CAMBRIDGE
Cambridge University Press & Assessment
978-1-009-45009-6 — A Clinician's Brief Guide to the Coroner's Court and Inquests
Gabrielle Pendlebury , Derek Tracy
Excerpt
More Information

Chapter 1

# Introduction

Gabrielle Pendlebury and Derek Tracy

People reasonably expect their healthcare professionals to avoid causing harm. In the UK, there are various clinical and governance checks and balances to ensure that the individual is safe and treated with appropriate evidence-based care, and safeguards by the state to explore and investigate when these appear to have been breached. These include internal organisational disciplinary proceedings, public complaints processes, ombudsman investigations, civil claims for compensation, and criminal prosecutions, among others. In England and Wales, the coroner's inquest is one such check and balance.

## A Unique Type of Court

The coroner's court in England and Wales is distinct from civil and criminal courts. It is inquisitorial, finding facts that lead to a conclusion, as opposed to the adversarial model of criminal and civil courts that seek a verdict or compensation. In the criminal court, the judge's determinations are guilty or not guilty. Civil courts decide whether a law was broken or a duty was breached. In criminal and civil courts, questioning is usually led by a barrister (counsel). However, at an inquest, the questioning is led by the coroner, who determines what has caused a death and what has contributed, more than minimally or trivially, to that death. Imprisonment or compensation are not available outcomes and there is no punishment.

The Notifications of Deaths Regulations 2019 (Regulation 3 [1]) imposes a duty on a registered medical practitioner to notify the relevant senior coroner of a death in certain prescribed circumstances (2). About half of all deaths in the UK are reported to the coroner, but not all of these lead to an inquest. If there is no doctor able to issue a certificate of death, explaining the cause of death, then it must be reported to the coroner. There are rules governing when a doctor can issue a certificate of death, they must know what illness caused the patient's death and must have seen and treated them for that illness within the last 28 days before they died (this can include via face-to-face or video) (3). These rules are in place to safeguard patients and ensure accurate reporting and registration of death.

Even when the cause of death is known or assumed to be known, some must still always be reported to the coroner:

- death linked to medical treatment or surgery;
- death linked to an accident;
- death linked to drugs or medication, whether prescribed or illicit;
- if there is a possibility the person died by suicide;
- if there are suspicious circumstances or a history of violence towards, or from, the deceased person.



© in this web service Cambridge University Press & Assessment www.cambridge.org

CAMBRIDGE
Cambridge University Press & Assessment
978-1-009-45009-6 — A Clinician's Brief Guide to the Coroner's Court and Inquests
Gabrielle Pendlebury , Derek Tracy
Excerpt
More Information



