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INQUESTS

AND THE ROLE OF THE CORONER

A BRIEF GUIDE FOR CLIENTS

Freeth Cartwright LLP solicitors

MEDICO-LEGAL DEPARTMENT

In this information sheet, we have set out some of the details relating to inquests and the role of the Coroner. You must remember, however, that this information sheet is intended as a guide only and is not meant to be a full statement of the law and rules applying to inquests.

If you find yourself in a situation where an inquest is likely to be held into a death, we recommend that you take legal advice as soon as possible. Our experienced team of inquest advocates will be pleased to advise you.

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1. WHO IS THE CORONER?

The office of coroner is the second oldest in the English legal system, dating back to the Middle Ages. The Coroner is an independent Judicial Officer, who has a duty under statute to investigate sudden, violent or unexplained deaths. He or she must be legally or medically qualified with a certain minimum level of experience. Most coroners are appointed on a part-time basis, although there are full time Coroners, mainly in metropolitan areas.

The Coroner is assisted by Coroner's officers who are usually serving police officers, permanently seconded from the local police force. Office accommodation and administrative staff are provided by the Local Authority.

2. WHAT DEATHS MUST BE REPORTED TO THE CORONER?

All citizens have a duty to report sudden, violent or unexplained deaths to the Coroner. The Registrar of Births and Deaths also has a responsibility to inform the Coroner of deaths in a wide range of circumstances. Essentially, the coroner's role is to help the administrative process of registering deaths by finding out who died, when, where and how.

A death should be reported to the Coroner if: -

- The death cannot readily be certified as being due to natural causes.
- The deceased was not seen by a doctor within the 14 days prior to death.
- There is any element of suspicious circumstances.
- There is any history of violence.
- The death may be linked to an accident (whenever it occurred).
- There is any question of self-neglect or neglect by others.



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- The death has occurred or the illness arisen during or shortly after detention in prison or police custody (including voluntary attendance at a police station).
 - The deceased was detained under the Mental Health Act.
 - The death is linked with an abortion.
 - The death might have been contributed to by the actions of the deceased himself (such as a history of drug or solvent abuse, self injury or overdose).
 - The deceased was receiving any form of war pension or industrial disability pension unless the death can be shown to be wholly unconnected.
 - The death could be due to industrial disease or related in any way to the deceased's employment
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- The death was during an operation or before full recovery from the effects of the anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred).
 - The death may be related to a medical procedure or treatment whether invasive or not.
 - The death may be due to lack of medical care.
 - There are any other unusual or disturbing features to the case.
 - The death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care).
 - It may be wise to report any death where there is an allegation of medical mis-management.

This list of circumstances is not exhaustive. It represents not just those deaths, which are required by statute to be reported but also certain other circumstances in which deaths should be reported, according to the practice of the local Coroner. Each Coroner tends to have their own preferred practice and may require deaths in certain circumstances to be reported whereas other Coroners may not.

Roughly speaking, about one third of all deaths require reporting to the Coroner.



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3 WHAT HAPPENS FOLLOWING THE REPORTING OF A DEATH?

In some cases, the Coroner and his officers will carry out initial enquiries which show that the death was from natural causes. No further action will then be taken unless there are circumstances which require an investigation.

However, about three quarters of reported deaths require the Coroner to order a post mortem examination because the death was not obviously natural. In suspicious or complex cases the post mortem will be carried out by a Home Office – approved Forensic Pathologist. We can however advise whether further investigations are required. If the coroner insists on a post mortem it must be carried out.

If the post mortem reveals that the death was from natural causes the Coroner may decide that a formal inquest may not be necessary.

The Coroner is entitled to permit the pathologist to take tissue samples from the deceased if these are necessary for the post-mortem examination. The family will usually be told that this has happened, and can give a direction about how they wish those samples to be disposed of after they are no longer needed.

However, by law, the Coroner must hold an inquest into a death where there is reasonable cause to suspect that the deceased:-

- (a) had died a violent or unnatural death; or
- (b) has died a sudden death of which the cause is unknown; or
- (c) has died in prison or so as to require an inquest under any Act of Parliament.

In general terms, the Coroner has a duty to hold an Inquest in any case where the death cannot be certified as being of natural causes. Deaths, which occur in prison will require an Inquest, even where they appear to be from natural causes.

In cases where there is a possibility that criminal charges will follow the Inquest, the Coroner is under a general obligation to refer the matter to the Police or Crown Prosecution Service before he proceeds with the Inquest. The Inquest is usually adjourned until after the criminal charges are dealt with.

