

Inquests and Coroners' Courts

The law relating to inquests is found in The Coroners' Act 1988 and Coroners' Rules 1994. Coroners are qualified as either lawyers or doctors.

When the Coroner must be informed of a death

The Coroner must be informed when someone dies unexpectedly. If anyone, including a doctor, is aware of circumstances requiring an inquest to be held they have a legal duty to inform the Coroner. The Coroner should be notified, for example, if there is any suggestion of medical error or there has been an accident or industrial disease leading to the death. Relatives who are concerned about the circumstances of a death can contact the local coroner.

The Registrar of Deaths is obliged to notify the Coroner in the following circumstances:

- Where the deceased has not been seen by a doctor after his death or in the 14 days preceding death;
- The deceased was not attended by a registered medical practitioner during his last illness;
- Death occurred during an operation or anaesthetic or within 24 hours of an operation;
- When the cause of death is unknown;
- If the death may have been caused by violence, neglect, abortion or suspicious circumstances;
- There is a suspicion of industrial disease or industrial poisoning;
- 'Stillbirth' where the child may have been born alive.

The Coroner may decide that the death was due to natural causes in which case a death certificate will be issued and there will be no inquest.

Purpose of the Inquest

To find out:

- Who has died;
- When and where they died;
- How (and in what circumstances) they died.

The Coroners' rules prevent the Coroner from apportioning blame for the death. However, the inquest can include an inquiry as to whether the death was caused by human fault or system failure.

Post-Mortem

The post-mortem will be carried out at the Coroner's request by a pathologist. Relatives are entitled to be represented by a medical practitioner at the post mortem or to have a second post-mortem carried out by their own pathologist. If the family are concerned about the deceased's treatment in hospital they can request that the post-mortem is not carried out by the hospital's own pathologist. Once a post-mortem has been carried out the funeral can take place. The Coroner will study the post-mortem report and unless he is satisfied that the death was by natural causes he will proceed to hold an inquest.

Will there be a jury?

The Coroner must sit with a jury if:

- Death was in prison or police custody;

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- Death was caused by an occurrence that needs to be reported to a government department;
- Death occurred in circumstances which may affect the health or safety of the public;
- The Coroner thinks it is necessary.

The family can make representations to the Coroner to sit with a jury if they have reason to suspect that the death was not a 'one-off', but occurred because of system failures, inadequate safety measures or where steps could be taken to avoid similar fatalities in the future.

Who can participate?

The inquest is held in public and anyone can attend, although parts of the inquest can be held in private. Interested parties can attend and question the witnesses and make submissions to the Coroner.

Interested parties include:

- Parent, spouse, child, personal representative of the deceased;
- Anyone whose actions may have contributed to the death;
- Chief officer of police;
- Anyone who the Coroner decides has 'proper interest'.

An interested person can be represented by a solicitor or barrister. If the Coroner agrees, they can be represented by someone who is not legally qualified. If there are concerns about the deceased's medical treatment the doctor or hospital are likely to be legally represented.

Although inquests are slightly less formal than normal Court proceedings, they are

often very emotional and many families find it easier if someone who is not emotionally involved can speak on their behalf. If a clinical negligence claim is likely to follow the inquest it will assist the family's solicitor to have the opportunity to question the doctors about the medical treatment.

Funding for representation at the Inquest

There is now limited provision for funding from the Lord Chancellor's Department for representation at an inquest. The Community Legal Service funding code guidance states that the applicant must be financially eligible and satisfy the Lord Chancellor that there is a significant wider public interest, that the deceased was an immediate family member and that the circumstances of the death appear to be such that funded representation is necessary to assist the Coroner.

Legal expenses insurers may be prepared to fund the inquest if there is cover in the policy for personal injury and death, particularly if a claim for compensation is likely to follow. If there is a successful clinical negligence claim, most of the costs of the inquest can be recovered along with the costs of the claim.

Disclosure of Evidence

The Coroner must supply interested persons with a copy of the post-mortem report and any documents put in evidence at the inquest, but these documents only have to be disclosed at the inquest. In practice most Coroners will release the post-mortem report and witness statements to the deceased's legal representative in advance of the inquest.

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It is arguable that where the Inquest is concerned with a potential breach of the deceased's right to life under Article 2 of the European Convention of Human Rights (ECHR) the requirement for an adequate and sufficient inquest may extend to the advanced disclosure of evidence and documents.

The deceased's medical records may be obtained under the Access to Health Records Act 1990. If a civil case is pending, application can be made to the civil Courts for disclosure of documents.

Procedure

Often the inquest is opened shortly after the death and then adjourned while the Coroner conducts his inquiry. Sometimes there will be a private pre-inquest hearing which interested parties attend and at which matters such as which witnesses to call and how long the inquest is likely to take are considered. The Coroner is assisted by his officers to gather evidence, obtain witness statements and liaise with the deceased's family. The Coroner's officer will supply a list of the witnesses that the Coroner intends to call to give evidence to the family's representative. The Coroner directs who will be called to give evidence but the family can make representations to the Coroner that additional witnesses should be called. The Coroner may be persuaded to call a particular witness if it can be shown that their evidence is relevant, important and not duplicated by others to be called. If the Coroner calls an expert witness to attend their fee will be paid by the Coroner. A witness will receive a formal summons to attend the inquest and will be fined if they fail to attend.

The Coroner may decide to obtain independent expert evidence to assist him.

