Being involved in an inquest

The role of the coroner

One of the roles of the coroner is to identify the cause of an otherwise unknown cause of death. The coroner is required to investigate any “violent or unnatural death” or any “a sudden death of which the cause is unknown.” Therefore, healthcare organisations will report certain deaths which occur whilst a patient is within their care to the coroner

The purpose of an inquest

If the cause of death is not identified in a post mortem, the coroner will formally open the inquest. An inquest is an inquisitorial process undertaken by the coroner to answer four questions: Who the deceased was and when, where and how the deceased came to his death.

The coroner has discretion to broaden the scope of her investigation into the circumstances of the death rather than simply the narrow question of “how the deceased came by their death.” Within healthcare, this allows the coroner to scrutinise an organisation’s systems and processes to assess whether any failures contributed to the death.

Who will be involved?

Certain individuals and organisations will be granted status as “Interested Persons” which provides them with certain rights in the process including receiving prior disclosure of evidence and questioning witnesses during the hearing.

The coroner has discretion to grant Interested Person status to anyone but the legislation confirms that the deceased’s family and anyone liable to be criticised will be granted this status. This may include both individual clinicians and healthcare organisations if their systems and processes may be criticised. An interested person may also be called as a witness.

The coroner’s powers and investigation

The coroner may hold a “Pre Inquest Review” hearing in order to seek the views of the Interested Persons concerning sources of evidence and the scope of the investigation.

The coroner has powers to require anyone within the UK to disclose of information and her officer will seek witness statements from all those she considers relevant. A coroner can require witnesses to attend the inquest hearing to give evidence.

The inquest hearing

It is the coroner's role to conduct the investigation and hearing. She will question the witnesses herself. Interested parties, or their legal representative, can then ask their own questions of the witnesses so long as they are relevant to the scope of the inquest.

The coroner has broad discretion with respect to the conduct of the investigation and examination of the evidence at the inquest hearing, although she is bound by common law procedural fairness.

After all the evidence has been heard, interested persons are not able to make submissions to the coroner on the facts but can make representations concerning the law, most commonly with respect to the verdicts which are available to the coroner

The verdicts

At the conclusion of the inquest, the coroner is required to complete Form 2 record answering the four questions above and may enter one of a number of short form "verdicts". Further, especially at the conclusion of a broader investigation, she may complete a "narrative verdict" detailing the circumstances of death. Common short form "verdicts" within a healthcare context include:

Natural causes: Where death caused by the normal progression of a natural illness which is not contributed to, to any significant degree, by any human intervention. In the case of a person who has a pre-existing medical condition, the coroner must consider whether the death was caused by the illness itself or some unnatural intervention which rendered that condition fatal in circumstances.

Neglect: Neglect requires a gross failure to provide the very basics of life (nourishment, liquid, warmth or medicine) to someone in a dependent position. There must be a clear connection between the neglect and the cause of death. Neglect can be a contributing factor towards another cause of death.

Responsibility for the death

The coroner is expressly prohibited by the Act from attributing any criminal or civil liability to any individual or organisation for the death. This does not prevent them from coming to factual conclusions concerning the causes or contributory factors causing death.

The documents, statements and live evidence produced during the course of inquest proceedings may all be relied upon the family in subsequent negligence claim. A successful claim depends upon establishing the existence of a duty of care, breach of that duty of care and that the breach caused the death. Although the cause of death identified by the coroner may be relevant to any subsequent claim, it is not decisive.

Reports to prevent future death

The coroner may also prepare a “Report to Prevent Future Death” at the conclusion of an inquest hearing which identify steps which she considers should be taken to avoid similar harm occurring in future. These are addressed to the relevant organisations and copied to the Ministry of Justice, which will publish them on-line.

Contact us

Should you have any queries in relation to the above, please contact a member of our **public law team** or our **professional discipline team**.

Emily Carter
Partner, Public Law
ecarter@kingsleynapley.co.uk
Direct +44 (0)20 7814 1255

Julie Norris
Partner, Regulatory and Professional Discipline
jnorris@kingsleynapley.co.uk
Direct +44 (0)20 7814 1290