Inquests: a guide to the essentials

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21.06.22

Coroners' rules

- Coroners & Justice Act 2009;
- Judicial Review & Courts Act 2022, Chapter 4: Coroners (received Royal Assent 28 April 2022);
- Coroners (Inquests) Rules 2013;
- Coroners (Investigations) Regulations 2013;
- Chief Coroner's Guidance, Advice and Law Sheets (Courts and Tribunals Judiciary website);
- Inquest Law Reports (for the true enthusiast);
- Coroner Bench Book (aimed at coroners, and NB not currently up to date).
- S.1 CJA 2009: Obligation to carry out an investigation where:
  - S.2.…the coroner has reason to suspect that
  a) the deceased dies a violent or unnatural death;
  b) the cause of death is unknown, or
  c) the deceased died while in custody or otherwise in state detention.

Scope

- **S.5 CJA 2009**
- **Matters to be ascertained**
- (1)The purpose of an investigation under this Part into a person's death is to ascertain—
- (a)who the deceased was;
- (b)how, when and where the deceased came by his or her death;
- (c)the particulars (if any) required by the 1953 Act to be registered concerning the death.

- (2)Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.

- (3)Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than—
- (a)the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
- (b)the particulars mentioned in subsection (1)(c).

- Subject to paragraph 7 of Schedule 5 (Prevention of Future Deaths reports).

Interested person status

- S.47(2)(a) – (m) C&JA 2009 sets out those who may have IP status.
- (a) close family members (including partners: those 'living in an enduring relationship at the time of the deceased's death' s.42(7));
- (f) a person who may by any act or omission have caused or contributed to the death of the deceased, or whose employee or agent may have done so;
- (l) a person appointed by a Government department to attend an inquest into the death or to assist in, or provide evidence for the purposes of, an investigation into the death under this Part;
- (m) any other person whom the senior coroner thinks has a sufficient interest.

- "Sufficient interest" not a technical term and coroner should given them an "ordinary meaning" (*Jervis* 8-24). May include public bodies (eg CQC, GMC, Local Child Safeguarding Board etc).
- For coroner to identify IPs and notify them of their rights. Can also apply for IP status prior to or at PIRH (worth approaching coroner's office early).
- IPs entitled to: notification of inquest hearing arrangements within 1 week of the date of inquest being set (R.9 C(I)R 2013); disclosure of documents relevant to the inquest, including PM report(s) (R.13), subject to the exceptions set out at R.15 (and also to object to written evidence being adduced), and to put relevant questions to witnesses, either in person or through a legal representative (R.21). Flows from the latter that IPs may also make submissions on the law at the end of the evidence.
- NB re medical practitioners and the obligation to self-refer (GMC, NMC etc) if adverse findings are made about conduct at inquest: consider whether to seek IP status under (f) or (m).

Pre-Inquest Review

- R.6 C(I)R 2013 and Guidance Note No. 22.
- Should be an agenda beforehand, circulated by coroner 14 days in advance to all potential IPs.
- PIRH likely to address appropriate IPs, disclosure of documents, further investigations, scope of inquest / whether Art. 2 is engaged, need for a jury, witnesses (identity, need for anonymity), expert evidence and hearing length, PII etc. Rulings should be made, with reasons.
- Also practical matters: need for / date of any further PIRHs, jury bundle, CCTV, picture(s) of scene, interpreter(s), expert(s), etc.
- Can seek disclosure of post-mortem report, relevant documents, statements etc. from coroner beforehand to ensure PIRH is effective and agenda items can be addressed.
- Can also seek coroner's provisional views on contentious issues to focus preparation.

Pre-Inquest Review (2)

- NB do not assume all IPs or relevant documents have been correctly identified (or, re latter, disclosed or passed to / on by the coroner).
- Consider potential conflicts of interest. Esp. re employees of state institutions, NHS, umbrella organisations etc: need for named individuals to be IPs and separately represented? Conflicts between employer / employees, and / or between different employees?
- Should any independent bodies have IP status? (E.g. CQC, Independent Office for Police Conduct – is there an investigation ongoing?) Has the correct NHS Trust / local authority been identified? (Particular concern in cases concerning mental illness.)
- Tactical considerations: what evidence might you want to preview prior to civil proceedings?