The Coroner must investigate a death where the body lies in his district. His duty to investigate is not dependent upon where the death occurred, but rather where the body is. Therefore, the Coroner has to enquire into deaths, which occurred overseas if the body is returned to his district for burial.

4. THE INQUEST

a) Opening – this is a formal first step. Usually no one needs to be present. The Coroners Officer will confirm the identity of the deceased and the Coroner will issue a temporary death certificate, which is accepted by most funeral institutions. He may also release the body. Sometimes a Coroner will ask the family to attend, for example to provide background information. The Inquest is then adjourned for the Coroner to complete his enquiries.

b) Resumption - the inquest will be resumed when the Coroner has completed his investigations. We would wish to obtain copies of all statements and records in order to prepare to represent you at the resumption of the inquest. Only the Coroner can call witnesses and decide what documents are used but sometimes we can help the Coroner by suggesting lines of enquiry. Evidence is usually given in person, under Oath (as in a criminal trial). Some uncontentious documents can be admitted as evidence without needing to call the author or maker of the statement.

c) Juries

Most Inquests are held before a Coroner alone. However, the Coroner must hold

the Inquest before a jury of between 7 and 11 people if the death occurred in

prison or police custody or in circumstances reportable to a government Inspector. The Inquest may also be before a jury where the death

occurred in

circumstances where important issues may be raised, such as public health and



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safety. Such circumstances rarely occur. Jury members are just ordinary

members of the public selected in the same random way, as juries in criminal cases.

c) The issues

The Inquest itself is often the only occasion on which a particular death is investigated. Relatives of the deceased often want to find out who was responsible for the death. The Coroner is expressly forbidden from enquiring in to blame or guilt. The Coroners Rules state that the proceedings and evidence at an Inquest should be directed solely to establishing: -

- (a) who the deceased was;
- (b) how, when and where the deceased came by his death;
- (c) the particulars required by the Registration Acts
- (e.g. occupation of the deceased etc.)

Neither the Coroner nor the Jury is allowed to express an opinion on any other matter (including blame or guilt).

The Coroners Rules further restrict the Coroner by stating that the verdict cannot be framed in such a way as to indicate either criminal liability on the part of the named person or civil liability on the part of a named person or organisation. The rules of evidence at an Inquest are less restrictive than in civil and criminal courts, in order to enable the Coroner (and the Jury) to come to a conclusion as to how, when and where a death occurred. Consequently, it is felt that in such circumstances it would be wrong for the question of blame or guilt to appear to be determined by the Coroner.

e) In cases in which the death occurred whilst the deceased was being cared for by any agency of the State the Human Rights Act may require



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the Coroner to hold a wider inquiry in order to establish both how and in what circumstances the deceased died.

Whilst relatives may be disappointed to learn that the Inquest will not determine who was to blame for the death, it can still be of help to them in finding out more about the death. For example, it may achieve the following:

- a conclusion about the death based upon the facts rather than rumours and allegations
- an independent examination of a death, so that there is no suggestion of a cover-up by any person or organisation
- information about the death which relatives might otherwise not have obtained
- persuade the Coroner to make recommendations so as to prevent similar deaths in the future, so satisfying relatives that at least something will be done and lessons learnt.

f) Questions

If there is likely to be a legal claim for compensation following a death, it is very important that the Claimant's solicitor knows about the Inquest. Although the Inquest will not decide any issues relevant to the compensation claim, such as who was to blame for the death, the Inquest does allow the Solicitor to ask questions of the witnesses and obtain information which would otherwise not be disclosed. The Solicitor is only allowed to ask questions which relate to the cause of death. If the Coroner does not like a particular line of questioning, or does not think it will help him (or the jury) to reach a verdict, he is entitled to rule that the question does not need to be answered. The Coroner decides which witnesses to call and can ask them what he wants and make whatever observations he likes. It must be remembered that the Coroner is holding an inquiry. All interested parties are there to help with the inquiry so it is not like an adversarial trial held in the Crown Court.



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5. VERDICTS

As stated above, the purpose of an Inquest is to establish who died and how, when and where the deceased came by his death. The Coroner is therefore required to state his finding as regards: -

- the identify of the deceased
- the medical cause of death
- the time place and circumstances in which the deceased died
- and his verdict.

