Coroners' inquests: Defining the inquisition

Despite not being a court of remedy, the inquest can be a valuable tool to provide a form of redress for bereaved families, writes **David Regan**

David Regan is a barrister practising from St John's Chambers
@StJohnsChambers
www.stjohnschambers.co.uk

In the ever more difficult climate of personal injury litigation, the coroner's inquest may often be the only practical source of independent investigation open to the bereaved. The coroners' court is a court of record rather than one of remedy: it is specifically prohibited from determining civil or criminal liability. But the opportunity to examine witnesses in public and the duty of a coroner to return a conclusion on that evidence provide a degree of public accountability and investigation free from the risk of costs and the plethora of other reasons which may prevent a civil case getting to trial.

The coronial process is inquisitorial rather than adversarial, a fact which can make its opportunities seem more limited. In the civil court the parties have significant control of the questions at issue and the evidence to be deployed, whereas in the inquest, the scope of the hearing is within the control of the coroner.

The scope of the inquest is defined by the Coroners and Justice Act and depends on whether article 2 of the European Convention on Human Rights is engaged. Article 2 imposes an obligation to carry out an effective and independent investigation into a death occurring where agents of the state were or might be implicated either in taking life without justification or in failing to protect life.

If an act or omission by an agent of the state has not contributed to the death, the inquest is limited to ascertaining 'how, when, and where the deceased came by his or her death'. If article 2 is engaged, this becomes a wider enquiry of ascertaining 'in what circumstances the deceased came by his or her death'. This is no mere difference in semantics and an article 2 inquest is inevitably more wide ranging.

But even if article 2 is not engaged, the scope of the inquiry available to the coroner can be very significant indeed. The coroner has significant discretion as to how to direct the investigation. Recent guidance in *R (Speck) v HM Coroner for York* succinctly defines the three relevant categories of issues: those which a coroner must investigate, those where there is a discretion to investigate, and those the coroner is not permitted to investigate.

Even in an article 2 inquest, the coroner is only obliged to investigate the issues which are, or at least arguably appear to be, central to the cause of death, which they can determine before hearing evidence. They have discretion to extend the investigation to matters which 'may possibly have contributed' to the death, but are prohibited from investigating factors which 'cannot even arguably be said to have made any real contribution to the death'.

In *Speck*, the court formulated and applied this test to the case of a woman who died in police custody, having been detained under the Mental Health Act and taken to the police station as a place of safety. The family sought a direction that the inquest should consider the reasons for the absence of a health-based place of safety in the city, and the appropriateness of the allocation of resources which had led to this.

The court upheld the coroner's decision that the family was unable to show that any entity was under a duty to create such a place, and thus its absence could not have caused or contributed to the death. Once that had been determined, the coroner was not merely not under a duty to investigate that issue: he was prohibited from doing so.

While that finding may appear stark, the guidance in *Speck* may serve to assist interested parties to widen the scope of an inquest. The inquest should not normally investigate issues of policy and resources. Yet, the coroner is under a clear duty to investigate not only matters which probably caused the death, but those which probably contributed to it as well, and has discretion to extend this inquiry, whether or not the inquest engages article 2. As such, it is vital that interested parties engage with the coroner at an early stage, when the scope of the inquest is being defined.

In cases of any complexity, coroners are increasingly conducting pre-inquest review hearings. Families will often wish the inquest to form part of an investigative process to prevent the recurrence of the circumstances which led to the death of their loved one, and the law requires the coroner to make a report to the appropriate authorities where anything revealed by the investigation 'gives rise to a concern that circumstances creating a risk of other deaths will occur, or continue to exist, in the future', where, in their opinion, action should be taken to reduce the risk. Obtaining recommendations to limit the chance of recurrence may well give families a greater degree of closure and reassurance than they would otherwise have. **SJ**