MILLS & REEVE
Achieve more. Together.

June 2019

briefing

The Role of the Coroner: what do they do?

Inquest rules & procedure: an overview

Introduction

The role of the Coroner has changed a lot in the eight centuries since the office was formally established in 1194. The Coroner started out as a medieval version of the fraud squad hunting down those who tried to evade paying taxes to the King by pretending to be dead. In the twenty-first century, the Coroner is an independent judicial officer charged with the investigation of sudden, violent or unnatural death. Further changes to Coronial procedures came into force on 25 July 2013. They are designed to last a lifetime...

We set out below some of the key points contained in The Coroners (Inquests) Rules 2013 (the Rules) and The Coroners (Investigations) Regulations 2013 (the Regulations).

Preliminaries

Who are the coroners?

The Chief Coroners' role is to monitor and modernise the process.

"Senior Coroners" are supported by "Area Coroners" (de facto deputies) and "Assistant Coroners". All coroners must be legally qualified before appointment.

Jurisdictions are merging to become large enough to support full time professional Coroners rather than a part-time service. The whole system has been "professionalised" with better training for Coroners with the aim of a more consistent approach and to reduce the amount of "local practice". However, differences of approach are still seen and different Coroners can still deal with matters in significantly different ways.

The Chief Coroner has been issuing "firm" guidance on various matters. These cover important areas of Coronial practice. They are strictly for 'guidance' and do not have the force of rules or regulations. That said, they have become 'highly persuasive' and almost always followed. These can be found on the judiciary website.

No more hanging around on the bench – the mandatory retirement age is 70.

Funding: who pays?

This is a difficult issue. The coronial service is funded by the relevant local authority. Following the changes brought by the new rules in recent years and the pressure on Coroners to complete investigations within six months, no new money has been made available to fund this "improved and faster" service.

This means, in our experience, Coroners continue to rely upon the good will of organisations to help with their investigations by obtaining statements, preparing reports, copying documents and disclosing papers. Naturally, it is always wise to help whenever possible and the local Coroner is likely to be grateful for all the help and understanding you can give.

The investigation

The Coroners and Justice Act 2009 (the 2009 Act) introduced the concept of a "coronial investigation". The whole process (including the inquest itself) is known as an investigation which commences as soon as a death is reported to the Coroner.

This means there does not have to be a formal "opening" of an inquest on notification which is then adjourned. The Coroner will wait until later in his investigation to decide whether or not to hold a formal inquest hearing. In our experience it is worth noting:

- in recent years, there has been a substantial reduction in the number of inquests which return a conclusion of "natural causes";
- the Coroner is empowered to issue a "report to prevent future deaths" at any point in time during the investigation and, if necessary, without a formal hearing (see below); and
- formal inquest hearings tend to be longer and much more complex with more difficult questions to be determined and a significant increase in the number of witnesses called to give evidence.

Duty to investigate

Under the 2009 Act the Coroner is obliged to investigate in the following circumstances:

> ***1 Duty to investigate certain deaths***
>
> *(1) A senior Coroner who is made aware that the body of a deceased person is within that Coroner's area must as soon as practicable conduct an investigation into the person's death if subsection (2) applies.*
>
> *(2) This subsection applies if the coroner has reason to suspect that:*
>
> *(a) the deceased died a violent or unnatural death,*
> *(b) the cause of death is unknown, or*
> *(c) the deceased died while in custody or otherwise in state detention.*

The 2009 Act refers to deaths in "state detention" which extends to immigration detention centres and secure mental health hospitals.

The Coroner is empowered to make preliminary enquiries to determine if the duty is engaged and an investigation is required.

The Coroner must attempt to identify the personal representative of the deceased's estate or "next-of-kin" and keep them informed.

The Coroner must not comment on or seek to determine matters of civil or criminal liability.

