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briefing

Inquests: the basics

Introduction

Benjamin Franklin said that “Nothing in life is certain except death and taxes”. The law makes provision for taxes and there are legal consequences of a death. One of the legal consequences is that when a death occurs in an unexpected, unknown or violent fashion a Coroner’s inquest may follow. It should not be taken to mean criticism.

The Coroner is an independent judicial officer. He will (usually) be a lawyer.

When is an inquest held?

Section 1 of the Coroners & Justice Act 2009 requires a Coroner’s investigation to be held if the Coroner has reason to suspect that a person has died:

- A violent or unnatural death;
- A death, the cause of which is unknown; or
- The deceased died while in the custody or otherwise in state detention – this also includes those subject to Deprivation of Liberty Safeguards and the Mental Health Act 1983.

The Coroner is under a duty to carry out preliminary investigations to determine whether there then needs to be an inquest hearing.

What is the format of an inquest?

An inquest is a fact finding exercise conducted by a Coroner to determine:

- Who has died?
- Where they died?
- When they died?
- How they died?
- And sometimes, by what means and in what circumstances they died?

It is important for everyone to remember that an Inquest is not a ‘trial’ and proceedings are not adversarial. Juries are not common but are necessary where the death:

- Occurred when the deceased was in custody or state detention and death was violent, unnatural or of unknown cause (if it was natural causes there is no need to call a jury);
- Was caused by accident, poisoning or disease which must be reported to a governor, department or inspector; or
- Resulted from an act or omission of a police officer in execution of his duty.

The Coroner may also decide to have a jury if he believes there is "sufficient reason" such as in complex or high profile cases. As a "rule of thumb", unless absolutely necessary, Coroners prefer not to call a jury.

There are no litigating parties to an inquest, merely "interested persons". Those who attend do so to "assist" the Coroner with his inquiry.

The inquest will generally take place in public and local press can come along.

What happens at an inquest?

The Coroner will generally welcome the parties to the inquest and explain its purpose. He alone decides which witnesses can give relevant evidence; he calls witnesses to the stand and asks the first set of questions.

All witnesses are required to testify on oath or affirm that the evidence they give is true.

An oath can be taken on any relevant holy book.

Generally the Coroner calls the pathologist to give evidence first. Otherwise the evidence of witnesses is usually given more or less in the same chronological order as the actual occurrence of events. It is for the Coroner to decide the order in which witnesses are called.

It is usual for witnesses at an inquest to sit in court until they are called to give evidence. After giving evidence witnesses may be "released" and may then leave court or stay if they prefer. It is good practice to wait until the next break before leaving. If not released, witnesses should remain in court.

Each witness will be asked questions by the Coroner first. Thereafter any interested person may ask questions of the witness. If the witness comes from a health and care organisation, the lawyer for that organisation will be the last person to ask questions.

If an interested person is not represented by counsel or a solicitor then the Coroner can assist them in the formulation of any questions they wish to ask. The Coroner has a positive duty to disallow any question which he considers to be not relevant or otherwise not a proper question. Questions which are intended to deal with issues of fault, blame or negligence are improper. In addition the Coroner should protect witnesses from humiliating, intimidating or abusive questions.

Potential conclusions

The conclusions which are most relevant are likely to be:

- Accident/Misadventure
- Open verdict
- Suicide

- Natural causes
- Alcohol/drug related
- Neglect

Where a person is suffering from a potentially fatal condition and medical intervention does no more than fail to prevent death, the underlying cause of death is the medical condition that proved fatal. In such a case the correct conclusion would be death from natural causes.

Where a person is suffering from a condition which does not threaten his life and undergoes treatment which leads to his death then, assuming there is no question of unlawful killing, the conclusion should be death by accident or misadventure.

Death by natural causes does not absolve anyone from fault (should there be any question of negligence) and death by accident or misadventure does not imply fault. The Coroner's conclusion is neutral.

If there is insufficient evidence to record any other conclusion an "open conclusion" may be recorded.

In more difficult cases, Coroners can give a "narrative" conclusion. This is a brief factual summary of the events which lead up to and caused the death. It should be neutrally worded so as not to imply or suggest fault.

A 'conclusion' of neglect

It is important to remember that conclusions of "neglect" are rare and (again) does not imply fault.

In this context "neglect" means a gross failure to provide adequate nourishment or liquid or provide or procure basic care or medical attention or shelter or warmth for someone in a dependent position who cannot provide it for himself. Failure to provide basic care for a dependent person whose physical condition is such as to show that he obviously needs it, may amount to neglect.

The required treatment can be for a person's mental condition if that is the area which obviously calls for medical attention, and a failure to provide mental health treatment can result in a neglect finding.

However there cannot be a finding of neglect unless there is a clear, causal connection between neglect and the death.

Most cases of neglect will be cases where there has been a failure to provide care rather than cases of providing the wrong type of care.

"Neglect" in the coronial sense has nothing to do with "negligence" as in civil negligence.

Can an inquest lead to a finding of negligence?

Strictly, the Coroner cannot frame a conclusion which leads to a finding of criminal or civil liability, including negligence.