There are a number of verdicts which may be reached and they include the following: -

(i) **Accidental Death**

This means that the death was not due to natural causes but due to some other factor or person. It does not mean that the death was a "pure accident" (i.e. no one to blame) but nor does it mean that someone or something might not later be held to have been at fault. It rules out the possibility that someone deliberately caused the person's death.

(ii) **Death by Misadventure**

This covers a death arising from circumstances in which the deceased either played a part or consented to a known risk of some significance (e.g. major surgery). This verdict is generally unpopular with the Coroners currently as it is not very different from Accidental Death.

(iii) **Suicide**

The deceased took his own life. This must be proved beyond reasonable doubt. Because suicide victims usually die alone, there is often no supporting evidence to confirm a death was suicide. Therefore in some cases of apparent suicide, an open verdict is recorded.

(iv) **Natural causes**

The deceased died a natural death, with no intervening factors.



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(v) Unlawful killing

This is the only verdict which indicates that someone might have been directly to blame for the deceased's death. A total indifference to the deceased's welfare must be shown and this verdict must be proved beyond reasonable doubt. This is an extremely rare verdict, because usually if a verdict of unlawful killing is contemplated the case will be handed over to the Crown Prosecution Service before the Inquest takes place. If there is such a verdict it does not necessarily follow that criminal charges will be brought in respect of such a death. The police and Crown Prosecution Service will be aware of the verdict but they have different criteria for assessing whether or not to bring criminal charges against any person. The Coroner is simply concerned with establishing how the deceased came by his death, not who was to blame for that death, nor whether there is sufficient evidence as to who was to blame.

(vi) Death due to Lack of Care

This is a verdict used increasingly in recent years, which can either be a verdict on its own or added to another verdict such as "accidental death aggravated by lack of care". It has been suggested that this wording should be replaced by the concept of "neglect" as essentially, it means no care or treatment at all, rather than that the care given was inadequate. This is not the same as negligence. As we have seen the Coroner's Court does not concern itself with civil liability.

(vii) Open Verdict

This is where a Coroner or Jury is unable to reach a conclusion as to the cause of death. This means there is no decision made as to how the deceased died. It is however a final verdict.

(vii) Narrative verdicts

As an alternative to a formal verdict a Coroner may decide simply to describe in words how the deceased came by his death or ask the jury to provide answers to a series of questions. This may provide much more information to relatives than the more traditional form of verdict.

6. OTHER DUTIES OF THE CORONER

Where a death is reported to the Coroner, no organs may be removed from the body without the Coroner's permission. A request for transplantation must therefore be made to the Coroner and although the Coroner will agree to a transplant where possible there are difficulties when the death arises from a criminal act because evidence has to be preserved.

The coroner has responsibility for, and control of the body from the time of the person's death until he releases the body to relatives for burial or cremation, usually when the inquest has been opened. Until released, the body is the property of the Coroner, and he is entitled to make decisions about the body. The Coroner will usually involve the family in any situation where difficult or upsetting decision may be required.

If there is a major civil disaster, such as at Hillsborough and on the Herald of Free Enterprise, then the Coroner may also be involved with the emergency services in organising body retrieval, identification and temporary mortuary organisation.

The Coroner also has a duty to hold treasure trove enquires. If someone finds gold or silver then a jury must decide whether it is treasure trove or not. To be treasure trove, the gold or silver must be shown to have been hidden, with a view to recovery at a later date, rather than simply being lost or abandoned. If the conclusion is that the property was simply lost or abandoned then it will be left to the finder and the owner of the land where it was found to argue over. If the conclusion is that it was hidden then it will be declared treasure trove and will be ordered to be seized by the Crown. When seizing the treasure, the Crown (in the form of the British Museum) must pay the finder a reward equivalent to the full market value of the treasure.

7. PAYING FOR REPRESENTATION

We would be happy to advise on how you can pay for representation at an inquest. This could be:

- a) on a private basis
- b) public funding
- c) trade unions
- d) legal expenses insurance
- e) no win no fee if a civil claim is being considered.



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8. FURTHER INFORMATION

This information sheet is not exhaustive and although all Coroners must comply with the Coroners Rules 1984, Coroners do have a certain discretion and practice does therefore vary from Coroner to Coroner. The new Coroners and Justice Act 2009 will change some of the above guidance when the Act comes into force probably in 2012. Readers are strongly advised to seek professional guidance if they are likely to be concerned with an Inquest. We offer a free review at an initial interview or by telephone without obligation. Home or hospital visits can also be arranged.

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