The purpose of the investigation

The 2009 Act reads as follows:

> ***5 Matters to be ascertained***
>
> *(1) The purpose of an investigation under this Part into a person's death is to ascertain—*
>
> *(a) who the deceased was;*
> *(b) how, when and where the deceased came by his or her death;*
> *(c) the particulars (if any) required by the 1953 Act to be registered concerning the death.*
>
> *(2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.*

If Article 2 Human Rights Act 1998 is engaged (for example in cases involving state detention), the Coroner needs to investigate the circumstances surrounding a death. This can lead to an inquest with a significantly wider scope looking in detail at the care and treatment within (or provided by) the state organisation along with policies and procedures. More witnesses are likely to be called. A jury may well be empanelled. If Article 2 is engaged, the conclusion of an inquest might use language critical of an organisation or an individual, although the Coroner has to take care with drafting as it would still be unlawful to determining matters of civil or criminal liability.

Interested persons (IPs)

An interested person is someone who has the right to participate in the inquest proceedings and to assist the Coroner adduce best evidence. They can be said to have an 'interest' in the outcome. This could be because of their relationship to the deceased or their involvement in the circumstances of the death. Both individuals and corporate bodies can be IPs.

An 'interested person' is defined in section 47(2) of the 2009 Act. This includes a long list of classes of people and organisations who may be deemed to be an IP. Interested persons can include:

- family members
- personal representative of the deceased's estate (i.e. the Executor of their Will);
- a beneficiary under a policy of insurance issued on the life of the deceased;
- a person who may have caused or contributed to the death of the deceased; and
- any other person who the Senior Coroner thinks has a sufficient interest.

It is for the Coroner to review the facts of each matter and to identify those who should be IPs. It is their obligation. That said, if an organisation or individual believes they should be an IP, it is appropriate to contact the Coroner highlighting the position.

The rights of IPs during an inquest include:

- to be notified by the Coroner with the details of the post mortem examination and toxicology reports;
- to be notified of the date, time and place of the inquest hearing within one week of the date being set;

- to be notified and to attend any pre-inquest hearing and make submissions;
- to receive disclosure of documentation held by the Coroner and which the Coroner considers is relevant to the inquest;
- to see written evidence and to object to it being adduced at a hearing; and
- to question witnesses at the inquest hearing.

Transfers

Investigations can be transferred between Coronial Jurisdictions. This can be done by the request of a Senior Coroner or by direction of the Chief Coroner. This can take place in order to transfer an investigation to a Coroner who is more experienced in handling a particular type of inquiry (e.g. major disaster) but could include transfer for the convenience of the family.

Although it is not likely to be a major problem, this involves organisations, on occasions, dealing with Coroners and attending inquests much further afield than they may be used to.

Post-mortem examinations (PME)

The Coroner has the power to order whatever type of examination he thinks necessary. This can include a partial post-mortem or a scan. A PME need not take place in the Coroner's district or neighbouring district (a provision often previously ignored). Any suitable and appropriate practitioner can be requested to conduct the PME.

There is considerable pressure on Coroners to reduce the costs of PMEs; some Coroners are grouping together to put the work out to tender. Scans are becoming more common.

After the PME

The Coroner has three options:

- if the PME reveals a death by natural causes the investigation can be discontinued;
- the matter may proceed to inquest even if the PME reveals a death by natural causes (e.g. if there is an issue of neglect); or
- to hold an inquest if:
    - there is still reason to believe the death was violent, unnatural or cause unknown; or
    - the deceased died in state detention.

If it is decided to hold an inquest, then it must be opened **as soon as practicable.**

Suspending the investigation or (if opened) the inquest

Three things to bear in mind:

- the Coroner **must** suspend an investigation if requested by a prosecuting authority which may involve a charge of homicide or related offence or where such a criminal charge has been brought;
- the Coroner **must** suspend an investigation if there is a public inquiry into the deaths; and

- the Coroner **may** suspend an investigation where he feels appropriate (e.g. Health & Safety Executive (HSE) investigation).

The inquest

The final part of the investigation, if one is held. Hearings are to be in public unless there are reasons of national security or if it is in the interests of justice not to do so.

