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briefing

Pre-inquest hearings. Be prepared!

Essential guidance

Coroners list more pre-inquest hearings. It is vital everyone knows, well in advance, what is to be discussed and decided. Proper preparation by all, including the Coroner, will lead to better outcomes. Coroners need to avoid any impression of bias.

Summary

Following allegations of collusion and conspiracy between the police and a Coroner, the Chief Coroner has given clear guidance on how to conduct pre-inquest hearings. It all seems sensible and Coroners would do well to follow them. Interested persons should always ask a Coroner to prepare an agenda before turning up to a pre-inquest hearing (PIH). It will also be helpful if interested persons suggest matters they would like to be included for discussion so everyone knows what is expected before the final hearing and proper preparation can be made to ensure a fair conclusion is reached.

The background

Ernest Andrew Brown v HM Coroner for Norfolk and the Chief Constable of Norfolk (2014)

The High Court handed down a decision following an application for an order to quash an inquest and to hold a fresh investigation. It was established that incomplete and inaccurate evidence was presented to the Coroner following an inadequate police investigation. It was decided that the Coroner, in that case, was unable to reach a safe and reliable conclusion as to how the deceased came about her death because vital evidence about the circumstances of death had not been brought to his attention.

It's all about creating the right impression

The claimant had made assertions of collusion and conspiracy between the police and the Coroner, some of which related to the conduct of events at the PIH. The Coroner was not asked to respond to these assertions for the purposes of this application. HHJ Peter Thornton QC (the Chief Coroner), who was sitting as a judge on this application, felt these assertions (irrespective of any truth in them) identified potential pitfalls for Coroners in the handling of PIHs, which could be avoided by good practice. He identified some "pointers" for Coroners in the hope that repeated good practice will avoid, or at least reduce, the number of complaints which may be levelled at Coroners in the future, particularly in relation to PIHs.

Best practice

- **Notice**: The Coroner should ensure that all interested persons, particularly bereaved families, have sufficient notice of the matters to be discussed at the PIH.

- **Agenda**: Coroners should provide a written agenda in advance and, if appropriate, express provisional views so that agreement or opposition could be expressed. The agenda should include, particularly in the more complex or difficult cases, the following:

  - A list of interested persons
  - A proposed list of witnesses, identifying those who might be called and those whose statements might be read
  - The issues to be considered at the inquest
  - The scope of the evidence
  - A statement as to whether a jury would be required
  - A statement as to whether Article 2 of the European Convention on Human Rights is engaged
  - Any issues of disclosure
  - The date of the final hearing
  - Any other relevant matters

  In a complex or difficult investigation, interested persons should be invited to respond to the Coroner's agenda in advance of the PIH, in writing, stating what they agree with and disagree with.

- **Disclosure**: The Coroner should also ensure that interested persons, particularly those who are unrepresented, have sufficient disclosure of relevant statements and documents before the hearing so as to be able to address the agenda on an informed basis. We suggest you should always invite the Coroner to disclose such evidence well in advance if it is not forthcoming voluntarily.

- **Recording of evidence**: "It's on the record". Coroners are required to make and keep a recording of a PIH under Rule 26 of the Coroners (Inquests) Rules 2013. The Coroner should take reasonable steps to ensure the recording equipment is working well and those who speak in court do so in such a way that the recording can be transcribed with accuracy and in full. An inadequate transcript can lead to suspicion and argument.

- **Conclusions and findings**: "Don't appear to pre-judge". Coroners should avoid giving the impression at a PIH (and in any documentation supplied before it) that the findings and conclusions of the inquest (or indeed final decisions of the PIH) are in any way predetermined, even when the evidence points substantially in one direction.

- **Appearance of bias**: Coroners should, at all times, take care in their dealings with interested persons not to give the impression of bias or favouritism. A Coroner should be careful in correspondence with an interested person, such as a health and care provider, not to appear to be too familiar with or close to the correspondent; they should also not encourage familiarity from the correspondent, even though they might have got to know the correspondent well in the course of their work as a Coroner. Coroners should only write letters (and emails) in the course of their work which would stand the test of looking fair and unbiased if read out in court in litigation.

  So avoid those first name terms!

Case law

Ernest Andrew Brown v HM Coroner for Norfolk and the Chief Constable of Norfolk (2014)

Legislation

Coroners and Justice Act 2009
Coroners (Inquests) Rules 2013

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: https://www.mills-reeve.com/foresight/inquests/information-on-inquests

Recent Feedback

" 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

Contacts

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