Disclosure

CJA 2009 Schedule 5: power of the coroner to require evidence to be given or produced:

- At the inquest, by giving evidence and producing any document in a person's custody or under their control relating to a matter relevant to the inquest; to provide a written statement during the investigation; to produce any documents or any other thing relevant to the investigation;
- Exception re privileged material that would not be required to be disclosed in civil proceedings.
- 'Relevant' = *"if a person conducting an investigation…would (if aware of its existence) wish to be provided with it"*.
- Schedule 6, paragraph 7(2): it is an offence intentionally to suppress or conceal a relevant document. Record disclosure process: invaluable in event of accidental failure to disclose.
- Coroner may serve a formal notice setting out consequences of failure to comply; opportunity to respond and explain that compliance is not possible or is unreasonable; coroner then makes a decision after considering the importance of the information and the public interest.

Disclosure (2)

- C(I)R 2013: Part 3: disclosure of documents by coroner to interested parties. NB disclosure to coroner, not to IPs or the public: Law Sheet No. 3, *Worcestershire CC v HM Coroner for County of Worcestershire* [2013] EWHC 1711.
- Onus on IPs to request disclosure from the coroner (NB blanket requests often safest); coroner must disclose upon request as soon as reasonably practicable, though onward disclosure is at the coroner's discretion.
- It is is possible to disclose evidence to a coroner with a notice of objection to onward disclosure – to be determined by the coroner
- Rule 15 sets out restrictions: statutory or legal prohibition; consent of author / copyright holder cannot be obtained; request is unreasonable; concerns criminal proceedings and is irrelevant.
- There is also an exception for disclosing documents/evidence on the grounds of public interest immunity – to be considered in the same way as in a civil court.

Conversion to Public Inquiry?

- Security sensitive material cannot be disclosed to the Coroner, only its existence can be disclosed
- The central question for a coroner is whether an inquest's function and the statutory questions can be adequately satisfied in the absence of that evidence being disclosed
- The coroner can determine that question in a number of ways: submissions or correspondence from the holder of the material; making a decision based on a confidential 'gist'; or appointing security cleared counsel to view the material and advise
- If the material is sufficiently relevant to the investigation such that a coroner needs to examine it, a judge should be appointed as the coroner – Schedule 10(3) CJA
- A judge can view the material, and consider the need for onward disclosure and any PII claims. If a PII claim is upheld and the material needs to be disclosed, the inquest may be converted into a public inquiry to facilitate closed sessions
- Once a public interest immunity exception is established, That question can be
- See Guidance Sheet No 30

Experts

- Coroner has a wide discretion re expert evidence (as with all matters): whether / what evidence to rely upon, which experts (if any) to call. Must be exercised reasonably and fairly. Court will only intervene if not satisfied that the decision made was not one that was open to the coroner on *Wednesbury* principles.
- Scope and nature of expert evidence will normally be considered at the PIRH.
- IPs may obtain their own expert evidence, but are reliant upon the coroner agreeing for it to be adduced at the inquest: may put the substance of the evidence before the coroner so that the coroner may be able to decide whether or not it is appropriate (*R (Takoushis) v Inner North London Coroner* [2006] 1 WLR 461).
- If circumstances arise, coroner may call an expert witness in the exercise of his / her discretion, even though strictly unnecessary, if only to allay rumours and suspicion: *R (LePage) v HM Assistant Deputy Coroner for Inner South London* [2012] EWHC 1485 (Admin).
- Coroner not obliged to accept expert's evidence, even if an IP whose conduct it addresses has done so previously: *R (Carole Smith*) v HM Coroner for NW Wales [2020] EWHC 781 (Admin).
- Not necessary to adduce expert evidence in order to fulfil Art 2 procedural obligations: *R (Goodson) v Bedfordshire and Luton Coroner* [2006] 1 WLR 432, 458.
- It is not the case that independent psychiatric evidence must be called in every case of suicide in prison where there may be a mental health issue; each case must be determined on its own facts: *Chambers v Preston & West Lancs Senior Coroner* [2015] EWHC 31 (Admin) at [31].

Juries

- S.7(1) CJA 2009: inquest must be held without a jury unless (2) or (3) apply.
- S.7(2): Jury is mandatory where coroner has reason to suspect:

  (a) that the deceased died while in custody or otherwise in state detention, and that either—

  (i) the death was a violent or unnatural one, or (ii) the cause of death is unknown,

  (b) that the death resulted from an act or omission of— (i) a police officer, or (ii) a member of a service police force, in the purported execution of the officer's or member's duty as such, or

