The Coroners' Court Support Service

Inquests

A factsheet for families

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An inquest is an investigation led by a coroner to find out how someone died. An inquest is held when a death was sudden, unexpected, in State care or the cause of death is unknown.

We hope this factsheet will provide some basic information to help you understand the inquest process. We recommend that you get specialist legal advice if your loved one died whilst in the care of the State (e.g. in a psychiatric unit, prison, immigration unit, or police custody) or if you are concerned that something went wrong that may have led to your loved one dying unexpectedly.

What is an inquest and when is one held?

An inquest is a fact-finding investigation led by a coroner to find out four facts about a death: who died, when they died, where they died and how they died. An inquest is not a civil or criminal trial and it is not the coroner's job to blame anyone for the death.

Where a death happens suddenly or unexpectedly, or where a death occurs in State detention, then it will be reported and referred to the coroner by, for example, a doctor, medical examiner or the police. The coroner then gathers information and evidence to consider if a full inquest hearing will be held.

Each coroner has wide discretion about how they manage their investigation for each case and can take different approaches to gathering in evidence, sharing it with the family and running inquest hearings. Except for the most straightforward of cases, the coroner's investigation takes place over a number of months and in complicated cases may take longer.

What is the usual inquest process?

Inquest processes can vary between different coroners' courts, however, the coroner is likely to take the following steps:

1. A death is referred or reported to the coroner. This can be done by doctors, prison staff, police or a medical examiner.

2. A coroner will review the information passed to them and decide whether to open an inquest or whether they need more information to consider the case before doing so. If a coroner opens an inquest, you will be notified of a hearing to open the inquest. This hearing takes place in court, however it is a very short hearing with the coroner simply stating the name of the person who died and that an inquest will be opened. There is no need for family to attend this hearing.

3. In most cases, a coroner will order a **post-mortem**, also known as an autopsy. This is performed by a pathologist, which is a specialist doctor. Most post mortems are done by examining the body and the deceased's organs to determine the likely cause of death. Sometimes tissues or organs will be sent for further tests to other specialists such as toxicologists (to look for legal and illegal substances in the system) and cardiopathologists. Families do not have to give consent for a post mortem to be carried out as it is a legal obligation of the coroner to conduct a post mortem if they feel it is necessary to determine how someone has died. If you have cultural or religious reasons for not wanting a post mortem then this can be raised with the coroner. A post mortem report will go through all of the pathologist's investigations and come to a likely conclusion on the medical cause of death.

4. Following the post mortem, the coroner may close the investigation if they feel that the death has been adequately explained and no further evidence is required. If the investigation continues, then the coroner will consider what other evidence they require, such as medical records, and statements from people who knew the deceased or had contact with them prior to their death.

5. The Coroner may ask you, as the family of the person who has died, to provide a **statement for the coroner** to help their investigation. The coroner wants the family to provide a statement to know more about the individual who died, what the family know about any events leading up the death and, importantly, any concerns that the family have around the treatment of the deceased prior to their death. Even if the coroner does not ask for this, you can write to the coroner setting out any concerns that you have about the circumstances of the person's death.

6. In some cases, after some initial evidence-gathering, the coroner will hold a **pre-inquest review hearing**. This is an administrative hearing to prepare for the inquest hearing itself. No witnesses attend and it is usually the family and representatives of the other organisations that may have been involved in the death (such as hospital Trusts, prisons, police, care homes) who will attend. The hearing is to make sure that all the evidence and witnesses that the coroner needs to answer the questions of who died, when they died, where they died and how they died, will be available at the inquest.

   The pre-inquest review hearing will look at the issues that the inquest will cover, if Article 2 is engaged, if there will be a jury at the inquest, the documents that the coroner has and needs to obtain, if any experts need to be asked about the case, the witnesses that should attend in person at the inquest hearing and practical arrangements such as the date and length of the final hearing.

7. The **inquest hearing** will then take place. Depending on the circumstances of the death this could last anywhere from a few hours to a number of weeks.

   During the inquest hearing the coroner will call witnesses to give evidence under oath. The coroner usually asks questions first and then the family and representatives of the other organisations will have the opportunity to ask relevant questions of the witnesses. If the inquest is being heard with a jury, then the jurors can also ask questions. Sometimes a witness will not be called to attend the inquest in person but, instead, their statement will be read out in the hearing so that it still forms part of the evidence.

   After all the witnesses have given their evidence, the coroner will summarise all the evidence heard before giving their findings of fact about what happened and giving a Conclusion (previously known as a 'verdict'). If there is a jury, then it is the jury who will determine the Conclusion at the end of the inquest. The coroner will give the jury guidance as to which conclusions they are allowed to reach, based on the evidence that has been heard and the law.

   The Coroner or jury will also complete a formal document called the Record of Inquest to record the findings of the hearing.

Inquest conclusions

There are several potential conclusions which can be reached in an inquest. It may be a 'short form' conclusion, or a 'narrative' conclusion. Coroners are encouraged to use short form conclusions where they can. In addition to a conclusion, the coroner will also record their findings of fact, a short narrative stating the circumstances that led to the death.