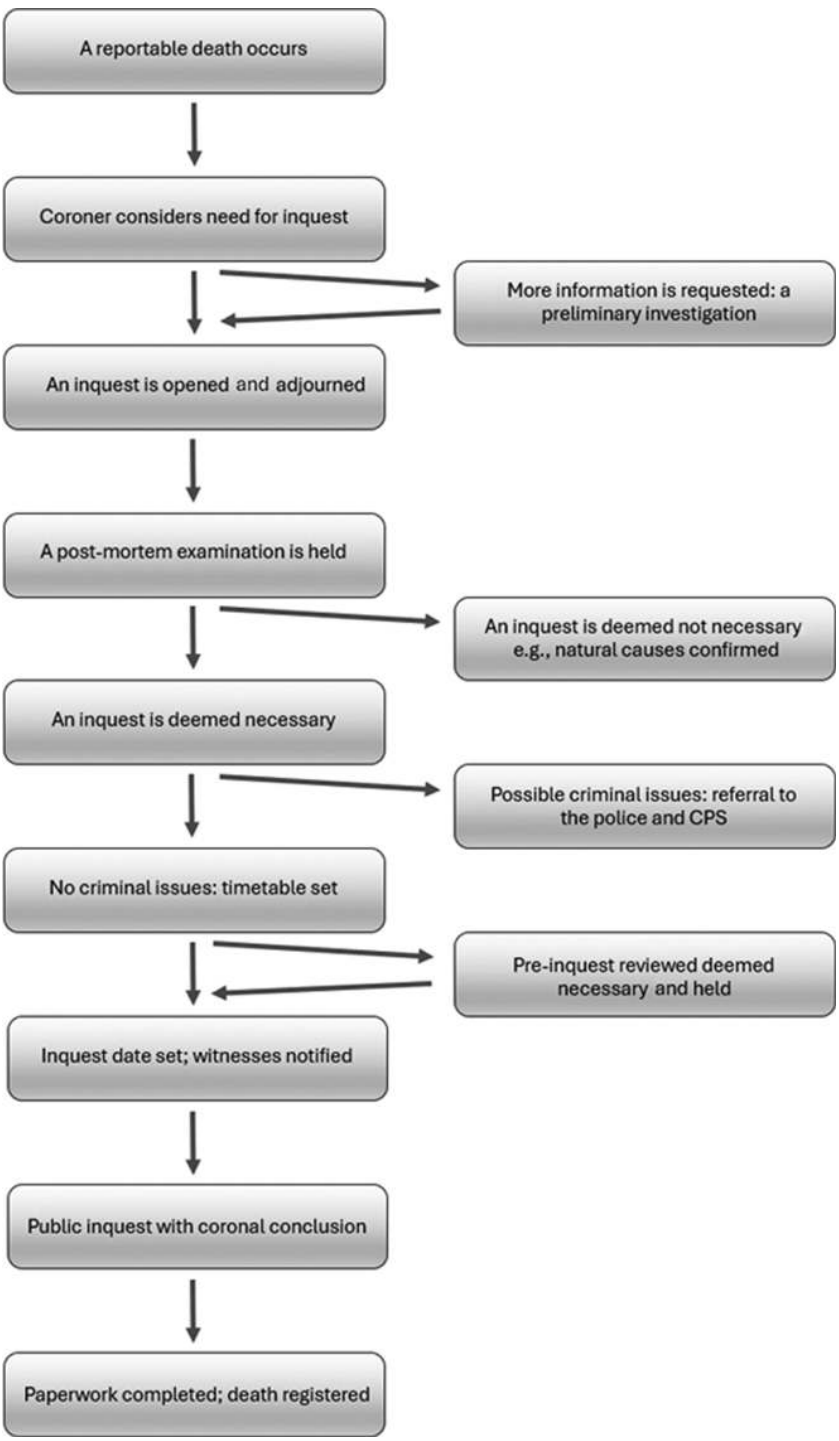



**Figure 1.1** A summary of the inquest process.
*Source:* Crown Prosecution Service (CPS).

© in this web service Cambridge University Press & Assessment www.cambridge.org

CAMBRIDGE
Cambridge University Press & Assessment
978-1-009-45009-6 — A Clinician's Brief Guide to the Coroner's Court and Inquests
Gabrielle Pendlebury , Derek Tracy
Excerpt
More Information



**Box 1.1 Legislation and Statutory Instruments used by coroners (5)**

Coroners and Justice Act 2009: CJA
The Coroners (Investigations) Regulations 2013: Regs
The Coroners (Inquests) Rules 2013: Rules
The Coroners Allowances, Fees and Expenses Regulations
Human Tissue Act 2004: HTA
Notification of Deaths Regulations 2019

Upon receiving such a report, the coroner's office will decide on the next steps. Within the coroner's court, there are no parties (neither defence nor prosecution as found in criminal trials, nor defendant or respondent as usual in civil cases), only 'interested persons' (4). There is no cross-examination, only questioning to elicit facts. There is no 'case' being presented.

The coroner's court also has no set 'procedural rules'. What this means is that the coroner (and not the interested persons) determines the process of investigation and hearings, the scope of the investigation and inquest, and which witnesses to call and which experts to instruct. The coroner may invite submissions from interested persons on these matters. In court, the coroner asks questions first of the witnesses and, although that may expose errors, it is essentially a neutral inquiry to establish the facts and understand decisions, actions and omissions that may have contributed to or prevented death. See Box 1.1 for a summary of the legislation and statutory instruments used by coroners.