  (c) that the death was caused by a notifiable accident, poisoning or disease.
- S.7(3): inquest may be held with a jury where coroner thinks there is sufficient reason to do so.
- 'Reason to suspect' a low threshold test: *R (Davey) v HM Coroner for Leicester City* [2014] EWHC 3982 (Admin). Family wishes + similarity of circumstances to those where a jury inquiry is mandated relevant: *R (Fullick) v HM Senior Coroner for Inner London North* [2015] EWHC 3522.
- Custody / state detention includes detention under the Mental Health Act.
- Accident is 'notifiable' if notice is must be given under any Act to either 'a government department' or 'an inspector or other officer of a government department', or the HSE: S.7(4)(a), (b) and (c).
- RIDDOR 2013 requires the reporting of 'a work-related accident' (Reg 6), i.e. 'an accident arising out of or in connection with work' (Reg 2(1)). Workplace deaths therefore very likely to require jury inquests, unless clearly not 'work-related'.
- S.7(3) exercise of discretion more likely if evidence of fault or omission on the part of a state agent, or there is a particular need for public scrutiny.

Engagement of Article 2

- A2 substantive obligation: to protect life, and not to take life deliberately
- A2 procedural obligation: to establish effective and independent investigation where death has taken place
- Inquests are one of the main ways to satisfy the procedural obligation in circumstances where there has arguably been a breach of the substantive obligations (see *ex parte Middleton [2003] UKHL 51*)
- It is essential that the key facts are exposed and that the procedures provide for accountability
- Effect on the inquest's scope: in addition to the four statutory questions, the inquest must also answer "in what circumstances the deceased came by his or her death" – s5 CJA 09
- The inquest should examine not just probable causes of death, but "measures which could have a real prospect of altering the outcome or mitigating the harm" - *R (Medihani) v HM Coroner for Inner South London [2012] EWHC 1104*
- As put in *R (Tainton) v HM Senior Coroner for Preston and West Lancashire [2016] EWHC 1396 (Admin)* at 41: "…the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to the death
- Effect on the inquest's conclusion: typically a narrative conclusion will be required, and the permissible contents of that narrative are much broader. See Guidance Sheet No 17.
- *R (Middleton) v HM Coroner for Western Somerset [2004] UKHL 10* at 20: "To meet the procedural requirement of article 2 an inquest ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case"

Rules of evidence & hearsay

- Coroner's inquest not bound by the strict rules of evidence: *R v Divine, ex parte Walton* [1930] 2 KB 29, 36 per Talbot J.
- Law Sheet No.4: Hearsay evidence.
- Hearsay evidence admissible, even documentary hearsay evidence, so long as it is relevant. Once admitted, value of the hearsay evidence will be a matter of weight in all the circumstances. In making that assessment, coroner (or jury) must consider all the circumstances and act fairly. LS No. 4: paras 1 and 5; *Polanski v Conde Nast Publications Ltd* [2005] UKHL 10, at [74] per Baroness Hale (civil case).
- R.23 C(I)R 2013: written evidence not admissible unless coroner is satisfied that (a) it is not possible for maker of the written evidence to give evidence at the inquest at all or in reasonable time; (b) good and sufficient reason to believe maker should not, or (c) will not attend the inquest hearing; (d) written evidence is unlikely to be disputed.
- Ground (d) commonplace: usually agreement reached; (b) and (c) present more grounds for challenge: *Shafi v HM Coroner for East London* [2015] EWHC 2106 (Admin). NB 'attend' may mean attendance via videolink / behind a screen (*Shafi*).
- Might a fast track / documentary inquest be appropriate, where circumstances of death are uncontentious (Guidance No 29)?

Calling evidence

- Law Sheet No. 5: The Discretion of the Coroner.
- Coroner's discretion re calling of witnesses formerly prescribed by statute (s.11(2) Coroners Act 1988); provision repealed by 2009 Act and not replaced, so position at law now defined by the case law.
- For the coroner to decide how to adduce the necessary evidence as to death: *McKerr v Armagh Coroner* [1990] 1 WLR 649.
- Coroner not required to call every witness who might have relevant evidence, but sufficient witnesses to undertake a proper inquiry: *R (Ahmed) v South & East Cumbria Coroner* [2009] EWHC 1653 (Admin); *Mack v HM Coroner for Birmingham* [2011] EWCA Civ 712 (CA).
- Coroner determines what witnesses are called and what cross-examination permitted and what evidence is considered relevant. Wide discretion in respect of each: courts will only intervene if coroner's decision is *Wednesbury* unreasonable (*Mack*).
- Will ordinarily be determined at the PIRH; IPs may make submissions beforehand / at the hearing re which witnesses should be called.
- NB coroner has same discretion re expert evidence.

