THE CORONER – WHAT IS EXPECTED OF YOU

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www.sunderland.gov.uk/coroner
History

• 1194
• The Crownet
• Raising Revenue
• Independent Judicial Officer
  – Inquisitorial jurisdiction; who, where, when, how
  – Article 2
    • Right to life
      • In what circumstances the deceased came about the death
  – Registration Particulars (and nothing else)
HAVE KNOWLEDGE OF

• NICE Guidelines
• National Care of the Dying Audit for Hospitals
• Good Medical Practice (GMC)
Becoming a Coroner

- 5 year legal qualification
- No more medical coroners
- No robes
- Appointed and funded by LA
- Police - main provider of Coroner’s Officers
Coroner’s Officers

- Routine work is performed by coroners officers
- Senior Coroner may delegate administrative but not judicial functions
- Many but not all are retired police officers
- In some (but not all) areas there is a duty rota for nights and weekends for coroners’ officers
- They have a demanding role
Caseload 2014

- 497,424 deaths in England and Wales
- 223,841 reported to Coroners (45% of all registered deaths)
- 25,889 Inquests
- PM rate – 40% (Sunderland – 29%)
- Average waiting time to Inquests – 28 weeks (Sunderland – 11 weeks)
The Legislation

Coroners and Justice Act 2009
= CJA

The Coroners (Investigation) Regulations 2013
= Regs

The Coroners (Inquest) Rules 2013
= Rules

The Coroners Allowances, Fees and Expenses Regulations 2013
= Fregs
Coroner’s procedure

- The procedure is inquisitorial
- It is not adversarial
- It is not a trial
- It is a fact finding inquiry, not fault finding or blame-apportioning
- The hearsay rules do not apply
- The coroner will select the witnesses
- The scope is limited – who, when, where and how; no finding of liability or fault
The Coroner & Justice Act 2009

- The Act was implemented on the 25/07/13

- The aim of the reform was to put bereaved people at the heart of the investigation

- The Chief Coroner and his office were create to provide governance to the service

- The concept of the coroner’s investigation was created which would include an inquest unless discontinuance applied
Coroners and Justice Act 2009

Investigations

✓ conclude by discontinuing if the death is natural
✓ conclude with an Inquest if the death is unnatural / violent / in State Detention
State Detention

- Prison
- Police Station
- Mental Health Hospital
- Immigration Detention Centre
- Those subject to Deprivation of Liberty Safeguarding (DoLS) because their liberty is restricted (welfare reasons)
- de facto detention?
Investigations (1)

- Do we have a proper and accurate identification?
- Is there any prospect of foul play?
- What are the **full** circumstances surrounding the death?
- Who is the **appropriate** family member to deal with?
- What is the relevant medical history?
- Can a treating doctor **reasonably** sign a certificate for a natural death?
- If so, what do the family think of this? What can they add?
- Do we **need** an autopsy? If so, what type? Who by?
- Regular information to family (retained tissue requirements)
Investigations (2)

- Are the extended pathology tests needed? (eg. toxicology)
- A detailed written medical background from GP and hospital?
- Ambulance logs/transcripts
- Is there a mental health background? Can be very complex
- Statements required concerning circumstances of the death
- Is the police inquiry sufficient?
- Do we need an independent review or expert witness?
- Read the file, what witnesses are required? Oral or doc?
- Fixing a date can be very difficult ......
Investigations (3)

- Notes
- Records
- Telephones
- Computers
- Clothing
- Photos
- Medical Equipment
- Medication
- Protocols
- Procedures
Liaison

- GP
- Hospitals
- Ambulance Service
- Funeral Directors
- Registrars
- Pathologists
- Other Coroners
- Police
- HTA
- Emergency planners
- Mental Health
- Alcohol and drug teams
- Safeguarding-Children (and now adults)
The Law

s14 Coroner directs whatever examination is required including toxicology and histology (‘may specify the type of examination’ by a ‘suitable practitioner’)

Reg 8 Coroner is required to carry out PM as soon as practicable

s14(5) Pathologist provides report as soon as reasonably practicable

s15 Pathologist can undertake PM in own area or any suitable place

Reg 10 Pathologist sets out who can attend PM – with Coroner’s permission

Reg 10 Coroner must notify PR, NOK or known IPs of date, time and place of PM unless it is impracticable or would cause unreasonable delay
Invasive v Imaging

• CT or MRI

• Angiography

• Issues:
  – Cost
  – Availability
  – Sensitivity
  – Inclusiveness
  – Whole/partial/screening
  – A cause or THE cause?

• An Adjunct or Replacement?
Investigation
Interested Persons

s47 Expanded list including: -
Spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half brother, half sister. For the purposes of this section, a person is the partner of a deceased person if the two of them (whether of different sexes or the same sex) were living as partners in an enduring relationship at the time of the deceased person’s death.

