# Dealing with inquests in the coroner's court: a guide

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# Dealing with inquests in the coroner's court

**Dealing with an inquest into the death of a loved one is never an easy process, even more so if you lack legal representation. In this guide to dealing with coroner's court inquests, we set out some tips to help you understand and prepare for the inquest process.**

## Legal representation

In cases where the facts relating to the death are not obvious and the issues are complex, for example where an unexpected death happened in hospital, the bereaved family would ideally be entitled to legal aid.

Unfortunately, however, the bereaved family will only be entitled to legal aid in limited circumstances, such as deaths in custody and in some cases involving the provision of mental health care.

With this in mind, if you are able to do so, it is still a good idea for you to arrange to have legal representation for the inquest. Having a solicitor or barrister putting forward questions on your behalf will nearly always be beneficial for you.

## INQUEST may be able to help

There are organisations that can sometimes arrange for individuals to be legally represented, potentially at no cost to the individual. INQUEST is a charity that does help in this regard, and they are worth contacting.

You should also consider approaching specialist solicitors who deal with personal injury and clinical negligence claims if the death raises such issues.

## Representation under a conditional fee agreement

In cases where the death took place in hospital, or as a result of an accident at work, and there may be a potential civil claim as a result, it's possible that a firm will take on the case under a conditional fee agreement (also known as 'no win no fee').

This means that you won't be responsible for any of the inquest costs until the end of the case, and only then if the claim is successful.

The vast majority of specialist firms will provide some initial advice for no fee. If you are unsure, just ask the solicitor to confirm that this will be the case.

## Befriending the coroner's officer

Befriending the coroner's officer is often a good first step. The officer is often a former police officer and will be very helpful in guiding and supporting you through the process.

All inquests have a coroner's officer assigned to the case and they will become the bereaved family's first port of call throughout the process leading up to the inquest hearing itself.

It is worth remembering that the coroners are often handling many matters, so it can take time for relevant information to be passed down.

If you need to know about progress regarding, for example, the provision of relevant documentation such as the post-mortem report and any witness evidence, we would advise you to get an update from the officer.

In the aftermath of the Covid-19 pandemic, the coroners' courts have become even busier. As a result, the likelihood that cases will experience delays is higher. Individuals beginning an inquest should prepare themselves for potential delays in the listing of an inquest.

Normally, an inquest should be held within six months of the date of death but, unfortunately, many inquests are listed outside of the six-month time period.

## Documentation is key

Making sure that the coroner has all the relevant information is vital. Nowadays most coroners will release relevant documentation to the parties before the inquest starts.

Make sure you ask the officer to provide you with all the documentary evidence upon which the coroner intends to rely at the inquest.

This will normally include:

- the post-mortem report and any toxicological reports;
- the witness evidence and list of witnesses (see below);
- the medical records and some form of police report if the police were involved.

If you can obtain such documentation this will give you a chance to review it and prepare your questions for the witnesses.

Do not be afraid to ask the officer if you think that there is any missing evidence.

## Witness evidence

It may be helpful to ask the coroner’s officer or the coroner for a list of witnesses, and specifically a list of the witnesses who will be giving oral evidence in court, as opposed to simply providing a written statement to be read out in court.

If you think there is a witness who should give evidence who is not on the list, or who is on the list but is not down to give oral evidence, then you should raise it with the coroner’s officer.

You will need to explain why a particular witness should give evidence orally. In order to do so you will need to argue that the particular witness needs to answer questions which directly relate to the death in question.

Getting the right witnesses on the day is key to ensuring that, as far as possible, your questions relating to the death are considered.

## The pre-inquest review

It is becoming increasingly common for the coroner to decide to hold a review sometime before the actual inquest takes place. This will usually be the case where the inquest is likely to last at least a day, and where there is a large amount of documentation.

The coroner will use these reviews to finalise the witness evidence and decide who will actually be called to give evidence, as well as defining the 'scope' of the inquest and the documentation that will need to be included in an inquest bundle. No evidence will be heard at this stage.

You need to be prepared to argue which witnesses should be called to the hearing and the documentation that should be referred to.

The review is usually relatively informal and will give you an opportunity to meet the coroner and also see inside the court itself, which can make the actual inquest potentially less daunting.

## Will the hearing be in person or held virtually?

Some coroners have fully embraced remote hearings, and some are keen to have all the evidence heard remotely with no one in court other than the coroner and the coroner’s officer (who have to be there by law).

There will of course be some circumstances, for example when a witness is a long way away, where it will make sense for their evidence to be dealt with via a link.

However, the Chief Coroner has given guidance to all coroners that, generally, witnesses should be attending the court in person, and they need a good reason why they should not attend.

Don't be afraid to inform the officer of your wishes and you can always refer the officer to the **Chief Coroner's guidance No 38** which deals with this issue and is a helpful guide.

## Will there be a jury?

In certain circumstances, such as an accident at work or in custody, a jury has to be called. In many cases it is at the discretion of the coroner.

Some instances where an inquest may involve a jury include if there are wider ramifications for the public.