Advocacy style

- Inquisitorial proceedings: limited fact-finding inquiry undertaken in public, not about determining or appearing to determine issues of liability and no 'case to be put'. Must modify approach accordingly.
- Issues re adversarial approach adopted by some lawyers + reports from INQUEST on the experiences of bereaved families → Law Society and BSB issuing new guidelines in September 2018 for all legal professionals practising in the Coroners' Courts.
- Emphasis on the bereaved family being at the 'front and heart' of the process; need to communicate with empathy and tact, avoiding re-traumatising the bereaved.
- Challenge evidence of other interested persons "with due sensitivity". Firm, searching – even robust – questioning still permissible, but need for respect and courtesy stressed.
- Applies to the Coroner as well: *Nguyen v Assistant Coroner for Inner West London* [2021] EWHC 3354.

Witness handling

- Similar points apply: need for patience, sensitivity and courtesy.
- Guidelines suggest avoidance of unduly complicated language, use of plain English etc, whenever possible.
- NB scope of jurisdiction and therefore also of questioning: must be directed to ‘how’ the deceased came by their death rather than ‘why’; avoid / be alert to illegitimate fishing expeditions / issues of culpability being raised.
- Limited to lines of questioning that the coroner permits: a coroner must disallow any question to a witness which she considers irrelevant (r.19(2) C(I)R 2013. Alienating a coroner may truncate an otherwise legitimate line of questioning.
- Unless the coroner determines otherwise, witnesses must be examined first by the coroner, then by any interested person who has asked to examine the witness and lastly (if represented) by their representative (r.21).
- R.22(1) C(I)R: no witness is obliged to answer any question tending to self-incriminate, and (2) if it seems to the coroner that a witness has been asked such a question, the coroner must inform the witness that they may refuse to answer it. (Should be considered prior to inquest, if it is thought issues may arise.)

Tactics

- As above, make best possible use of PIRH(s): disclosure, witness identification & selection, scope, need / wish for a jury, expert evidence etc.
- What is the client hoping to achieve / avoid? Is the coroner's / jury's conclusion the key concern, or desire for particular findings of fact / specific admissions or concessions to be made / not made (with an eye to future civil proceedings)? Is a PFD (or avoidance thereof) the main objective?
- Can further documents be prepared to assist the coroner / jury? (Either neutral, e.g. a chronology, or written submissions etc.)
- Keep evidence to be considered and given under continual review.
- What findings of fact must be made / evidence put forward in order to ensure that particular conclusions may safely be left to the coroner / jury?
- Which witnesses address these issues in their evidence? Has contradictory evidence come to light?
- Read the room: what does the coroner / jury seem most concerned by / interested in?
- Consider / suggest appropriate form of words for Box 3 and / or a narrative conclusion (if sought): what evidence will this require?
- Should an SI report / action plan etc be looked at again in light of the evidence? Can the client respond flexibly / give instructions quickly, dependent upon the evidence that comes to light / any requests from the coroner from further information?

Potential conclusions

- Must always be sufficient evidence for a conclusion on the '*Galbraith* plus' basis: (a) is there sufficient evidence on which the conclusion could properly be reached, and (b) would it be safe for the conclusion to be reached / left to the jury? (Cf Law Sheet No. 2: *Galbraith* plus)
- Two alternatives for conclusions which are sanctioned by CJA 2009, C(I)R 2013 and common law: short-form conclusion and narrative conclusion. Also permissible to combine the two types of conclusion. Must be entered in Box 4.
- Short-form conclusion preferable: *"Wherever possible coroners should conclude with a short-form conclusion. This has the advantage of being simple, accessible for bereaved families and public alike, and also clear for statistical purposes."* (Guidance No. 17, para 26).
- Standard of proof for all conclusions (short form and narrative): balance of probabilities, including suicide and unlawful killing: *R(Maughan) v HM Senior Coroner for Oxfordshire* [2020] UKSC 46; Law Sheet 6. Every element of the offence must be established, but on balance of probabilities rather than beyond reasonable doubt. (NB no impact on Rule 25.)
- 9 short form conclusions appear in notes to Record of Inquest form scheduled to the C(I)R 2013: (i) accident or misadventure, (ii) alcohol/drug related, (iii) industrial disease, (iv) lawful/unlawful killing, (v) natural causes, (vi) open, (vii) road traffic collision, (viii) stillbirth, (ix) suicide.
- Narrative conclusion: in a non-Article 2 case, should be a brief, neutral, factual statement and should not express any judgment or opinion (*Jamieson*). By contrast, a conclusion in an Article 2 case may be a 'judgmental conclusion of a factual nature [on the core factual issues], directly relating to the circumstances of death' *(Middleton*) at [37].