Short form conclusions include: accident, misadventure, alcohol or drug related death, industrial disease, unlawful/lawful killing, natural causes, road traffic collision, stillbirth or suicide.

A narrative conclusion is a form of words which seek to explain the circumstances in a descriptive way.

Documentary inquests

In some cases, a coroner will hold a 'documentary' or 'read only' inquest. This is an inquest where no witnesses will be called to speak in court and the coroner will consider all the evidence gathered and come to a conclusion based on reading the information gathered.

Article 2 inquests

Article 2 refers to an inquest where Article 2 of the European Convention on Human Rights is 'engaged', such as when someone has died under the care of the State, or whilst in State custody.

A coroner will decide if Article 2 is engaged. If Article 2 applies in an inquest it can lead to a wider investigation into the circumstances of the death, although the differences in practical terms may not be that significant in some cases.

Perhaps most importantly for families, if Article 2 applies, it often means that the family will then be entitled to Legal Aid funding to pay for their legal representation at the inquest.

Jury inquests

There are some cases where a jury will be asked to hear the inquest hearing alongside the coroner. This is usually where the person died while in custody or state detention and the death was either violent or unnatural, or the cause of death is unknown. In these cases, it is ultimately the jurors who finds the fact and conclusion in the inquest and not the coroner.

Prevention of future deaths reports

An additional duty of the coroner is to try and prevent future deaths. Throughout the inquest investigation, the coroner is under a duty to consider whether there is evidence that there is an ongoing risk of death to others. If there is, the coroner must prepare a Prevention of Future Deaths report (sometimes called a Regulation 28 report) highlighting their concerns and directed to the person or organisation that has the authority to make improvements. These reports are published on the Government website.

Key questions

Who can attend an inquest?

Inquests hearings are open to the public, unless there are exceptional circumstances. This means that anyone is free to attend an inquest.

Unless the family are called to attend as a witness, then you can choose to attend or not to attend.

In addition, as it is an open hearing, the press are also entitled to attend inquest hearings and may well be present if they consider that the case is of interest to the wider public. There are guidelines for the press for reporting on inquests to ensure it is done sensitively.

What documents can I see?

As the family is an 'Interested Person' (i.e. has special legal standing at an inquest), you should be given access to all the documents disclosed in the inquest. You may have to write to the Coroner to request these and some of the documents may contain upsetting material, although any photographs or graphic material is normally not within the disclosure.

What do people wear to inquests?

The coroner will likely wear a suit and representatives from the other organisations are normally dressed formally or in smart work-wear. As a family, you can wear whatever you feel comfortable in.

What time do inquests start and finish?

The coroners court will tell you what time your hearing will take place and an estimate of when it is likely to finish. Most courts open at 9am, with hearings starting from 10am and finishing by 5pm.

Can I have an interpreter?

If English is not your first language, then you can request an interpreter which should be provided by the coroners court to ensure you understand the proceedings. You should contact the coroners court as early as possible to inform them of your requirements.

What about the funeral and death certificate?

If a coroner is holding an inquest, they will release an interim death certificate which should allow you to deal with the majority of aspects of the deceased's Estate and allow you to obtain a Grant of Probate. A funeral can be arranged as soon as the post mortem examination has been completed and the coroner releases the body to the care of the funeral home. At the conclusion of the inquest a final death certificate will be issued.

Legal representation for families at inquests

Whilst legal representation at an inquest is not mandatory, many families find it helpful to have legal support, particularly where they have concerns about the treatment the individual received before their death. It is likely that the other organisations involved and in attendance at the inquest will have legal representatives. It can be helpful to get legal advice at all stages of the inquest process and it is never too early or late to contact a legal representative to see if they can help.

There are a number of ways that legal representation at an inquest can be funded without any upfront cost to the family including through Legal Aid public funding, an existing insurance policy, or with a 'no win, no fee' arrangement.

Helpful inquest organisations

The Coroners' Courts Support Service (CCSS): The Coroners' Courts Support Service offers emotional support and practical help to bereaved families, witnesses and others attending an Inquest at a Coroner's Court. They have a volunteer system in place at many coroner's courts offering first hand support to families attending court.

T: 0300 111 2141

E: helpline@ccss.org.uk

W: https://coronerscourtssupportservice.org.uk/

AvMA (Action Against Medical Accidents): AvMA offers self-help guides containing clear explanations of the inquest procedure, focusing on deaths where the family have concerns there was medical negligence. They can sometimes offer expert representation at an inquest where there are reasonable grounds to believe that the death occurred because of poor medical care.

T: 0345 123 2352

W: https://www.avma.org.uk/help-advice/inquests/

INQUEST: INQUEST is a charity that provides specialist support and advice for bereaved people following a state related death (such as deaths involving the police, prisons or where someone is detained under a Mental Health Act section), with the influence to achieve change in legislation, policy and practice.

T: 020 7263 1111

W: https://www.inquest.org.uk/

This factsheet was prepared by CCSS and **RWK Goodman**, an accredited law firm representing families nationwide at inquests. RWK Goodman offer a free, no obligation discussion about inquests and what options may be available to you should you want to explore legal representation or concerns you have about a loved one's death.