Time is of the essence

Coroners are under pressure to deal with matters quickly for the benefit of families. As a "rule of thumb", inquests need to be completed **within six months** from the date the Coroner is made aware of the death. Inquests not completed **within 12 months** must be reported to the Chief Coroner, with an explanation for the delay.

An inquest does not have to be opened straightaway but as soon as reasonably practicable once the Coroner determines that the duty to inquire into the death arises. This can be at any time during the investigation but is most likely after the PME report is to hand.

Setting the date

Be prepared to get your witnesses and staff lined up immediately. **Dates** for future hearings should be set **straightaway** as far as possible. Organisations and their staff are much less likely to receive sympathy from Coroners if suitable and convenient dates are not provided and immediately upon request.

The Coroner must notify all interested parties within a week and make the arrangements for the inquest to be in public.

Pre-inquest hearings

These are an increasing feature. They remain discretionary. They are supposed to take place in public. The Coroner should set an agenda so all interested parties can prepare. See our briefing on pre-inquest hearings: https://www.mills-reeve.com/foresight/inquests/information-on-inquests

Disclosure

The basic principle is based upon transparency – both on the part of the Coroner and the interested persons.

Organisations need to be prepared to face censure if it is the case that "relevant documents or information" have not been sent to the Coroner.

Organisations should be prepared to answer questions in connection with their compliance with their statutory duties.

It is the **duty of the Coroner** to disclose documents but Coroners often rely on the good will of interested parties – especially large organisations.

The following points need to be noted:

- The Coroner **must** disclose relevant documents to interested parties upon request. To some this might be helpful. Disclosure should be by electronic means, where possible. The documents are set out in rule 13:

Disclosure of documents at the request of an interested person

13.—

> *(1) Subject to rule 15, where an interested person asks for disclosure of a document held by the Coroner, the Coroner must provide that document or a copy of that document, or make the document available for inspection by that person as soon as is reasonably practicable.*
>
> *(2) Documents to which this rule applies include—*
>
> *(a) any post-mortem examination report;*
> *(b) any other report that has been provided to the Coroner during the course of the investigation;*
> *(c) where available, the recording of any inquest hearing held in public, but not in relation to any part of the hearing from which the public was excluded under rule 11(4) or (5);*
> *(d) any other document which the Coroner considers relevant to the inquest.*

The Coroner can refuse to disclose if (rule 14):

- there is a statutory or legal prohibition (e.g. police reports);
- copyright issues arise and consent cannot be obtained;
- the request is unreasonable;
- the document relates to contemplated or actual criminal proceedings; or
- the Coroner considers the document is irrelevant to the investigation – and where the Coroner does not intend to rely on it.

The Coroner cannot charge for documents disclosed during an investigation.

The Chief Coroner has issued a law sheet - Case of Worcestershire (law sheet No. 3). This case considered the age old issue of what should be disclosed to the Coroner, given the likelihood of onward disclosure to all other interested persons going forward. In particular Rule 14 – Exceptions was considered as the Local Authority did not believe some documents should be disclosed to the other interested parties. The matter was considered by the High Court as to whether or not the Coroner should have disclosure from the Local Authority or not. The Court highlighted that it is a balancing exercise between disclosure and public interest.

The Court ordered that the Local Authority should disclose the documents to the Coroner. It will then be for the Coroner to consider whether or not disclosure to the other IPs is appropriate or not. During the course of the inquest the information was disclosed to the IPs.

Coroners' powers to require evidence

The Act makes it possible for the Coroner to require disclosure of documents from others. The 2009 Act gives the Coroner the power to summon witnesses and require the production of documents – with a £1,000 fine for default.

For the power to be exercised, the document must already exist (clinical notes or policy documents for example). The Coroner has no power to require a document be written or produced if it is not already in existence. This includes witness statements and reports. However most requests for statements produce a positive response from witnesses – the Coroner does have the power to summon a person to come and give evidence in person if they do not produce a statement.

In discussions, Coroners universally regard this power under the 2009 Act as a power to require production of investigation reports and internal statements from, and interview notes with, staff. In effect, this mirrors the civil courts' powers of disclosure/discovery.