© in this web service Cambridge University Press & Assessment www.cambridge.org

CAMBRIDGE
Cambridge University Press & Assessment
978-1-009-45009-6 — A Clinician's Brief Guide to the Coroner's Court and Inquests
Gabrielle Pendlebury , Derek Tracy
Excerpt
More Information

Chapter 2

# History of the Coroner's Court

Arif Naqvi and Gabrielle Pendlebury

## How the Role of the Coroner Was Established in England and Wales

The office of the coroner has a long history. In Middle English, the word coroner meant 'crown', derived from the French '*couronne*' and Latin '*corona*', and was used to refer to an officer of the Crown. The role of the coroner probably existed in Anglo-Saxon times, but it was only given something akin to statutory recognition in 1194 (6), when the 'Articles of Eyre' decreed that an office of *custos placitorum coronae* (Latin for 'keepers of the pleas of the Crown') be established.

The Eyre system was designed to protect the financial interests of the king. It required every county to elect three knights and clerks to maintain records on issues of interest to the Crown. These records allowed royal functions (including justice) to travel the whole country to handle all matters of financial interest to the king in local affairs. Under the Eyre system, 'keeping the pleas' was an administrative task assigned to the locally resident coroner, while 'holding the pleas' was a judicial one left to judges who travelled around the country holding assize courts (periodic courts held to handle the most important local cases). In effect, the coroner was the local representative of the Crown in each county.

The role of the coroner developed organically out of their responsibility to protect the king's financial interests. Coroners were required to be landed gentry (7), presumably to ensure appropriate liability for tax-collecting duties, with their possessions being used in the event of a failure of collection. The duties of early coroners included the investigation of almost any aspect of medieval life that had the potential to bring revenue to the Crown. Coroners investigated suicides because the goods and chattels of those found guilty of the then crime of '*felo de se*' (or 'self-murder') would be forfeited to the Crown, as were shipwrecks and discoveries of buried treasure. Indeed, a historical remnant is that identifying treasure troves that may belong to the State remains one of the duties of coroners today.

A key financial interest was levying a fine known as the '*murdrum*', from which the word 'murder' is derived. The fine was instituted following the Norman Conquest, after King William noticed that many of his soldiers would be found slain in outlying places and he was unable to ascertain who was responsible. To deter local communities from killing Normans, a heavy fine was therefore levied on any village where a corpse was discovered, with a presumption that the deceased was Norman, unless they could be proved to be English. The person who found a body from a death thought sudden or unnatural was required to raise a 'hue and cry' (shouting and loudly pursuing anyone they witnessed committing a crime) and to notify the coroner (8).



© in this web service Cambridge University Press & Assessment www.cambridge.org

CAMBRIDGE
Cambridge University Press & Assessment
978-1-009-45009-6 — A Clinician's Brief Guide to the Coroner's Court and Inquests
Gabrielle Pendlebury , Derek Tracy
Excerpt
More Information



