39 Essex CHAMBERS

Managing your civil claim Seminar

Thursday, 7th November
5.15pm - 7.00pm

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39 Essex Chamber
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39 Essex Chambers
#39Events

Inquests for the Civil Litigator

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OVERVIEW

1. Introduction – when is an inquest opened?
2. Scope – what questions do inquests consider?
3. Causation
4. Conclusions – what are short form vs. narrative conclusions?
5. Prevention of Future Deaths Reports
6. Why C's legal reps would attend an inquest
7. Why D's legal reps would attend an inquest

WHEN IS AN INQUEST OPENED?

- A senior coroner is made aware that the body of a deceased person is within the coroner's area, and has reason to suspect that *either* –
  - The deceased died a violent or unnatural death, *or*
  - The cause of death is unknown, *or*
  - The deceased died in custody or otherwise in state detention

- A senior coroner has a duty to investigate.

- Coroners and Justice Act 2009
- The Coroners (Inquest) Rules 2013
- Chief Coroner's Guidance, Advice and Law Sheets

PROCEDURE FOR INQUEST

1. Where duty to investigate arises, inquest must be held (unless investigation discontinued)
2. Families and any other interested person should be notified in advance of inquest being opened
3. Open the inquest as soon as possible, usually in public
4. Record the opening hearing
5. Receive evidence, including on identification
6. Set date and directions for inquest, and pre-inquest review ("PIR")
7. Consider if jury required – see s.7 CJA
8. Publish notice of all hearings
9. Disclose documents to IPs unless documents restricted by rule 15

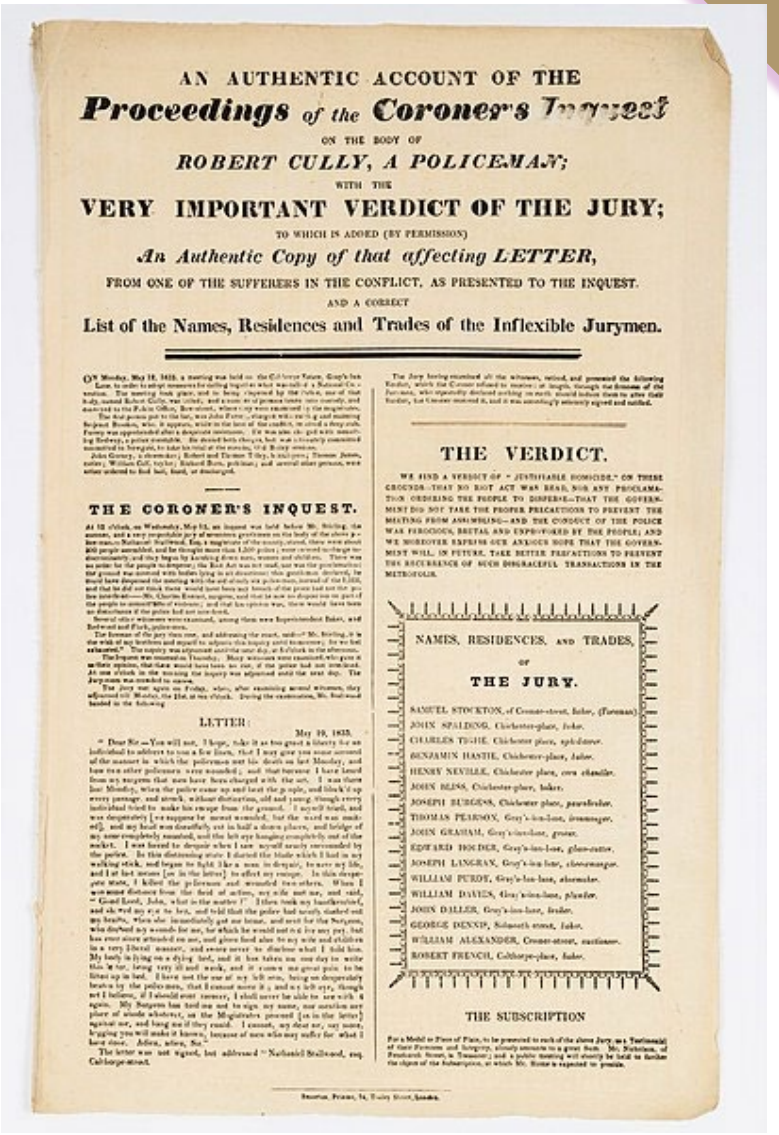
THE FOUR QUESTIONS

Central questions provided by Coroners and Justice Act 2009, ss. 5 and 10:

1. Who died?
2. How/by what means did they die?
3. When did they die?
4. Where did they die?

ARTICLE 2 INQUESTS

- **Article 2:** "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which the penalty is provided by law."
- ***Jamieson*** **vs.** ***Middleton*** **inquests**
- **Court considers** *"by what means and in what circumstances…"*
- **Sometimes errors of individual state actors vs systemic failures**



AN AUTHENTIC ACCOUNT OF THE

Proceedings *of the* **Coroner's Inquest**

ON THE BODY OF

ROBERT CULLY, A POLICEMAN;

WITH THE

VERY IMPORTANT VERDICT OF THE JURY;

TO WHICH IS ADDED (BY PERMISSION)

An Authentic Copy of that affecting **LETTER,**

FROM ONE OF THE SUFFERERS IN THE CONFLICT, AS PRESENTED TO THE INQUEST.

