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Inquests & Loss of Life Claims

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About the Coroner

- **Independent judicial officer**
- **What does a coroner do?**
  - **-who**
  - **-where**
  - **-when**
  - **-how**
- **Coroners officer**

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Coroners look into violent or unnatural deaths, sudden deaths of unknown cause, and deaths which have occurred in custody or state detention.

The coroner will establish whether an inquest is required. If an inquest is held, the coroner will establish the identity of the person who has died, and where, when and how the person came by their death.

Inquest will not looks at a crime or negligence. It is to determine what happened.

The coroner can assist in the prevention of future deaths. The coroner has a power to report the circumstances of a case to an appropriate authority. Such a report can be a very useful tool in ensuring that similar fatalities are avoided.

Coroners' officers work under the direction of coroners and liaise with bereaved families, the police, doctors, witnesses, mortuary staff, and funeral directors. They gather all documents/witnesses etc under the direction of the coroner.

The Coroners and Justice Act 2009 ("the 2009 Act") made a number of changes to the coroner system. It created a new national head of the coroner system, the office of Chief Coroner. It introduced the new concept of "*investigation*" into a death.

Source: https://www.judiciary.uk/wp-content/uploads/JCO/Documents/coroners/guidance/chief-coroners-guide-to-act-sept2013.pdf

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Reporting a Death the Coroner

- Not all deaths are reported - Medical certificate of the cause of death (MCCD) can be provided

- Reported deaths:
  - poisoning/chemicals
  - trauma/violence/physical injury
  - self harm
  - notifiable accident/incident
  - neglect or failure of care
  - unnatural death of some sort
  - death in custody

- Anyone can report a death to the coroner if they believe it needs to be and hasn't been done so

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Not all deaths are reported to the coroner.

In many cases the GP, or a hospital doctor who has been providing treatment during the final illness, is able to issue a Medical Certificate of the Cause of Death (MCCD) without reference to a coroner.

When is a death reported to a coroner?

A death should be reported to the coroner when a doctor knows or has reason to believe that the death:

- Occurred as a result of poisoning, the use of a controlled drug, medical product or toxic chemical;
- Occurred as a result of trauma, violence or physical injury, whether inflicted intentionally or otherwise;
- Is related to any treatment or procedure of medical or similar nature;
- Occurred as a result of self-harm, (including a failure by the deceased person to preserve their own life) whether intentional or otherwise;
- Occurred as a result of an injury or disease received during, or attributable to, the course of the deceased person's work;
- Occurred as a result of a notifiable accident, poisoning, or disease;
- Occurred as a result of neglect or failure of care by another person;
- Was otherwise unnatural.

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The coroner should also be informed where:

- The death occurred in custody or otherwise in state detention – of whatever cause.
- No attending practitioner attended the deceased at any time in the 14 days prior to death or no attending practitioner is available to prepare a MCCD.
- The identity of the deceased is unknown.

Can anyone else report a death to a coroner?

If someone believes that a death has not been reported to the coroner when it should have been, they may report the death to the coroner themselves. This should normally happen before there has been any interference with the body and before a funeral takes place.

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The Investigation

- Is a post mortem necessary?
- Will a post mortem lead to an inquest?
- An inquest is only part of the investigation
- Preliminary inquiries:
  - should there be an investigation?
  - Does Article 2 of the European Convention on Human Rights apply?
- Inquiries lead to a decision - inform the family/next of kin of deceased

The coroner's investigation into a death

The coroner may decide that a post mortem examination and inquest are not necessary because the cause of death is clear and there is a doctor who can sign the Medical Certificate of the Cause of Death (MCCD) to that effect. In such cases, the coroner will advise the Registrar of Births and Deaths that no further investigation is needed.

The coroner may ask a pathologist to examine the body and carry out a post mortem examination (also known as an autopsy). If so, the examination must be undertaken as soon as possible.

The 2009 Act introduces the new concept of the coroner's "*investigation*" into a death. An inquest is only part of the investigation, and may not be necessary. A lot of the coroner's work actually takes place before any formal inquest hearing. It also allows the coroner time to consider whether the duty to hold an inquest applies in a particular case, rather than having to open an inquest as soon as practicable.