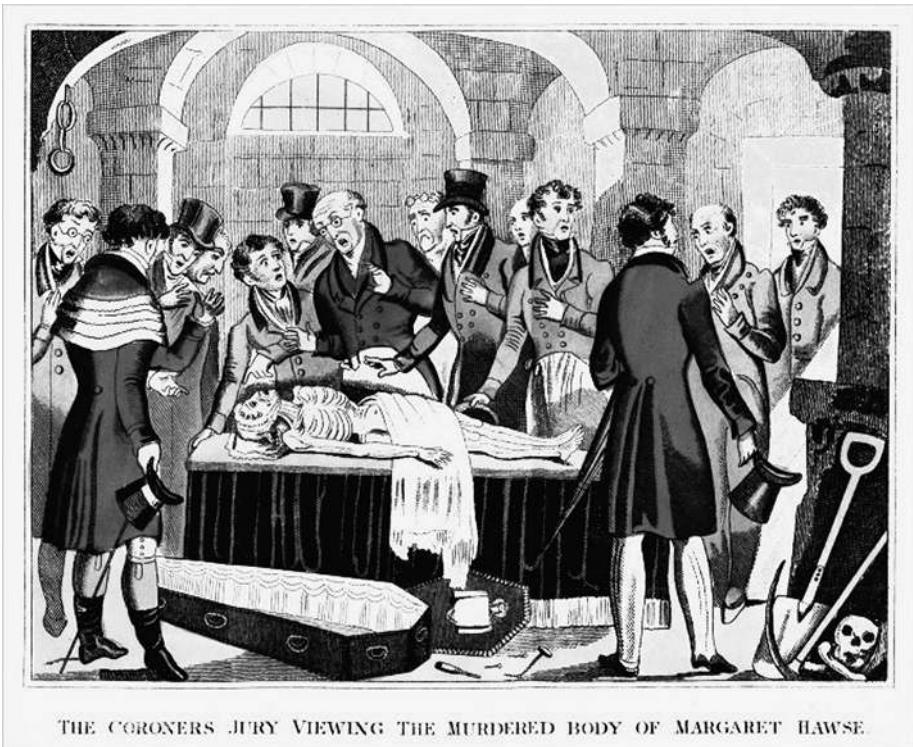



**Figure 2.1** The coroner's jury viewing the murdered body of Margaret Hawse from John Fairburn's chapbook of 1829.
Courtesy of Bishopsgate Institute.

The coroner's jury would be summoned to participate in an inquest which had the purpose, then as now, of ascertaining the identity of the deceased and how, when and where they had died. Many early coroners' inquests dealt with the 'Presumption of Normanry' which could only be rebutted by the local community (which thus avoided a fine) by the 'Presentment of Englishry' (9). Jurors may have been able to identify the deceased and could examine the body to discover the cause of death, potentially obvious from any injuries that might be seen. Until modern times, the jury was required to view the body, and inquests were held promptly as refrigeration was not an option.

Coroners were considered the principal agents of the Crown in bringing criminals to justice (7). During the thirteenth and fourteenth centuries, before the rise of what became the justices of the peace, they were apparently responsible for preserving order. Coroners were introduced in Wales through the Statute of Rhuddlan in 1284, following the military conquest of the country by Edward I of England in 1282. The role of coroners narrowed in the sixteenth century. In this period, judicial functions were centralised in the King's Court, 'escheators' emerged and took over the coroner's financial duties, and justices of the peace took over other duties. The sole important role that coroners retained was that of holding inquests into cases of violent or unnatural deaths.

© in this web service Cambridge University Press & Assessment www.cambridge.org

CAMBRIDGE
Cambridge University Press & Assessment
978-1-009-45009-6 — A Clinician's Brief Guide to the Coroner's Court and Inquests
Gabrielle Pendlebury , Derek Tracy
Excerpt
More Information



Public interest in unnatural deaths ensured that coroners retained an important role. Public concern and panic caused by inaccurate recording of the actual numbers of deaths arising from epidemics such as cholera prompted the government to pass the first Births and Deaths Registration Act in 1836. Ten years later, The Coroners' Society of England and Wales was formed by Sergeant William Payne Esq., HM Coroner for Southwark and the City of London. This coincided with concern that easy access to various poisons, alongside inadequate medical investigations into the actual causes of deaths, was leading to many homicides going undetected.

By the end of the nineteenth century, the role of the coroner had largely achieved its current shape. The Coroners Act of 1887 became the basis for modern coroner law (now framed in the Coroners Act 1988 and the Coroners Rules 1984), and in 1888, The Local Government Act finally abolished the election of coroners who were now to be appointed by local authorities.

## The Medical Examiner

The Coroners and Justice Act 2009 (4) ('the Act') revised the law on coroners and criminal justice in England and Wales and created a new office: the medical examiner, who would have a defined geographical area to oversee, with national coverage. The principal purpose of the Act was to establish a more effective, transparent, and responsive justice and coroner service for victims, bereaved families and the wider public. The role of the medical examiner in this new system was to examine every death that occurs in their locality and refer those which require further investigation to the coroner.

