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briefing

Coroner's inquests: outcomes

Introduction

The Coroner's court is a fact-finding inquiry and not an adversarial trial with a verdict. There is no set list of conclusions just some suggestions in the notes to the Coroners (Inquests) Rules 2013. They are not binding and Coroners are free to use their own words (though not encouraged). The Chief Coroner's guidance No. 17, paragraph 26, states that "where possible, Coroners should conclude with a short form conclusion".

Standard of proof

The usual standard required for a Coroner to reach a conclusion is the civil standard being "on the balance of probability", though for unlawful killing it needs to be up to the criminal standard "beyond all reasonable doubt".

Natural causes

There is no formal definition of this though it is suggested that the normal progression of a natural illness, without any significant element of human intervention, is indicated. The Coroner's bench book suggests:

> "*…the result of a naturally recurring disease running its full course*"

An "unnatural death" is one caused or accelerated by any act, intervention or omission, other than a properly executed measure intended to prolong life.

The question of what amounts to a death by "natural causes" was considered in the case of *R (Touche) v Inner North London Coroner* [2001].

It was held by the Court of Appeal that a death by "natural causes" should be considered an "unnatural death" where it was wholly unexpected and would not have occurred but for some culpable human failing, Lord Justice Brown stated that:

> "*It is the combination of their unexpectedness and the culpable human failing that allowed them to happen which to my mind makes such deaths unnatural. Deaths by natural causes though undoubtedly they are, they should plainly never have happened and in that sense are unnatural*".

Further Jervis on Coroner's (13th Ed, 2014) provides that when considering the conclusion of natural causes:

> "*…the critical question is not whether a cause of death is unnatural, but whether the death is. So if a natural cause of death (e.g. a disease occurring naturally) is provoked in a person by unnatural means (e.g. deliberate or accidental ingestion of pathogens) or is provoked naturally but there was an effective opportunity to prevent its taking its course (e.g. failure to treat where this would have been successful), then that death is an unnatural one*".

Medical care

However, in some deaths under medical care, the dividing line between a natural cause and a death arising from some element of treatment (or lack of it) may be more difficult to establish. *R v HM Coroner for Birmingham ex parte Benton* [1997] provides helpful clarification of the meaning of the conclusion of "natural causes" in the context of an admission to hospital (as distinct from accident or misadventure) as follows, emphasising that such a conclusion does not equate to a finding that there have been no errors in the medical management:

- Where the patient was suffering from a potentially fatal condition, and the medical intervention (even if wrongly given) merely failed to prevent the death, the proper conclusion was "natural causes" as it was the underlying condition which had caused the death.
- If there was a failure to give medical treatment to such a patient, even negligently, this would still amount to a death from natural causes.
- If the patient was suffering from a condition which was not life-threatening but the treatment (for whatever reason) caused death, the proper conclusion was accident or misadventure, unless there was a question of unlawful killing.

The Court stressed that a conclusion of death by natural causes was not in any way a finding of no fault on the part of the doctors, just as the recording of death by accident or misadventure would not imply that there was fault. Fault is not an issue in the Coroner's Court.

Accident/misadventure

Accidental death/misadventure are appropriate traditional short-form conclusions to return in a case where it is found that the medical treatment caused the death: see *R v HM Coroner for Birmingham ex parte Benton* [1997].

Generally speaking most cases that fall into this category are self-evident with the cause of death arising from some unnatural event which was neither unlawful nor intended by the deceased to result in death.

Although there is no real distinction between accidental death and misadventure, some Coroners prefer to use misadventure to denote where someone deliberately undertakes a task which then goes wrong, therefore causing death.

Suicide

It must be shown on the balance of probability that:

- The death occurred as a result of a deliberate act by the deceased.
- That in doing so and at all relevant times, the deceased intended the consequence would be death.

In reality other possible explanations should be ruled out.

Open conclusion

This is the proper conclusion where the evidence does not fully disclose as to how the cause of death arose. There is insufficient evidence to justify another conclusion. It is a conclusion in its own right and not simply as a result of a jury's failure to agree.