The Coroner has the power (where appropriate) to direct evidence be given by video-link or from behind a screen.

Written evidence: rule 23

The Chief Coroner is encouraging Coroners to read evidence and admit documents to save money and time and to avoid witnesses being brought to court unnecessarily.

The relevant rule reads as follows:

> ***Written evidence***
>
> *23.— (1) Written evidence as to who the deceased was and how, when and where the deceased came by his or her death is not admissible unless the Coroner is satisfied that:*
>
> *(a) It is not possible for the maker of the written evidence to give evidence at the inquest hearing at all, or within a reasonable time;*
> *(b) there is a good and sufficient reason why the maker of the written evidence should not attend the inquest hearing;*
> *(c) there is a good and sufficient reason to believe that the maker of the written evidence will not attend the inquest hearing; or*
> *(d) the written evidence (including evidence in admission form) is unlikely to be disputed.*

Offences: beware!

There are some offences under the 2009 Act, including:

- failure to comply with a notice requiring evidence to be given or produced;
- altering evidence;
- preventing evidence from being given;
- destroying or concealing documents; and
- giving false evidence.

The rules on contempt of court apply to Coronial proceedings.

Recording proceedings

The Coroner is now obliged to take a recording of proceedings and is obliged to provide a copy of the recording to any interested party. The court office can charge £5 per recording.

Coroners no longer have to take a formal note and can rely upon the recording; though it is anticipated personal notes will still be taken.

Submissions: rule 27

No party can address the Coroner on the facts. Submissions on law only are permitted

Juries

Most of us who deal with inquests regularly know that Coroners tend to avoid juries, if possible. Cost and time are often cited as the reasons. A jury should be regarded as the exception to the general rule. The rules emphasise that inquests must be held without a jury except in limited circumstances.

A jury must be summoned if:

- the deceased died in custody or state detention and the death was violent, unnatural or cause unknown (there is no longer any need for a jury inquest where the deceased died in custody from natural causes);
- death resulted from an act or omission of a police officer in the execution of duty; or
- death was caused by accident, poisoning or disease which must be reported to a Government department or inspector.

There is a residuary power enabling the Coroner to call a jury if he believes there is "sufficient reason".

Public Funding for Families

Only in exceptional circumstances will this be available and where applicants qualify financially.

As an aide memoire (and not part of the rules) if requested to do so, the Lord Chancellor can authorise the funding of representation in individual cases. The Funding Code sets out the following alternative grounds of granting this "exceptional funding":

- there is a significant wider public interest in the applicant being legally represented at the inquest
- funded representation for the family of the deceased is likely to be necessary to enable the Coroner to carry out an effective investigation into the death, as required by article 2 European Convention on Human Rights (the right to life).

These tests are very difficult to satisfy. Historically less than 20% of requests are have been granted.

On 20 February 2015, Mr Justice Green in the High Court ruled in *R (on the application of Joanna Letts) v The Lord Chancellor* that the exceptional funding guidance was predicated upon legal errors. In light of the judgment, the Lord Chancellor has since amended the Guidance for Legal Aid funding in August 2015.

The Guidance sets out that funding will be provided where:

- the procedural obligation under Article 2 ECHR arises and, in the particular circumstances of the case, representation for the family of the deceased is required to discharge it.

A few more cases are now funded by Legal Aid but still very much the exception.

The conclusion of the inquest

The form which the Coroner or jury complete is called *The Record of the Inquest*.

The term "verdict" is thought to conjure up ideas of criminal proceedings so the term is "the conclusion". Short form conclusions and narrative conclusions can be given.

Conclusions will be set out on the record of the inquest

No conclusion can be framed as to appear to determine issues of criminal (on behalf of a named person) or civil liability.

The Coroner (or jury) must make a "determination" (to be recorded on the "record of the inquest") on the following questions:

- who the deceased was;
- when the deceased came about his or her death;
- where the deceased came about his or her death; and
- how the deceased came about his or her death (to include the circumstances in Article 2 cases).