## Coroners in the Twenty-First Century

At the beginning of his appointment, the first Chief Coroner of England and Wales, Sir Peter Thornton KC, Chief Coroner 2012–2016, gave the following summary of the purpose of a twenty-first-century coroner system (10).

**(1) The need to know**

The public, especially bereaved family members and friends, need to know what happened and how the deceased came by their death. This applies particularly to deaths in custody or at the hands of an agent of the state, where there is a wider duty to protect citizens from wayward or mistaken actions by the state as well as to expose wrongdoing and bad practice. However, the public need to know applies to all deaths where there is a real element of uncertainty.

The interests of the bereaved family is [sic] at the heart of this public process, which is designed to give them answers, where that is possible. It is not a question of laying blame or apportioning guilt, either civil or criminal, as that is expressly forbidden by law. The investigation process is inquisitorial (rather than adversarial), with a view to seeking out and recording as many facts concerning the death as the public interest requires. Although it is a fact-finding exercise and not a method of apportioning guilt, the process can still find fault in someone or something. Where something has gone wrong, it can and must record how they either led directly to the death or contributed to it – for example, hospital or care home neglect – but only by giving statements of fact, not by giving an opinion or judgment. (Statements of fact can be verified or proven to be true. An opinion or judgment is based on those facts, an attempt to draw a conclusion from factual evidence. This is not within the remit of the coroner (or jury).)

A determination may not be framed in such a way as to appear to determine any question of criminal liability on the part of a named person, nor of civil liability (4).

© in this web service Cambridge University Press & Assessment www.cambridge.org

CAMBRIDGE
Cambridge University Press & Assessment
978-1-009-45009-6 — A Clinician's Brief Guide to the Coroner's Court and Inquests
Gabrielle Pendlebury , Derek Tracy
Excerpt
More Information



The coroner is an independent judicial officer, with powers to summon witnesses and jurors and hear evidence under oath. They have a duty to conduct a full, fair, and fearless investigation (11). The verdict of the coroner or the jury can be in a short-form (such as 'unlawful killing', 'suicide', or 'accident', or it can be expressed in a brief, neutral, factual statement that expresses no judgment or opinion.

**(2) Preventing Future Deaths**
The coroner system exists to provide justice to the public not only in identifying causes of death but in preventing future deaths of a similar nature, something which families often feel passionately about. They say, and rightly say, our beloved should not have died in those circumstances, and what is more we do not want his death to be in vain; we do not want it to happen to anyone else in that same way.

Coroners are under a duty, and one which I shall emphasise, to report to Government and local government and agencies and institutions so that lessons can be learned for the future.

**(3) Compassion and understanding**
An understanding of the fragility of life and 'the need for compassion and understanding, and the provision of a system of fair justice for everybody, in life and in death.'

## Recent Changes to the Coroner's Court

The role of the coroner has been broadened, in particular, Clauses 37 to 41 of the Judicial Review and Courts Bill (12) (the Bill), introduced in the House of Commons on 21 July 2021, deal specifically with coroners.

The Bill aims to broaden the circumstances in which a coroner might *discontinue* an investigation. If they are satisfied that the cause of death has become clear in the course of the investigation, and an inquest into the death has not yet begun, a coroner is enabled to call off the inquiry. Previously, unless the cause of death had been revealed by a post-mortem examination, once an investigation had been started, the coroner had no power to discontinue it and there had to be an inquest.

The Bill aims to give the coroner more flexibility in how they hold inquests. Specifically, it allows a coroner to decide to hold an inquest in writing, without a hearing, in specified circumstances. It also makes it possible to devise rules to allow all participants, including the coroner, to participate remotely in pre-inquest reviews and inquests. In addition, it replaces and replicates the effect of a provision in the Coronavirus Act 2020 to make it possible for coroners to hold inquests without a jury where they have reason to suspect a death has been caused by COVID-19.