Preliminary inquiries

The new statutory regime permits a coroner to make preliminary inquiries to see whether there should be an investigation. The coroner may make whatever inquiries seem necessary.

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Purpose of the investigation

The coroner's investigation will seek to determine:

- who the deceased was; as well as
- where, when and how the deceased came by his or her death

In deaths where Article 2 of the European Convention on Human Rights applies, the question of "how" is treated more broadly and is to be read as including:

- by what means and in what circumstances the deceased came by his or her death

If the coroner decides to investigate the cause of death he must identify the deceased's personal representative or next of kin and inform them of the decision.

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The Post-Mortem Examination / Autopsy

- An independent, judicially authorised medical examination to ascertain the cause of death
- Pathologist examines and reports
- Can include CT Scans, MRI scans, tests of organs, tissues or fluids
- Determines the medical term for the death
- Ability to request a non-invasive post mortem - Article 9 HRA

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The coroner's post-mortem examination is an independent, judicially authorised medical examination to ascertain the cause of death.

The coroner's post-mortem examination is also referred to as an autopsy.

The coroner will often need to instruct a pathologist to examine the body and report on the medical cause of death. This will be to ascertain whether the death was natural and how, in medical terms, the death occurred.

The term "*post-mortem examination*" can include other forms of examination other than the invasive post-mortem examination (autopsy). Cross-sectional imaging (the results of a CT scan or MRI scan) may also be used where appropriate. See the Chief Coroner's Guidance No.1 The Use of Post-Mortem Imaging (Adults).

The term "*post-mortem examination*" also includes the examination or testing of organs, tissue or fluids (which may be requested after the initial autopsy has been carried out).

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In relation to Article 9 - Coroners Guidance notes are:-

1. There must be an established religious tenet that invasive autopsy is to be avoided before any question of avoidance on Article 9 grounds arises.
2. There must be a realistic possibility – not a more than 50/50 chance – that non-invasive procedures, which can include a CT scan and a coronary angiography but also the growth of blood and urine cultures, will establish the cause of death.
3. The whole post-mortem examination must be capable of being undertaken without undue delay.
4. Critically, the performance of non-invasive or minimally invasive procedures must not impair the effectiveness of an invasive autopsy if one is ultimately required. That is of course a matter of judgment for the coroner.
5. There must be no good reason (founded on the coroner's duty to ascertain how, when and where the deceased came by his or her death) to require an immediate invasive autopsy in any event. A forensic autopsy in a homicide case will either always, or almost always, be required and the need for it will either always, or almost always, override any religious objection.
6. Non-invasive procedures must be capable of being performed without imposing an additional cost burden on the coroner.

In this case the family agreed to discharge the cost. In other cases facilities at no additional cost may be available to coroners.

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After the Post-Morten Investigation

- Does the investigation continue?
  - Natural cause of death
  - Natural cause of death warrants more investigations
  - Violent or unnatural death or unknown cause of death or died in custody
- Releasing the body
  - As soon as practicable
  - Longer than 28 days?

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Once the post-mortem process (including any histology or toxicology) has concluded, the coroner must decide whether to continue the investigation.

There are three main options:

- The post-mortem reveals that the deceased died of natural causes and the coroner thinks that it is not necessary to continue the investigation. The coroner must discontinue the investigation. No inquest will be held.
- The post-mortem reveals that the deceased died of natural causes but the coroner considers that it is necessary to continue the investigation. This could include cases where neglect might be a factor and the coroner wishes to test this at inquest. The coroner must then hold an inquest and must open the inquest as soon as practicable.
- If after the post-mortem the coroner (still) has reason to suspect that the deceased died a violent or unnatural death, or the cause of death is unknown or the deceased died while in custody/state detention The coroner must hold an inquest and must open the inquest as soon as practicable.

Releasing the body for burial or cremation

The regulations require a coroner to release the body for burial or cremation as soon as practicable. If the coroner cannot release the body within 28 days of being made aware that the body is within his or her area then he or she must notify the known next of kin or personal representative of the deceased of the reasons for the delay.