AND A CORRECT

List of the Names, Residences and Trades of the Inflexible Jurymen.

THE CORONER'S INQUEST.

THE VERDICT.

NAMES, RESIDENCES, AND TRADES, OF THE JURY.

THE SUBSCRIPTION

CAUSATION

- Not ‘but for’ causation
- “whether on the balance of probabilities, the event or conduct more than minimally, negligibly, or trivially contributed to the death"
- Acts and omissions considered

CONCLUSIONS

3 Stage Process

(1) Make findings of fact on the evidence (not recorded)

(2) Distil from facts, 'how' deceased came by death (Box 3)

(3) To record conclusion, which must flow from and be consistent with (1) and (2) (Box 4)

Short Form vs Narrative Conclusions

Short Form

- Lawful/unlawful killing
- Suicide
- Accident
- Misadventure
- Open conclusion

Narrative

- Non-Article 2
- Article 2

NEGLECT

- Medical context: Gross failure to provide basic medical attention to someone in a dependent position

- Prison death cases, 'only in the most extreme circumstances (going well beyond ordinary negligence)…"

- Requires clear and direct causal connection
  - '*more than minimally, negligibly, or trivially contributed to the death'*
  - '*the opportunity of rendering care… which would have prevented death'*
  - 'real possibility' not enough – must be on BOP
  - Missed opportunity not enough

Record of Inquest

Following an Investigation commenced Sixth May 2021;
And an Inquest opened on the Eleventh August 2021;
And an Inquest hearing at Courtroom 2, Town Hall, Town Hall Square, Leicester on the Fourteenth to Sixteenth June and Twenty-Ninth June 2023, heard before His Majesty's Area Coroner Mr I M Cartwright in the said coroner's area.

The following is the record of the inquest (including the statutory determination and where required, findings)

1 Name of Deceased (if known)

2 Medical cause of death:

[redacted]
I b Gambling Disorder
I c

3 How, when and where and for investigations where section 5 (2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death.

[redacted] a 40-year-old man who was discovered deceased by attending police officers and [redacted] South Yorkshire [redacted] having [redacted] His death was confirmed at the scene by one of the attending paramedics.

4 Conclusion of the Coroner as to the death.

[redacted] died as a result of his own actions, intending those actions to cause his death. At the time of his death, [redacted] was suffering from a gambling disorder, which was longstanding, [redacted] and which contributed to his decision to take his own life. In the months prior to his death, the evidence showed that [redacted] had been assessed as a low-risk gambler by the operator with whom he was gambling, although [redacted] gambling activity, deposits made and losses suffered were most intensive in the 10 weeks prior to his death. The same operator did not intervene or interact with [redacted], in any meaningful way, between 2019 and the date of [redacted] death, when more efforts to intervene or interact should have been made. Opportunities were missed which may possibly have changed the outcome for [redacted]

5 Further particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death.

(a) Date and place of birth: [redacted]	
(b) Name and Surname of deceased: [redacted]	
(c) Sex: **Male**	(d) Maiden surname of woman who has married: ----------
(e) Date and place of death: **Twenty-Second April 2021** [redacted] **Mexborough, South Yorkshire**	
(f) Occupation and usual address: **Warehouse Manager,** [redacted] ---------- [redacted]	

PREVENTION OF FUTURE DEATHS REPORTS

- Reg 28 of the Coroners (Investigations) Regulations 2013
  - where an investigation gives rise to a concern that future deaths will occur and the Coroner is of the opinion that action should be taken to reduce the risk of death, the Coroner *must* make a report to the person s/he believes may have the power to take such action.

- Before deciding if a PFD is necessary Coroner will consider the current position:
  - What changes have been made since the death?
  - What plans are there to implement changes?

SO WHY WOULD THE CLAIMANT BE INTERESTED IN ATTENDING AN INQUEST?

SO WHY WOULD THE CLAIMANT'S LEGAL REPS BE INTERESTED IN ATTENDING AN INQUEST?

- Building the case
- Aim to widen the scope of inquest as much as possible, aiming for Article 2
- Gathering evidence
  - Policies and procedures
  - SIR reports and interviews
- Question likely witnesses to the civil claim
- Identify breaches
- Neglect finding
- Potentially achieve pre-action settlement
- <u>BUT: Inquests do not also produce the outcome that families expect or want</u>

SO WHY WOULD THE DEFENDANT BE INTERESTED IN ATTENDING AN INQUEST?

SO WHY WOULD THE DEFENDANT'S LEGAL REPS BE INTERESTED IN ATTENDING AN INQUEST?

- Support witnesses called by the Coroner
- Assist the Coroner in their investigative duty
- Ensure that correct factual findings are made
- Limit liability / limit exposure
- Prevent a finding of neglect
- Avoid a Prevention of Future Deaths report being made or, if one is made, ensure that it makes reasonable achievable findings to the appropriate body

- <u>BUT: remember the Duty of Candour</u>

QUESTIONS?

Thanks for listening!

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