© in this web service Cambridge University Press & Assessment www.cambridge.org

CAMBRIDGE
Cambridge University Press & Assessment
978-1-009-45009-6 — A Clinician's Brief Guide to the Coroner's Court and Inquests
Gabrielle Pendlebury , Derek Tracy
Excerpt
More Information

Chapter 3

# The Role of the Coroner

Lydia Brown

**Key Points**

- Do not presume that the coroner and family will have an intuitive understanding of all medical matters; ensure as a witness that your explanations are clear and simple. If the matter is complex, consider using visual aids or potentially video assistance.
- The inquest is not there to consider fault or blame against an individual or organisation.
- The coroner will use their discretion to select witnesses, set the scope of the inquiry and to decide on expert evidence.
- In certain situations, a witness statement may be read out without the need for the witness to attend (R23). This is at the discretion of the coroner; there are no set rules.

The role of the coroner is to investigate violent, unnatural or unexplained deaths, as set out in the Coroners and Justice Act of 2009 (4). The coroner is a creature of statute; the oldest Judicial office confirmed in 1194 (6), but in existence before that time to assist the Crown with the valuable and inevitable business of death.

The coroner is an Independent Judicial Officer and remains responsible to the Crown rather than the government of the day, but the practicalities are administered by the local authorities who pay for the appointed coroners and provide office and court support. Many also use the investigative abilities of the local police force, although the coroner's officers can alternatively be employed by the local authority. There is considerable divergence of individual coroners' practices, resourcing and individual discretions that can result in bafflingly different experiences for those exposed to the service.

To qualify for appointment into this judicial office, the individual must reach the basic eligibility criteria (13) of being 5 years qualified and legally experienced as either a solicitor, barrister or fellow of the Chartered Institute of Legal Executives, but gone are the days when a medical qualification was an accepted criteria and no medical knowledge is required at all. This may be a helpful insight when the coronial questioning seems possibly eclectic or even remarkably uninformed – there is no guarantee that the 'learned coroner' understands your specifically detailed branch of medicine sufficiently to question or challenge the evidence as presented. It is for the witness to explain and possibly even bring in visual aids or offer video assistance for the more challenging technical inquests.

## Scope of the Inquest

The scope of any inquest should be set out at the start and is limited by the statutory framework from where the coronial duties arise. The power of the coroner to



© in this web service Cambridge University Press & Assessment www.cambridge.org

CAMBRIDGE
Cambridge University Press & Assessment
978-1-009-45009-6 — A Clinician's Brief Guide to the Coroner's Court and Inquests
Gabrielle Pendlebury , Derek Tracy
Excerpt
More Information



investigate deaths is wide ranging, but not limitless, and is constrained by the law to four questions (4):

> Who was the person who died? How, when and where did they come about their death?

In the vast majority of cases heard, the answer to three of these questions is just a factual recording of non-contested information, readily known to all involved. It is rare that the identity of the deceased must be investigated by the coroner and tends to be a formality. As so many deaths occur in hospitals or care situations, 'when and where' is again commonly just a formality. The deceptively tricky explanation of 'how' a death occurred tends to be the focus of most inquests. It must be explained to many families grieving their loved one that the law cannot and must not try to answer the question of 'why' this had to happen; that must be left to one side however persistent the requests to explore the sometimes messy and often complex personal lives of the suddenly deceased. The inquest should find and record the facts neutrally, succinctly and without expressing any judgement or opinion.

It is often helpful to set out what the inquest process must NOT achieve, in contrast to the statutory purpose. The inquest is not a vehicle to resolve family grievances or hospital complaints, it does not consider issues of fault or blame against an individual or an organisation. It must not phrase any conclusion to appear to determine any question of criminal or civil liability, and any coronial conclusion will not impede the workings of the adversarial courts. If criminal proceedings are pending, the inquest process will be suspended and only resumed if there is 'sufficient reason' to do so after the criminal matters have been concluded. The coroner works in tandem with other statutory organisations who may be investigating deaths (such as the Care Quality Commission [CQC] and Health and Safety Executive [HSE]) to decide who should proceed first.