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Before the Inquest

- **6 months to complete from the date the coroner is made aware of the death or as soon as reasonably practicable**
- **Pre-Inquest Reviews – scope/any matters of concern/agenda/written submissions**
- **Interested parties receive relevant documents**

Documents:

1. **Any post-mortem examination report**
2. **Any other report that has been provided to the coroner during the course of the investigation**
3. **Any other document which the coroner considers relevant to the inquest**

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Under the new rules the inquest must be completed within six months from "*the date on which the coroner is made aware of the death, or as soon as is reasonably practicable after that date*".

Pre-Inquest Review Hearings; The coroner may hold one or more hearings before the inquest itself. These are known as pre-inquest review hearings, where the scope of the inquest and any matters of concern can be considered. Where possible coroners should set out an agenda in writing in advance of the hearing and, where appropriate, invite written submissions to be considered at the hearing.

Providing Information and Documents

Under the rules a coroner must normally disclose copies of relevant documents to an interested person (e.g. the next of kin) on request, at any stage of the investigation process.

The rules list the documents that should be provided:

- Any post-mortem examination report
- Any other report that has been provided to the coroner during the course of the investigation
- Any other document which the coroner considers relevant to the inquest

There are restrictions on providing documents and a coroner may refuse to provide a document or a copy of that document in certain circumstances.

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The Inquest

- **Witnesses**
- **Witness evidence**
- **Expert evidence**

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Witness Attendance and Evidence

Where possible coroners should set out in advance of the hearing for all interested persons an agenda in writing and where appropriate invite written submissions to be considered at the hearing.

Upon attendance at the inquest witnesses must give evidence under oath, or affirmation if they prefer, unless they are too young to do so.

Written evidence is also provided to the coroner prior to the inquest taking place. The coroner will review this evidence prior to the inquest and decide whether it is necessary to call upon each witness to provide evidence in person. There are occasions that the coroner will not feel this to be appropriate.

The coroner leads the inquest and takes witnesses through their evidence asking all relevant questions.

Interested persons (or their representatives), and the jury if applicable, are permitted to ask questions of witnesses.

Expert Evidence

There is a distinction between witnesses of fact and expert or professional witnesses. Expert witnesses are able to give opinion evidence and are entitled to be remunerated for giving evidence.

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The Proceedings

- **Disclosure**
- **Recording of Proceedings**
- **Inquest by Jury**
- **Length of the Inquest**

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Prior to the proceedings, disclosure of relevant information should be made.

Disclosure should be by electronic means where possible (or inspection made available).

A coroner must normally disclose copies of relevant documents to an interested person at any stage during the investigation process and include:

- Post-Mortem examination report
- Any other report provided to the coroner during the course of the investigation
- Any other document which the coroner considers relevant to the inquest

A coroner may refuse to provide a document or a copy of that document where:

- There is a statutory or legal prohibition on disclosure
- The consent or an author/ copyright owner cannot be reasonably obtained
- The request is unreasonable
- The document related to contemplated/ commenced criminal proceedings
- The coroner considers the document to be irrelevant to the investigation

The coroner is required to make a recording of all inquest proceedings. The duty to record proceedings relates to the main inquest hearing and any pre-inquest review hearings.

The inquest proceedings are recorded and a copy of the CD can be obtained.

Is a Jury Required at an Inquest

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An inquest must be held without a jury apart from in the following circumstances.

A jury must be summoned where:

- the deceased died while in custody or state detention, and the death was violent or unnatural, or of unknown cause;
- the death resulted from an act or omission of a police officer or member of a service police force in the purported execution of their duties; or
- the death was caused by an accident, poisoning or disease which must be reported to a government department or inspector. This includes, for example, certain deaths at work.

Jury inquests are no longer required where the deceased died in prison, unless the coroner has reason to suspect that the death was unnatural or of unknown cause.

In relation to deaths in hospitals and nursing homes, some deaths in the healthcare sector fall within the requirement to have a jury at an inquest. A Health and Safety Executive information sheet provides examples as:

- a confused patient falling from a hospital window on an upper floor;
- a patient being scalded by hot bath water where the patient was vulnerable and adequate precautions were not taken;
- a resident falling in the lounge area, where there is a history of falls but reasonably practicable measures had not been put in place to reduce the risks;
- a resident falling out of bed, where an assessment had identified the need for bedrails (or other preventative measures) but these had not been provided.

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How Long will an Inquest Take?

An inquest can be listed for as little as one day, or as long as several weeks depending on the severity of the incident and the amount of witnesses to be heard.