After the inquest

The Coroner can charge for disclosure of documents and tapes after the inquest.

Appeal?

The means of redress and challenging decisions is by way of judicial review proceedings. Most organisations will not wish to incur the expense or additional publicity incurred by this. Complaints as to the conduct of a Senior Coroner can be made to the Chief Coroner.

Reports to prevent future deaths (PFD reports): Schedule 5 (of the 2009 Act) reports

It is worth noting the following points which arise from the regulations:

- The Coroner is under a duty to report when he or she feels some action might prevent future deaths. The report has to go to the person or organisation with power to take some action.
- Once the Coroner has concerns over an issue that might require action, he has no discretion and must issue a report.
- The duty arises at any time during the investigation. A report could be made even if there is no inquest or, if an urgent problem is identified, before the inquest is held.
- A response to such a report should include any actions proposed (if appropriate) and be accompanied by a timetable for implementation. The time limit for a response is 56 days.
- Reports and responses are sent to the Chief Coroner who will publish further.

PFD reports are already sent to other interested parties (including the family). For health and care providers they are usually sent to the CQC.

Coroners are under pressure to issue more reports as this is seen as an integral part of protecting the public and good governance. The Chief Coroner can follow up reports with relevant Government departments.

Although the chance to make submissions to the Coroner might be reduced if a PFD report is made before the inquest hearing, organisations are well advised to identify key risks and issues as soon as possible to demonstrate to the Coroner that action has already been taken before the final inquest hearing.

Please see our briefing on PFD reports for more detail.
https://www.mills-reeve.com/foresight/inquests/information-on-inquests

Conclusion

Inquests take on ever more the appearance of a civil trial. While blame and fault are not in issue, the pressure is on organisations to prepare the evidence and to assist the Coroner with all proper requests. Coroners set strict deadlines and timetables and demand compliance with hands-on “case management”. Coroners examine witnesses (those that are called) ever more closely.

When it comes to investigating ”PFD” issues, Coroners probe in detail. While organisations might have excellent investigation reports in place, completed action plans signed off by the board and a senior manager available to explain the changes to the Coroner, what about staff at the coal face? Will they be able to satisfy the Coroner that those changes and improvements to prevent future deaths and problems have been put into practice?

In addition to excellent action plans, you need to make sure they are implemented and communicated to the staff responsible, audit evidence will be helpful here to show that they are putting the changes into routine practice and can confirm this to the Coroner in the witness box.

Finally, if appropriate, it is essential that each organisation’s statutory duties have been complied with. Since Coroners are at liberty to ask witnesses about this and have been encouraged to do so!

Food for thought.

What should you do now?

Keep up-to-date with developments and the Chief Coroner’s guidance.

- Make sure your team knows the rules.
- Contact Stuart Knowles or any of our experienced inquest team (see below) to discuss and help. If you would prefer more in-depth training, we can put together a session for your team.

Legislation

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

Case Law

R (on the application of Joanna Letts) v The Lord Chancellor
R (on the application of Smith) (FC) (Respondent) v Secretary of State for Defence (Appellant) and another

Useful links

The Worcestershire Care (Law Sheet No. 3)
Chief Coroner Guidance – Judiciary Website
Lord Chancellor Guidance on Legal Aid Funding

Check out our additional briefings on pre-inquest hearings and PFD reports on the inquest support page.
https://www.mills-reeve.com/foresight/inquests/information-on-inquests

Mills & Reeve online inquest support

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

There is also a set of videos with top tips on what to do and others tell their stories of how 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

Feel free to contact our inquest specialists as any time:

Neil Ward
Partner
for Mills & Reeve LLP
+44(0)121 456 8202
neil.ward@mills-reeve.com

Jill Mason
Partner and Head of
Health & Care
for Mills & Reeve LLP
+44(0)121 456 8367
Jill.mason@mills-reeve.com

Duncan Astill
Partner
for Mills & Reeve LLP
+44(0)1223 222477
duncan.astill@mills-reeve.com