Potential conclusions – Box 3

- Box 3 on the Record of Inquest records 'how, when and where' the deceased came by his / her death and does not technically form part of the conclusion, though the conclusion must flow from and be consistent with its contents (and Box 3 contents must likewise flow from and by consistent with the finding of facts).
- Often a brief – even one sentence – summary of the coroner's findings of fact, which are given orally beforehand in open court. (Jury must be directed to make findings of fact for themselves based upon the evidence they have heard. They will not normally record these findings of fact publicly except insofar as they form part of the answer to 'how' or part of a narrative conclusion.)
- Usually a technical description of the mechanism of death, e.g. 'by hanging from an exposed beam using a ligature made from a bedsheet' (with conclusion of 'suicide' entered in Box 4); 'from trauma consistent with an un-witnessed fall downstairs' (with conclusion of 'accident' entered in Box 4).
- NB where the coroner (or an IP) wishes to record a short form conclusion but circumstances of the death are complicated, a longer and more detailed Box 3 entry can be a way of ensuring salient facts are formally recorded / avoiding a narrative conclusion: *"If the three stage process of (1) findings of fact, (2) the answer to 'how', and (3) a short-form conclusion is properly followed, there will often be no need for a narrative conclusion"* (Guidance No. 17 'Conclusions').
- 'How' usually means 'by what means', but in Art. 2 inquests 'by what means and in what circumstances' (section 5(2) CJA 2009; *R (Middleton) v HM Coroner for West Somerset* [2004] 2 AC 182, and judgmental language is permissible.

Potential conclusions – unlawful killing

- Unlawful killing as a conclusion was previously only open to a coroner/jury on the criminal standard of proof: beyond reasonable doubt. Following *R (Maughan)*, all inquest conclusions can be found on the civil standard (balance of probabilities)
- Not just homicide offences: consider health and safety offences which caused death
- If there is a suspicion that a criminal offence led to the cause of death, a coroner must open an inquest but adjourn it until the outcome of criminal proceedings has been finalised – Schedule 1(1) CJA 09.
- An inquest must be resumed if no further action taken and period of adjournment expired – Schedule 1(7) CJA 09
- An inquest may be resumed following criminal proceedings or criminal charge if the coroner thinks there is sufficient reason for resuming the inquest. The inquest's determination cannot be inconsistent with the criminal proceedings – Schedule 1(8) CJA 09
- Likely to be relevant in an A2 context where actions of the state did not form a central part of criminal proceedings
- The evidence and findings of an inquest can result in the CPS revisiting a charging decision

Potential conclusions - neglect

- Not a free-standing conclusion, but may be a 'finding' (recorded in Box 4) or a 'rider' to a short form conclusion / part of a narrative conclusion.
- Test remains that set out in *R. v North Humberside Coroner Ex p. Jamieson* [1995] Q.B.1, CA 25:
- *"Neglect in this context means a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, 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 that he obviously needs it may amount to neglect. So it may be if it is the dependent person's mental condition which obviously calls for medical attention … In both cases the crucial consideration will be what the dependent person's condition, whether physical or mental, appears to be."*
- Key elements in a medical context (where the question of neglect is raised most): deceased must have been in a dependant position, failure must be 'gross' (not to be equated with negligence, even gross negligence), and failure must have involved a lack of necessary medical attention.
- Concerns basic medical attention: not complex-decision making or incorrect treatment.
- Must also be a clear or direct causal connection between the failure and the cause of death.
- It should be noted that in medical cases (separate from neglect), art.2 is likely to become engaged only where there has been a breach of the state's duty amounting to a "systemic failure", not in an "ordinary" case of negligence: *R. (Parkinson) v Kent Senior Coroner* [2018] 4 W.L.R. 106; [2018] EWHC 1501 (Admin) at [89], following *Fernandes v Portugal* [2018] Inquest L.R.