As previously advised, the coroner has authority to order that not all witnesses be called to give oral evidence and this can very much vary the length of the inquest.

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Possible Conclusion of the Inquest

- Accident or misadventure
- Alcohol or drug related
- Industrial disease
- Lawful or unlawful killing
- Natural causes
- Open
- Road traffic collision
- Stillbirth
- Suicide
- Use of a Narrative

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The word "*verdict*" is no longer used. This is because this is now the expression used in relation to criminal proceedings.

Verdicts are now known as conclusions.

The conclusion of an inquest does not determine any criminal or civil liability but the recording or transcript of the inquest and of course the conclusion can be used as guidance by the CPS when considering any criminal proceedings and the estate of the deceased in relation to a claim for compensation.

Generally, the coroner's conclusion will be one of the following:

- Accident or misadventure
- Alcohol or drug related
- Industrial disease
- Lawful or unlawful killing
- Natural causes
- Open
- Road traffic collision
- Stillbirth
- Suicide

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Alternatively, or in addition to one of the short-form conclusions above, the coroner (or jury) may supply a narrative conclusion.

Narrative conclusions must be directed to the issues which are "*central*" to the cause of death or to the "*disputed factual issues at the heart of the case*". The coroner does not have to state a conclusion on every issued raised.

Where a jury is invited to write a narrative, the coroner may elicit the conclusion either by identifying the issues and providing them with examples of possible narrative conclusions or to provide them with written questions in the form of a questionnaire (the answers will stand as the narrative conclusion).

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Are the General Public able to Establish the Conclusion to an Inquest

All inquests must be held in public in accordance with the principle of open justice.

Therefore, members of the public and journalists have the right to attend. Whether a journalist attends an inquest and reports upon this is a matter for them.

However, parts of a very small number of inquests may be held in private for national security reasons.

In addition, sensitive information such as suicide notes and personal letters will not usually be read out at the inquest, unless the coroner decides it is important to do so. If they are read out, their contents may be reported upon.

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Reports to Prevent Future Deaths (PFD reports)

For a long time it has been recognised that an important consequence of inquests is avoiding the repetition of inappropriate conduct and in encouraging beneficial change. If a coroner believes that action needs to be taken in the interest of preventing future deaths they are obliged to report this to a person who has authority to take such actions.

Once the report is made, action is to be taken to eliminate or reduce that risk.

The coroner may recommend that action should be taken, but not what that action should be.

The time limit for responding to the coroner's report is 56 days.

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Cases Involving Children

Cases where a child has been bereaved are of particular sensitivity.

The Childhood Bereavement Network have recognised this and made a number of observations:

- *"Bereaved children and young people need to understand the cause of death."*
- *"Gossip in local communities can impair children and young people's ability to build an accurate picture of what has happened. It can upset them greatly and be seen as disrespectful to the person who has died. Coroners should take this into account when liaising with the press."*
- *"Some family members find it difficult to communicate with each other following a death. Coroners must be aware that sometimes one member of the family cannot represent the whole, and must make arrangements for all interested parties to be involved."*
- *"Coroners must be aware that it is natural for family members not to speak openly. This can be especially relevant with regard to children. Adults in the family often have an inbuilt desire to protect which can leave children with an incomplete picture, together with a sense that this subject is not to be talked about. Often a more emotionally neutral third party like a Coroner or specialised child bereavement service can be a useful starting point to give parents the confidence to involve their children in matters that affect them greatly."*

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Clinical Negligence Claims

When all the facts about the cause of death are known it is possible that civil proceedings may be brought and a claim for damages made by way of clinical negligence claim.

It is important to remember that an accidental verdict does not automatically prevent a clinical negligence claim from being pursued, the burden of proof is different in both cases. Similarly, a finding of lawful/unlawful killing does not automatically mean a claim for damages will be successful.