Additionally, if there is a jury, some would argue that the jury is likely to be more sympathetic towards the bereaved family and may at the end come up with a more satisfactory (as far as the bereaved are concerned) conclusion/verdict than if there was a coroner alone.

However, a jury's sympathy is not guaranteed. Over the years we have seen some very sympathetic coroners and some very unsympathetic juries.

## What do I call the coroner and what do I wear?

The coroner should be called either Sir or Madam, or sometimes you will hear her being addressed as Ma'am.

There is no particular dress code. However, we would recommend that you dress in smart casual if you are able to.

Any legal representatives will normally wear a suit. If there is a barrister attending court, they will not need to wear a wig which they would do in a civil or criminal court.

## Who, where, when and how?

Nearly every inquest starts with the coroner explaining what a coroner has to do during an inquest. The coroner's job is to answer four questions, who died, where did they die, when did they die and how did they come by their death?

The first three questions are often relatively easy to answer and so the focus for most of the families we represent is on the last question, how did they die?

The coroner is not allowed to assign blame during the inquest, nor can the coroner reach any conclusions relating to civil or criminal liability. The role of the coroner is to carry out a fact-finding exercise.

That being said, the coroner also has a duty to thoroughly investigate all actions or inactions which may have impacted the situation.

This may mean that evidence is heard describing, for example, poor care provided to someone in hospital. If this lack of care – on the balance of probabilities – was related to the death, the coroner ought to explore this issue during the hearing.

## The inquest itself

Make sure to arrive at the court at least 20 minutes before the hearing is due to start. Go to the coroner's officer when you arrive and ask if there is a room which can be used by you and the rest of the family and friends throughout the day.

In our experience it is far nicer for the family to have their own room rather than having to spend time sitting in a waiting area, potentially surrounded by all the other witnesses and legal representatives.

Check with the officer that all the witnesses have turned up. Ideally one family member, if they are up to it, should give oral evidence, even if just to give a bit of history about the deceased and to paint a picture of them as a person, otherwise the whole process can become rather impersonal.

## The process

Most inquests start at either 9:30 or 10am and usually will finish by 4pm, with a break for lunch and sometimes with other comfort breaks.

If any of the evidence becomes too difficult for someone to hear (often this is evidence from the pathologist) you should not be afraid to either ask the coroner for a short adjournment or simply rise from your seat and go out of the court. You can ask to be brought back in once the difficult evidence has been heard.

Once the inquest gets underway the coroner will decide in which order the witnesses will give evidence and when the coroner will put in the documentary evidence.

Witnesses giving oral evidence will usually be questioned by the coroner first, then by you or your legal representative, and then by lawyers representing other interested parties, such as a hospital or employer.

## The conclusion / verdict

Once all the evidence has been heard, the coroner will ask if anyone wants to make any submissions on possible conclusions or verdicts. If no submissions are made, the coroner will still reach their conclusion.

Put simply, the coroner can reach a one-word/short form conclusion (such as accident or misadventure or suicide) or can decide to reach a narrative conclusion.

A narrative conclusion usually consists of one or two more descriptive sentences as to how somebody died. However, the coroner is not allowed to use words such as fault or negligence.

If you do not have legal representation, the coroner will not expect you to make detailed submissions.

For more information on the legal position regarding conclusions you can read through the Chief Coroner's Guidance No. 38, which gives a helpful summary of the legal positions. The guidance is available to download free of charge **here**.

As well as the conclusion of the coroner, the medical cause of death has to be established. Normally this will be set out in the post-mortem report but the medical cause of death can be changed after the coroner has heard the evidence

## The death certificate

At some point before the inquest started you should have been provided with an interim death certificate.

Once the inquest has been concluded you'll be able to apply for a final death certificate which can be obtained from the relevant probate registry.

If needed, the coroner’s officer will be able to give you more information in that regard.

## Prevention of further deaths reports

The coroner has a duty to consider whether a report should be made to the 'relevant authority', if there is a concern throughout the inquest process that future deaths might occur in similar circumstances.

As an example, we were once involved in a case where such a report was made to the chief executive of the relevant hospital where a death occurred when a drug was administered to the wrong patient. The coroner was concerned that such a situation could happen again as he was not satisfied that the process of identification of patients was as good as it should have been.

There is no significant sanction accompanying such a report but a response should be provided to the coroner and, most importantly, to the family, usually within a timeframe of about two weeks.

## Appeals

It is possible to appeal against any decision made by the coroner (for example, a decision not to hold an inquest at all). However, in our experience it is very difficult and often costly to succeed in such an appeal.

There are only really two routes you can take; one is by way of 'judicial review' for which you generally need the permission of the High Court, or there is another statutory route where you need the permission of the Attorney General.

If you are considering an appeal, we would strongly advise you to find a solicitor who deals with judicial review cases and bear in mind that there is not much time. Most judicial reviews have to take place within three months of the date of the inquest.

## How we can help

We have prepared this free guide to inquests in the hope that it may be of some assistance to you at such a difficult time.

If you would like to speak with a member of the team you can contact our medical negligence solicitors by telephone on **+44 (0)20 3826 7517** or complete our **enquiry form**.

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