Personal Representative (PR) of the deceased
Medical Examiners
Beneficiary under a policy of insurance
Person whose act or omission may have contributed to the death
Trade Union where death was at work or from prescribed disease
IPCC
Appointed Government department
Any other person with sufficient interest
Inquest - General

An Inquest is a part of the investigation and is required where death is:

- Unnatural or violent
- In custody or state detention

r5(1) An Inquest must be open as soon as reasonably practicable

r5(2) Coroner must where possible set dates for subsequent hearings

r11 must have all hearings in public including the opening (unless matters of national security dictate otherwise)

r25 all hearings must be recorded (£5 for a CD)

r8 must complete all Inquests in 6 months, or as soon as reasonably practicable.
Inquest – Disclosure

r13(1) provide
• Document (includes PM, any report, recording of Inquest, any relevant documentation - r13 (2))
• make it available for inspection

Can disclose:
• Electronic copy
• Redacted version of all or part of the document

r15 Restriction on disclosure:
• statutory or legal prohibition
• consent of author or copyright of owner cannot be reasonably obtained
• request is unreasonable
• document relates to contemplated or commenced criminal proceedings
• the Coroner considers the document to be irrelevant

Disclosure costs:
• No fee before the Inquest is concluded
• Post Inquests fees = Freg 35
Pre Inquest – Reviews

• CC Guidance No 4 on “potential pitfalls” : see Brown v HM Coroner for the County of Norfolk [2014] EWHC 187 (Admin)

• Suggested PIR agenda:
  • Who are the Interested Persons [IP’s], and should there be any others?;
  • The identification of who shall be the witnesses called and read;
  • The issues to be considered at the inquest;
  • The scope of the evidence;
  • Whether a jury shall be required;
  • Whether Article 2 ECHR is engaged;
  • Any issues of disclosure;
  • Whether an expert witness is required to assist the court on particular matters;
  • The date of the final hearing;
  • An estimate of the time that should be set aside for the case.
  • IP’s should have sufficient disclosure of statements and documents in advance of the PIR
The scope of the inquest usually needed to decide ‘How’ a death came about is one that examines ‘by what means’ the death occurred. [See R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson [1995] QB 1].

If Article 2 is engaged, a wider scope is needed, one that looks as “by what means AND in what broad circumstances’ the death occurred.[section 5(2) Act; R (Middleton) v HM Coroner for West Somerset [2004] 2 AC 182].

In an Article 2 inquest, the coroner must record ‘in what circumstances’ the deceased came by his or her death (section 5(2), 2009 Act). The inquest must enable the coroner [or jury] to express their conclusions on the central issue(s). The Middleton case illustrates how by adding the words “and in what broad circumstances” the law was changed to allow inquests to satisfy the requirements of an Article 2 compliant investigation by allowing a jury to reach a conclusion on the events leading up to the death or on relevant procedures connected with the death.
Article 2

- An Art 2 compliant investigation is needed where the state may be implicated in a death
- The inquest is the forum through which the UK seeks to provide such an investigation
- Has there been an arguable breach of the state’s general duty to protect life? Has there been any arguable breach of the *Osman* test that the state knew or ought to have known of a real or immediate risk to the life of the deceased and failed to take measures within the scope of their powers: *Osman v UK* [1998] 29 EHRR 245.
- Engagement of Article 2 does not always mean a jury inquest is needed
Gross Negligence Manslaughter

- *R v Adomako* [1995] 1 AC 171 (HL) says the following elements are to be proved -
  - (1) a duty of care owed to the deceased,
  - (2) a breach of that duty of care,
  - (3) the risk of death (not just the risk of serious injury) was a reasonably foreseeable consequence of the misconduct
  - (4) the breach caused the death, and
  - (5) having regard to the risk of death involved, the misconduct was grossly negligent so as to be condemned as the serious crime of manslaughter.

- All elements must be proved to the criminal standard and be proved to relate to one identifiable person (but who shall not be named)
- Medical deaths?: ‘Mistakes, even very serious mistakes, and errors of judgment, even very serious errors of judgment, and the like, are nowhere near enough for a crime as serious as manslaughter to be committed’: *R v Misra*
Corporate Manslaughter

- Corporate manslaughter contrary to section 1 of the Corporate Manslaughter and Corporate Homicide Act 2007
- Key issues: How were an organisation’s activities managed or organised? Did this cause death? Was it a gross breach of a relevant duty of care owed to the deceased?
- A breach of a duty of care is gross ‘if the conduct ... falls far below what can reasonably be expected of the organisation in the circumstances’: section 1(4)(b) of the 2007 Act.
Mental Health

• Voluntary patient?