In cases where death is due to medical negligence, personal injury or accident it is possible to make a claim on behalf of the deceased's Estate for the following:

- Damages for pain and suffering prior to a person's death
- Financial losses incurred by the person who has died before their death (this might include expenses incurred, or loss of earnings whilst in hospital)
- Financial losses incurred by the estate as a result of the death, for example funeral expenses
- A claim for financial dependency for those financially dependent upon the deceased, normally their spouse or children. This claim is made in relation to The Statutory Bereavement Award which is a fixed sum, currently £12,980 for a death occurring after 1st April 2013. This can only be claimed by the husband or wife of the deceased, or the parents (if the deceased was under 18 and unmarried)

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Human Rights Act – The Right to Life

- Article 2 of the Human Rights Act - encompasses an obligation on the state to protect life by a system of laws
- Investigative obligation - a means of investigating deaths whereby the state may be responsible
- Effects the 'how' element of the Coroner's investigation

  - by what means and in what circumstances the deceased came by his/her death

The duty to investigate arises in:

- A death in prison or in state custody
- A police shooting
- The death of a detained psychiatric patient
- The death of a voluntary psychiatric patient, where the patient was vulnerable

A death in a hospital due to alleged clinical negligence, would not ordinarily require an Article 2 inquest if a civil claim can be made.

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Deprivation of Liberty Safeguarding (DoLS)

- **The use of DoLS is widespread and increasing with most cases concerning vulnerable people with dementia.**
- **Any detention amounting to deprivation of liberty must be authorised under the statutory scheme otherwise = unlawful detention.**
- **Death occurs at a time when an individual is deprived of their liberty under the mental Capacity Act 2005.**
- **When a death occurs it should be reported to the coroner and the death must be investigated. The investigation cannot be discontinued.**

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Guidance on Deprivation of Liberty Safeguards (DoLS)

In December 2014 the Chief Coroner issued Guidance on Deprivation of Liberty Safeguards (DoLS).

This guidance concerned persons who die at a time when they are deprived of their liberty under the Mental Capacity Act 2005 (MCA 2005). Under the MCA 2005 a person who lacks capacity and is in a hospital or care home for the purpose of being given care or treatment may be detained in circumstances which amount to deprivation of liberty.

No detention amounting to deprivation of liberty may be permitted without authorisation under the statutory scheme. It would amount otherwise to false imprisonment. The MCA 2005 was amended by the Mental Health Act 2007 to provide a new statutory scheme for persons in hospitals or care homes who were proved on a balance of probabilities to lack capacity. The scheme, set out by the MCA 2005, provides safeguards known as Deprivation of Liberty Safeguards (DoLS).

The Chief Coroner has noted that:

- The use of DoLS in hospitals and care homes was widespread and increasing.
- The Department of Health (DH) and Care Quality Commission (CQC) expect applications for DoLS to rise from 13,000 a year to over 100,000.
- Most cases concern vulnerable people with dementia. Others may have a severe learning disability or acquired brain injury.

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The Guidance Concluded:-

- The Chief Coroner's present view, subject to a decision of the High Court, is that any person subject to a DoL is *"in state detention"* for the purposes of the 2009 Act.
- When a person dies the death should be reported to the coroner and the coroner should commence an investigation.
- The person is not *"in state detention"* for these purposes until the DoL is authorised.
- The investigation cannot be discontinued. There must be an inquest.
- There is no requirement for a jury where the death was from natural causes.
- In many cases the inquest may not be an Article 2 inquest.
- In practice the coroner, through his or her officers, will find out whether a DoLS authorisation is in place, obtain a copy of the authorisation, obtain a medical report, and check with the family that they have no concerns about the circumstances of the death.

The outcome of these inquiries, all part of the necessary investigation, will then be placed before the coroner who will conduct a brief public inquest, usually based on the papers.

The person is not 'in state detention' for these purposes until the DoL is authorised.

This is likely to be challenged based on a case decided in 2015. Where a judge said *"…no formal order or authorisation is necessary for there to be a deprivation of liberty under Article 5."*

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Natalie is a Partner leading the Abuse and Clinical Negligence team and is based at Park Square, Leeds.

Natalie specialises in Serious Injury claims and claims involving Abuse Law. She represents those who have sustained life changing injuries and families of the bereaved in fatal injury claims, having a specialist interest in Inquests. She works closely with Claimants' and their families providing a high level of support and advice on all aspects. She has considerable understanding of the Court procedure and leads in negotiation and advocacy.

She has worked on complex claims involving group actions and claims against Local Authorities and other institutions and is a recommended lawyer in the Legal 500 2019.

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