However:

- The Coroner can reach a conclusion which makes it difficult to defend a negligence claim by, for example, deciding that a death was due to neglect

- The Coroner can make findings which make it difficult for the deceased's estate to bring an action in negligence by, for example, making it clear that there was no causal connection between the treatment the deceased received and his death

Article 2 right to life and narrative verdicts

Article 2 of The European Convention on Human Rights states that everyone's right to life shall be protected by law. This means more than the State's duty not to take life. It also includes a duty to:

- Take reasonable steps to protect life.
- Carry out a reasonable investigation of all deaths which occur where the deceased was in the care of the State at the time of the death.

Such insights normally arrive only when a patient is under the care of the state, for example, if someone is in custody or detained under the Mental Health Act 1983.

Where the inquest is being carried out to discharge the state's duty to hold an inquiry under Article 2, the Coroner will look carefully at the inquiry that the organisation has carried out into the death as part of his duty to understand the circumstances of the death.

An inquest to which Article 2 applies may well result in a narrative conclusion. A narrative conclusion may also identify matters that may reduce the risks to others in the future.

When should an organisation be represented at an inquest?

It is not necessary or appropriate to be represented at all inquests. However we advise you to consider being represented where:

- There is a reasonable possibility of a negligence claim being made arising out of the death;
- The family are legally represented and lawyers for the family may seek to "cross examine" witnesses;
- There is a possibility of a neglect conclusion or allegations which may adversely impact on the public standing of your organisation;
- There is a death in custody;
- There is a direct link between treatment or care and the death (such as the suicide of a mental health patient); or
- The death was of a high profile individual, attracts media interest or you have particular concerns about the potential consequences.

If you are considering whether you require representation please call us to discuss the matter on a confidential basis and we can offer you a risk assessment. See contact numbers below.

What should witnesses do if called to give evidence at an inquest?

The first thing to remember is that an inquest is not a trial and no one will be found "guilty" or held accountable in negligence.

As a checklist we would recommend:

- Inform your line manager, risk manager and/or legal services manager depending on your local protocol as soon as possible. Management will make a decision as to whether the trust should be legally represented. If the trust is to be legally represented at the inquest, make sure you work with the lawyers at all stages.
- Find out which other employees of your organisation have been called to give evidence and liaise with them.
- Obtain all of the relevant notes to acquaint yourself (if relevant) with the medical and care history.
- Check to see whether there is any outstanding complaint about the circumstances which led to the death.
- Prepare an accurate and comprehensive statement for yourself setting out what happened when you were involved in the case in chronological order, and use the notes to refresh your memory. It should be based on the facts alone not your opinion. See our separate advice note on writing statements.
- Check the contents of your statement with your line manager, risk manager and/or lawyer or legal services manager depending on your local protocol before it is seen outside your organisation.
- When approved, send your draft statement to the Coroner's Officer. Please be aware that it will be disclosed to the other interested parties, including the family, before the inquest.
- Provide the Coroner's Officer with any dates that you are unable to attend the inquest.

A post mortem

A Coroner is not under a positive duty to order a post mortem examination (PM) of the body of the deceased in every case but can do so if the cause of death is unknown. A PM may include a body scan.

If he directs or requests a PM this will override the wishes of the personal representative or family of the deceased. This will delay any funeral until the PM has been completed and the Coroner certifies that the body may be released for burial/cremation.

When a death occurs in hospital the PM should not normally be undertaken by a pathologist who is connected with a hospital if:

- The conduct of any member of hospital staff is likely to be called into question.
- A relative of the deceased objects to the hospital pathologist conducting the PM.

The hospital pathologist may also indicate that, in the circumstances, he does not wish to undertake the examination.

However, if the obtaining of another pathologist with suitable qualifications and experience would delay the PM unduly, then this rule does not apply.

If there is reason to believe that an inquest may be required to be held or a PM may be required then, unless the consent of the Coroner has been given, tissue for donation or a transplant cannot be removed from the body.

Legislation

Coroners and Justice Act 2009
Coroners (Inquests) Rules 2013
The Coroners (Amendment) Rules 2005
Human Rights Act 1998

Births Deaths and Registrations Act 1953
Registration of Births and Deaths Regulations 1987
Ministry of Justice & The Coroner's & Justice Act 2009

Cases

R (Middleton) v West Somerset Coroner HL 11/03/04
R (Sacker) v West Yorkshire Coroner HL 11/03/04

Publications and articles

Human Tissue Act – Post Mortem Examination

Mills & Reeve on-line inquest support

You will find this guidance and a lot more information and guidance documents on our free on-line support page.

There is also a set of videos with top tips on what to do and others tell their stories of who they got through the process. All designed to make it a little bit easier for you.

Follow the link or type in:
https://www.mills-reeve.com/foresight/inquests/information-on-inquests

Recent Feedback

"I'm most grateful for your support during the Inquest. It was outstanding. "
Executive Director Forensic Services, NHS Client

"I feel genuinely privileged to know that you are on our team and offer my heartfelt thanks"
Dr Stephen Merron, Consultant Anaesthetist, University Hospital North Midlands NHS Trust

Contacts

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