The investigatory process varies widely between individual deaths, from a single hearing when the inquest is opened and concluded at the same time, with no need for live witnesses and no disputed evidence. An example is a death from mesothelioma, almost always a consequence of exposure to asbestos fibres and therefore if the exposure is due to employment, classed as an unnatural death due to industrial disease. Other inquests can require days of court time, numerous witnesses and a long list of 'interested persons' (see below) who have an interest in the findings and conclusion.

The duty and responsibilities of the coroner are best described in the leading case of *Jamieson*:

> It is the duty of the coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated . . . He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedure to be followed. (11)

While the language may seem a little archaic today, the sentiments resonate. The discretion of the coroner to select the witnesses, to set the scope of the inquiry and decide if expert evidence is required cannot be challenged unless it is unreasonable. It is not infrequent that witnesses say when contacted by the court officials that they will not be attending court, for a miscellany of reasons and excuses, but this is due to a fundamental misunderstanding of their duty to the court. The coroner has the power

© in this web service Cambridge University Press & Assessment www.cambridge.org

CAMBRIDGE
Cambridge University Press & Assessment
978-1-009-45009-6 — A Clinician's Brief Guide to the Coroner's Court and Inquests
Gabrielle Pendlebury , Derek Tracy
Excerpt
More Information



to summon a witness to court, and failure to present can have the consequences of arrest and even imprisonment. On rare occasions, it is necessary to utilise these statutory powers if the mere threat proves insufficient.

## Rule 23

It is commonly the case that witness statements are provided and the evidence can be simply read onto the court record, without the need for the witness to attend to answer any questions. This is a procedure under Rule 23 of the Coroners Rules 2013 (14) (Chapter 10). R23 evidence can be accepted for many different reasons, including 'good and sufficient reason' why the maker of the statement should not attend. There is no list of what satisfies this criterion; this remains firmly within the discretion of the coroner. Examples of where evidence might be admitted under this provision include the witness being on maternity leave or long-term sick, no longer residing in England or Wales (the coroner powers are limited geographically) or being incarcerated, but nothing gives an automatic right of non-attendance: each case is judged on its own facts.

## The Statement: A Coroner's Perspective

Preparation for an inquest by the witnesses is key to a positive outcome and the preparation needs to commence as soon as the death occurs or it is recognised that the coroner is involved. Chapter 9 will detail this process, but from a coroner's perspective, a good statement does not have to be pages long, encompassing each twist and turn of the treatment and crammed full of medical descriptions or, even worse, medical abbreviations. Remember that the coroner is unlikely to have a medical qualification and the family and legal representatives will be even less likely to be able to understand or follow this unless clear, jargon-free explanations are provided. If something was not done that should have been done, set this out clearly and unambiguously, when this was identified and how it was corrected. If there is an explanation for how it happened, provide that to the court to assist with the findings of fact; remember the court is not looking to establish fault or blame. The same approach should be adopted for things that were done in error, with an explanation and, if appropriate, acknowledgement of the consequences of the act.

Unless there has been a specific request for an overview report, avoid detailing other clinicians' involvement, in particular any perception of criticism of other individuals. If the coroner requires additional statements, they will be requested, or this should be identified by the legal advisers. It will rarely be beneficial for the surgeon to set out that it was all the fault of the anaesthetist, or the midwife to allege in a statement that the doctor should have sought senior assistance (unless this was clearly and unequivocally documented at the time). There should be adequate provision for the contents of any statement to be discussed with a legal overview for advice, but be mindful that timetables can be tight and it will only be to the detriment of the statement provider if the job is put off for so long that it has to be submitted before the Trust incurs potential penalties. The coroner has the power to require statements to be submitted under a 'Schedule 5' notice by a certain date with the threat of a fine 'not exceeding £1000 on a person who fails without reasonable excuse to do anything required'. No coroner will wish to invoke this fine, but this enforcement is in the statute for good reason, and it can and has been used as a last resort to move the investigation forward. Avoid this potentiality by early positive

© in this web service Cambridge University Press & Assessment www.cambridge.org