Prevention of future deaths: *"vitally important if society is to learn from deaths"* (Guidance No. 5: para 2)

- Para 7(1) Sch.5 CJA 2009 & C(I)R 2013 Part 7, Regs 28 & 29
- Chief Coroner Revised Guidance No. 5 (revised 4 November 2020)
- 7(1)Where—
- (a)a senior coroner has been conducting an investigation under this Part into a person's death,
- (b)anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
- (c)in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
- the coroner must report the matter to a person who the coroner believes may have power to take such action.
- (2)A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.
- (3)A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.
- Pre-condition to making a report that the coroner has considered all the documents, evidence and information relevant to the investigation (Reg 28(3)).
- Normally made at end of an inquest, but may be made before if coroner considers the matter is urgent and further relevant information unlikely to be produced.
- Should be sent out within 10 working days of end of inquest; 56 days to respond, subject to extensions agreed by coroner.

Prevention of future deaths - continued

- PFDs should be *"clear, brief, focused, meaningful and, wherever possible, designed to have practical effect"* (Guidance para 4).
- Coroner has no power to revoke a PFD; appropriate remedy to correct errors of fact is to respond (Guidance para 39).
- 'Giving rise to a concern' is a relatively low threshold. Concern is of a risk to life caused by present or future circumstances (*Coroners Inquests into the London Bombings of 7 July 2005*, per Lady Justice Heather Hallett, Assistant Deputy Coroner for Inner West London, ruling 6 May 2011, transcript p15).
- Need not be restricted to matters causative (or potentially causative) of the death, nor relate to deaths in similar circumstances.
- Not for the coroner to dictate precisely what action should be taken: a PFD report raises issues and is a recommendation that action should be taken, but not what that action should be (Guidance para 27).
- Exceptionally, where duty to report does not arise, coroner may send a letter to relevant person / organisation(s) to highlight concerns. (Can be suggested as an alternative to a report, in borderline cases.)
- Best way to avoid: provide robust evidence that remedial actions have already been taken (or are underway within a clear timeframe). Can update action plans etc during inquest: ensure client is able / willing to respond and or provide instructions swiftly.

Challenges to coronial decisions and conclusions

- Judicial review of any coronial decision or conclusion – the usual public law grounds will apply (this includes non-compliance with the A2 procedural duty)
- Statutory review by s.13 of the Coroners Act 1988: where a coroner refuses/neglects to hold an inquest, or where it is necessary or desirable in the interests of justice that an investigation (or, as the case may be, another investigation) should be held
  - Interests of justice: examples given by statute are fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, discovery of new facts or evidence
- Differences in remedies – statutory review can only quash an inquest or a determination made at inquest

Considering a future claim

- Opportunity to obtain pre-action disclosure, ‘dress rehearsal’ for cross-examination / testing of (potential) future witnesses of fact and expert witnesses.
- Inferior court of record; inquest conclusion accordingly not binding on any person raising the same question in subsequent litigation.
- However may curtail the issues that require determination in any potential civil claim / obviate the need for a trial altogether.
- Short form conclusions and narrative conclusions: ‘brief, neutral factual statement’, but NB (i) Box 3 findings of fact and (ii) Article 2 ‘enhanced’ inquest, which permits ‘judgmental conclusion of a factual nature’.
- Consider possibility of HRA claims by family members: breaches of Article 2 ECHR (operational duty – see *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72), NB lower standard of proof, also Articles 3 and 8 ECHR.
- Dependency claims: Fatal Accidents Act 1976, psychiatric injury claims (as secondary victim) as well as claims founded in negligence.
- Limitation: if representing bereaved family or estate, may need to issue protectively (against all potential defendants) and then seek a standstill agreement.

Costs and funding

- Legal aid funding not generally available to bereaved families (Law Society recommendations notwithstanding) and coroner has no power to award costs of legal representation.
- Legal Help and Exceptional Case Funding
- Means and merit tested: application to Legal Aid Agency.
- Merit: potential risk of human rights breach if not granted (Art 2) / wider public interest that makes funding necessary.
- Means: comprehensive financial information required and stringent criteria to be met.
- As of Jan 22, means testing has been removed in A2 inquests (merits test only)
- Alternatives: private funding, or conditional fee agreement.
- Inquest costs may be recoverable inter partes as part of a subsequent civil claim if reasonable, proportionate and can properly be said to be incidental to the civil claim (*Ross v Bowbelle* [1997] 2 Lloyd's Rep 296).
- Cannot expect to recover 100% of the costs, and procedural costs / costs of persuading a coroner to reach a particular conclusion cannot be recovered within the civil action *(Lynch & Others v Chief Constable of Warwickshire Police & Others* (2014) SCCO 14. Recoverability of costs requires forensic analysis and is case-specific.
- NB if an unqualified admission of liability is made by (potential) defendant(s) pre-inquest, inquest costs will probably not be recoverable (though this is rare).