, but as before the coroner's conclusions would not determine civil liability. The right to refuse to answer questions that could lead to self-incrimination may be replaced by a requirement to answer all inquiries provided that they could not be used as evidence in any subsequent trial.

The wording of verdicts has been criticised for being meaningless or even offensive to the general public in its apparent simplicity in complex cases. The proposed alternative is a narrative outcome that provides a fuller account of the facts, including causation, and helps to identify risk areas that can be addressed in future.

The verdict of 'suicide' is proposed for consideration. This requires proof 'beyond reasonable doubt' and therefore great effort is expended in trying to ascertain whether the person truly intended to take their own life. Concern has been raised about the degree of distress caused to the family in doing this in the public arena. A more neutral statement of 'death from a deliberate act of self-harm or injury' is proposed as an alternative.

The need for a mechanism of appeal against the outcomes of coroners' investigations is emphasised in both reports and much greater public awareness of the new systems is hoped for.

References

- Allen, R. (2002) *Deaths Reported to Coroners. England and Wales, 2001*. London: Home Office.
- Department of Health (2001) *Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Stationery Office.
- Chambers, D. R. (1985) Medical evidence to the coroners court. *Medicine, Science and the Law*, **25**, 103–107.
- Coroner Review Group (2003) *Death Certification and Investigation in England, Wales and Northern Ireland. The Report of a Fundamental Review*. London: Stationery Office.
- Knapman, P. (1993) The crown's quest. *Journal of the Royal Society of Medicine*, **86**, 716–720.
- Knight, B. (1999) *History of the Medieval English Coroner System*. <http://www.Britannia.com/history/coroner1.html>
- Levine, M. B. (1995) The coroners' court: the past, the present and the future. *Medicine, Science and the Law*, **35**, 9–11.
- Levine, M. B. & Pike, J. (1999) *Levine on Coroners' Courts*. London: Sweet & Maxwell.
- Smith, J. (2003) *Third Report – Death Certification and the Investigation of Deaths by Coroners (The Shipman Inquiry)* (Cm 5854). London: Stationery Office. <http://www.the-shipman-inquiry.org.uk/thirdreport.asp>
- Tarling, R. (1998) *Coroner Service Survey*. London: Home Office.
- Williams, R., Morgan, H. G. & Davis, B. (2001) *Deaths of Detained Patients in England and Wales: A Report by the Mental Health Act Commission on Information Collected From 1 February 1997 – 31 January 2001*. Nottingham: Mental Health Act Commission.
- R v. HM Coroner for North Humberside and Scunthorpe, ex p. Jamieson* [1995] 1 Q.B.1.

Multiple choice questions

- 1 The coroner system:**
 - a originated in England
 - b was introduced in the Articles of Eyre
 - c was originally concerned with bringing criminals to justice
 - d has remained largely unchanged through history
 - e is in use in many countries around the world.
- 2 Concerning coroners in England and Wales:**
 - a they must hold medical and legal qualifications
 - b the majority are part-time
 - c they can be dismissed only by the Home Secretary
 - d they appoint their own deputy
 - e there are 123 coroners in England and Wales.
- 3 Concerning the role of the coroner:**
 - a they must investigate all reported deaths
 - b they must decide whether a post-mortem is necessary
 - c they are obliged to inform the media about an inquest
 - d they record data for the Home Office
 - e they are not permitted to question the witnesses.
- 4 Regarding an inquest:**
 - a the process is inquisitorial
 - b it is held in the Crown Court
 - c the intention is to identify those who are at fault
 - d members of the deceased's family can question witnesses
 - e a jury sits in a minority of cases.
- 5 Regarding giving evidence to an inquest:**
 - a witnesses are under oath
 - b witnesses can request anonymity
 - c witnesses can refuse to answer questions that may incriminate them
 - d an ordinary witness should offer an opinion on the facts of the case
 - e witnesses should use technical language wherever possible.

MCQ answers

1	2	3	4	5
a F	a F	a F	a T	a T
b T	b T	b T	b F	b T
c F	c F	c F	c F	c T
d F	d T	d T	d T	d F
e T	e T	e F	e T	e F