Neglect

The leading authority on neglect remains *R v HM Coroner of North Humberside and Scunthorpe Ex p Jamieson* [1995]. For a conclusion to be returned which includes a rider of neglect the Court must be satisfied that the deceased was in a dependent position and that as a matter of law there is evidence of:

- A gross failure
- Clear and direct causal connection between the gross failure and the death

The definition of the term "neglect" is set out in *Jamieson* in which it was held that:

> "*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 (as it would, for example, if a mental nurse observed that a patient had a propensity to swallow razor blades and failed to report this propensity to a doctor, in a case where the patient had no intention to cause himself injury but did thereafter swallow razor blades with fatal results). In both the cases the crucial consideration will be what the dependent person's condition, whether physical or mental, appeared to be*"

Neglect and medical cases

"Neglect", it is suggested:

- Can only be directed to the quality of the act in the circumstances operating at the time without the application of hindsight and not to the quality of the outcome.
- It is not an appropriate rider where a doctor has made a clinical judgment about a patient which is challenged as being negligent. It is only appropriate in medical cases where the medical treatment was so poor as to amount in fact to a gross failure to provide basic medical attention – e.g. complete failure to institute routine blood pressure monitoring for a period of two hours.

Consequently in the context of medical cases for a conclusion including a rider of neglect to be returned the following components must be present:

- With respect to the failure:
  - That failure must be gross
  - There was a failure to provide basic care
  - The need for the basic care must be obvious – "it must be as plain as a pikestaff"
  - The need for the basic care must be obvious and judged according to what the dependent's condition appeared to be, not to what it actually was
- With respect to causation:
  - There must be a clear and direct causal connection between the conduct which is alleged to amount to neglect and the death

- There must be a real opportunity of doing something effective in rendering care to the deceased which would have prevented death

Narrative

While there is a list of suggested conclusions which can be used to complete the "Record of the Inquest" (the document used to record the conclusion) and which are colloquially referred to as "short form conclusions", these notes do not form part of the rules and are not binding.

The only requirements of a "conclusion", statutory or otherwise, are that:

- It "… shall not be framed in such a way as to appear to determine any question of – (a) criminal liability on the part of a named person, or (b) civil liability"

- It is expressed in concise and ordinary language so as to indicate how the deceased came by his death

Accordingly a short narrative conclusion is available to the Coroner or jury.

However, although encouraging the use of such conclusions (then verdicts) the House of Lords, in the case of *R (Middleton) v West Somerset Coroner and another* [2004], strongly discouraged including *"… expressions suggestive of civil liability, in particular 'neglect' or 'carelessness' "* and related expressions in any narrative conclusion, expressly stating that such expressions should be avoided.

The problem of judgmental language is obvious and care needs to be taken. For example in the original Hillsborough inquest the Court rejected a conclusion of "accidental death caused by a failure of the police to divert supporters away from the tunnel".

The question of the causal connection

How wide will the Coroner cast his net?

When the State may be implicated in someone's death, there must be an effective official investigation into that death. This is so because of the provisions of Article 2 of the European Convention on Human Rights. This investigation will normally be at an inquest.

If there is no need for such an investigation, the inquest will normally only consider how the deceased came by his death in a very narrow sense: in effect, what killed him or her? If an "Article 2" style inquest is held, the wider circumstances of the death must be investigated. How broad should the investigation be – how far can or should the Coroner go?

A High Court case concerning a death in custody, *R (on the application of Lewis) v Mid and North Division of Shropshire Coroner and others* [2009], emphasised that Article 2 does not require Coroners to investigate matters over and above those that "bear a causal relationship to the death". The Coroner was entitled to refuse to allow the jury to address the fact that the prison officer who found the deceased hanging did not immediately enter the cell to provide assistance. It could not be said on the balance of probabilities that the deceased was still alive when he was found, so the officer's actions could not be said to be causative of death – the Coroner was therefore entitled to stop the jury from addressing the prison officer's inaction. However, had the Coroner decided to allow the jury to consider this issue, he would have been entitled to do so. This confirms that at the end of the day the scope of an inquest remains very much a matter for the individual Coroner.

Case law

R (Touche) v Inner North London Coroner
R (Middleton) v West Somerset Coroner and another [2004] 2 AC

R (on the application of Lewis) v Mid and North Division of Shropshire Coroner and others [2009]

Legislation

Coroners Act 1988
Coroners and Justice Act 2009
Coroners (Inquests) Rules 2013
Chief Coroner guidance No. 17

Mills & Reeve on-line inquest support

You will find this guidance and a lot more information and guidance documents on our free on-line support page.

There is also a set of videos with top tips on what to do and others tell their stories of who they got through the process. All designed to make it a little bit easier for you.

Follow the link or type in:
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"I'm most grateful for your support during the Inquest. It was outstanding. "
Executive Director Forensic Services, NHS Client

"I feel genuinely privileged to know that you are on our team and offer my heartfelt thanks"
Dr Stephen Merron, Consultant Anaesthetist, University Hospital North Midlands NHS Trust

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