If funding permits the family can obtain independent expert evidence in relation to issues such as the standard of medical care given to the deceased. Where such evidence is obtained and clearly indicates sub-standard care, it may be sensible to disclose the report to the Coroner on a confidential basis at an early stage. This will sometimes prompt the Coroner to obtain his own expert report, with a view to the Coroner's expert giving evidence at the hearing. It is sometimes possible for the family to agree with the NHS Trust or other treatment provider a single joint expert, and then invite the Coroner to call that expert. An independent expert's medical report considering the standard of medical care generally is admissible. However, the Coroner is not obliged to commission or call independent expert evidence or to allow the family to bring their own expert along to give evidence at the inquest.

At the inquest the Coroner will conduct proceedings. No-one wears robes and the Coroner is addressed as "Sir" or "Madam". Witnesses give evidence on oath. The Coroner calls and questions each witness first. The representative of a witness is the last to question them.

The pathologist who performed the post-mortem will be called to give evidence on his report. The family may find it distressing to listen to the details described by the pathologist and may prefer to leave the court whilst this evidence is given.

The witness at an inquest does not have to answer any questions that may tend to incriminate them. The standard rules of evidence do not apply and the Coroner can

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admit hearsay evidence in either written or oral form. At most inquests, potential witnesses are permitted to remain in Court throughout. The statement of a witness the coroner has decided not to call to attend can be read out in their absence. A Coroner has discretion to admit documents which he considers to be relevant and properly admissible, unless an interested party objects. If objections are raised, the document may still be admitted if the Coroner determines that the maker is unable to give oral evidence within a reasonable period. Any documentary evidence that a Coroner admits at an inquest must be read aloud, unless the Coroner directs otherwise. The latter situation might arise, for instance, in the case of a distressing suicide note in order to spare the feelings of the family.

Verdict

The Human Rights Act and the European Convention have had a significant impact on the way certain inquests are conducted in the UK. The ECHR has repeatedly interpreted Article 2 of the European Convention as imposing on member states substantive obligations not to take life without justification and to establish a framework of laws, precautions, procedures and means of enforcement that will, to the greatest extent reasonably practicable, protect life. The ECHR has also interpreted Article 2 as imposing on member states an adjectival procedural obligation to conduct "an effective official investigation" by an independent official body into deaths where there has been an arguable breach of the obligation not to take life and it appears that agents of the state are, or may have been, implicated. An NHS Trust would qualify as an 'agent of the state'. However, recent case law indicates that Article 2 only applies

in respect of medical treatment where there is evidence of gross as opposed to 'ordinary' negligence.

In England and Wales an inquest is the means by which the state ordinarily discharges its procedural obligation to investigate under Article 2, except where a criminal prosecution intervenes or a public inquiry is ordered into a major accident. To meet the procedural requirement of Article 2 an inquest ordinarily has to culminate with an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case. In some cases a short verdict in traditional form would suffice. However, in other cases "how" the deceased met their death needs to be interpreted in a broader sense than simply "by what means", and encompass "by what means and in what circumstances". This can be achieved by the Coroner delivering a narrative verdict.

When all the evidence has been heard the Coroner will sum up the facts. If there is a jury he will direct them as to the law. Interested parties can address the Coroner on matters of law. No-one may address the Coroner or the jury as to the facts. However, when addressing a Coroner as to what verdict should be considered or left for the jury it is difficult to do so without some passing reference to the facts.

There is no statutory or common law provision that a verdict has to be returned in a particular form. Some Coroners prefer narrative verdicts or brief, neutral, factual statements.

Short form verdicts include:

- Death from natural causes;

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- Death as a result of accident / misadventure;
- Suicide (and where appropriate "whilst the balance of his/her mind was disturbed");
- Unlawful killing;
- Death from industrial disease;
- Death from dependence on drugs/non-dependent abuse of drugs;
- Death from want of attention at birth;
- Death from attempted / self-induced abortion;
- Lawful killing;
- Open verdict;
- Stillbirth;
- Execution of death sentence.

Where appropriate short form verdicts may include the riders "contributed to by neglect" or "contributed to by self-neglect".

Prevention of similar fatalities

Rule 43 of the Coroners' Rules permits the Coroner to report to a person or authority, action that a Coroner believes should be taken to prevent the recurrence of similar fatalities.

Challenging a Coroner's decision

The Coroner's decision and/or the inquisition may be challenged by way of:

- Judicial Review;
- An application to the Divisional Court;
- An application to the High Court under the Human Rights Act 1998.

There are numerous grounds of challenge based upon public law principles. Courts are concerned with the fairness of the procedure and whether the Coroner has properly exercised his powers. Some of the grounds of challenge upheld in the past have included:

- Refusing to hold an inquest;
- Insufficiency of the inquiry in rejection of relevant and available evidence;
- Refusal to allow representatives to make submissions at the close of evidence;
- Pressure on the jury to return a particular verdict;
- Sitting too long with a jury without a proper break;
- Failing to address the jury on the standard of proof to be applied to a suicide verdict;
- Bias on the part of the Coroner such that he or she should have excused themselves.

This information sheet has been prepared to highlight some key issues relating to Inquests and Coroners' Courts. It is intended to be for general guidance only and is not a substitute for specific advice. It is based upon our understanding of the legal position as at September 2005 and may be affected by subsequent changes in the law.

For further information on inquests please contact: Patricia Fearnley on 01892 510000 or by email at patricia.fearnley@ts-p.co.uk.