Rabone v Pennine Care NHS Trust [2012]
UKSC 2 [2013] – basis of decision was a voluntary patient is in a vulnerable position, effectively controlled by the hospital, having many similarities with a detained patient and in some circumstances the position of a voluntary patient equates to that of a detained person requiring an Article 2 compliant investigation.
Inquest – Jury 1

s7 Inquest must be held without a Jury unless:

- died in custody or state detention AND death is violent, unnatural or of unknown cause
- death resulted from an act or omission of a police officer in the purported exercise of their duty
- death caused by a notifiable accident, poisoning or disease
- Coroner thinks there is sufficient reason for doing so
Inquest – Jury 2

s8 7-11 persons

r29 may make up Jury numbers using people in the vicinity

r33 Coroner must direct the Jury as to the law and provide the Jury with a summary of the evidence

s9 majority conclusions allowed after sufficient time to deliberate
Inquest – Evidence

r17 evidence by video link

r18 evidence behind a screen

r19 examination of witnesses

r20 order of examination

r21 privilege against self incrimination

r23 written evidence

NB: Montgomery v Lanarkshire Health Board 11.03.15 – consent to treatment

NB: Powers under s 32 and Sch 5
Inquest – Conclusions

s10 r33 and Schedule 2 of the Rules
• verdict = **Conclusions** – alcohol/drug related, road traffic collision
• inquisition = Record of Inquest
• particulars for registration = Findings
• who, where, when, how = Determinations

s10(2) no determination shall be framed in such a way as to appear to determine any question of: -
• criminal liability on the part of a named person
• civil liability
CONCLUSIONS
(PREVIOUSLY VERDICTS)

• Accident
• Misadventure
• Alcohol related
• Drug related
• Industrial disease
• Lawful Killing
• Unlawful killing*
• Natural causes
• Open
• Road traffic collision
• Stillborn
• Suicide*
• Narrative (e.g. recognised complications of a necessary surgical procedure) or a questionnaire

(* Beyond reasonable doubt; others on the balance of probabilities)
Neglect

A gross failure to provide adequate nourishment or liquid or provide basic medical attention or shelter or warmth for someone in a dependent position (because of age, youth, illness or incarceration) who cannot provide it for himself. Failure to provide medical attention for a dependent person whose physical condition is such as to show he obviously needs it may amount to neglect... Neglect can rarely if ever be an appropriate verdict on its own. Neglect may contribute to a death from natural causes. Neither neglect or self neglect should ever form part of any verdict unless a clear and causal connection is established between the conduct so described and the cause of death. (Jamieson 1995 QB 1)
Sch7 para 5 Reg 28 and 29 Actions to prevent other deaths

- now in the Act
- mandatory
- applies during the investigation and Inquest
- concerns that circumstances creating a risk continue and action should be taken
- copies now sent to the Chief Coroner’s Office
- responses due within 56 days
- Summary published
- Chief Coroner Guidance 5
Coroner investigations
A short guide

This leaflet aims to help you if someone close to you has died and their death has been reported to the coroner. It doesn’t go into detail, but explains where you can get more information.

This leaflet is a brief summary and does not cover every circumstance.

The Guide to Coroner Services is a more detailed booklet and has more information on everything in this leaflet. It is available from:

- www.gov.uk
- your local coroner’s office, or
- the Ministry of Justice by emailing coroners@justice.gsi.gov.uk or calling 020 3334 3555 and asking for the coroner team.

What does a coroner do?

A coroner is an independent judicial office holder, appointed by a local council. Coroners usually have a legal background but will also be familiar with medical terminology.

Coroners investigate deaths that have been reported to them if it appears that:

- the death was violent or unnatural
- the cause of death is unknown, or
- the person died in prison, police custody, or another type of state detention.

In these cases coroners must investigate to find out, for the benefit of bereaved people and for official records, who has died and how, when, and where they died.

More information on what to expect is at:
www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner
Guide to Coroner Services

Will the inquest be reported by the press?
Useful Contacts

Office of the Chief Coroner
11th Floor - Thomas More Building
Royal Courts of Justice
London
WC2A 2LL
Email: chiefcoronersoffice@judiciary.gsi.gov.uk

The Coroners’ Society of England and Wales
www.coronerssociety.org.uk
Andre.Rebello@liverpool.gov.uk

Coroners' Officers and Staff Association (COASA)
http://www.coasa.org.uk/
“The coroner frequents more public-houses than any man alive. The smell of sawdust, beer, tobacco-smoke, and spirits is inseparable in his vocation from death in its most awful shapes. ”

Charles Dickens, Bleak House, Chapter XI
TOP TIPS

• Good notes on medical records
• Evidence of clear and informed consent to procedures
• Be able to justify decisions taken
• Clear statements without over using complex medical terms
• Openness
• Good Court Craft
TOP TIPS

• Communication
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