Inquests: changes introduced by the Coroners and Justice Act 2009

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The Coroners and Justice Act 2009 (CJA) came into force on 25 July 2013. The following secondary legislation came into force on the same date:

- The Coroners (Inquests) Rules 2013
- The Coroners (Investigations) Regulations 2013
- The Coroners Allowances, Fees and Expenses Regulations 2013.

From this date all investigations, including deaths which were already being investigated by a coroner (counting those which had reached the inquest stage), are dealt with under the new regime. However, any decision taken by a coroner before the new arrangements came into force remains valid. This article details some of the main changes under the new legislation.

The Chief Coroner

Peter Thornton QC (who also sits as a Judge at the Old Bailey) is the Chief Coroner. This post was created by the CJA to provide judicial oversight. His main responsibilities, as set out in his own guidance, are to:

- provide support, leadership and guidance
- set national standards for coroners
- develop training for coroners and staff
- approve coroner appointments
- keep a register of coroner investigations lasting more than 12 months and reduce unnecessary delays
- monitor investigations into deaths of service personnel overseas
- oversee transfers of cases between coroners
- direct coroners to conduct investigations
- provide an annual report to the Lord Chancellor, to be laid before Parliament
- collate, monitor and publish coroners' reports to prevent other deaths.

Coroner areas & appointments

The CJA changes the name of 'coroner districts' to 'coroner areas'; each will correspond to one or more local authority area. The intention is to have fewer, larger coroner areas, each supporting a full-time caseload, following the recommendation of the Luce Review in 2003. Larger coroner areas will mean economies, for example, there is likely to be more sharing of staff and other resources. However, it is hoped that it will bring about greater consistency of practice.

The CJA changes the titles of the office of coroner and amends the eligibility requirements and the appointment process. Under this Act there are senior coroners, area coroners and assistant coroners, who are all to be appointed by local authorities. Such posts are no longer offices for life and applications have to go through an open advertising procedure. Peter Thornton's aim has been to make sure the process is fair and transparent.

Newly appointed coroners must be legally qualified (Schedule 3). Transitional arrangements apply to medical practitioners in post when the changes came into effect (paragraph 3 of Schedule 22). The CJA introduces a mandatory retirement age of 70, although transitional arrangements disapply this provision for those coroners in post when the CJA came into force (paragraph 3 of Schedule 22).

Investigations & inquests

The investigation into the death becomes the focus of the process under the CJA, with the inquest forming only a part of the investigation (section 6). This recognises that much of the coroner's work takes place before the formal inquest hearing. It also allows the coroner time to consider whether the duty to hold an inquest applies.

A coroner has a duty to investigate a death if:

- the body is within that coroner's area and
- the coroner has reason to suspect that:

  - the deceased died a violent or unnatural death
  - the cause of death is unknown
  - the deceased died in custody or state detention.

The requirement to investigate where the death is sudden has been removed.

According to Peter Thornton QC, some 220,000 deaths a year are reported to coroners. Some 95,000 undergo a post-mortem and an estimated 32,000 progress to an inquest. These figures are approximately three times higher than other countries and Peter Thornton QC aims to reduce the number of inquests. The new statutory regime for the first time permits a coroner to make "whatever inquiries seem necessary", including a post-mortem, to see whether there is a duty to investigate. If it becomes apparent that the death is a result of natural causes, for example, an inquest does not need to be opened (section 4).

The purpose of the investigation (or inquest) is to ascertain (section 5(1)):

- who the deceased was
- how, when and where the deceased came by his/her death
- the particulars or "findings" (if any) required by the 1953 Act to be registered.

In deaths where Article 2 of the European Convention of Human Rights is engaged, the question of "how" is broadened to include ascertaining in what circumstances the deceased came by his or her death (section 5(2); *Middleton (R (Middleton) v HM Coroner for Western Somerset* [2004] 2 AC 182).

When the coroner conducts an investigation he must hold an inquest. This duty ceases when there is discontinuance under section 4 of the CJA. The inquest must be completed within six months from "the date on which the coroner is made aware of the death, or as soon as is reasonably practicable after that date".

The coroner must open an inquest as soon as is reasonably practicable, and, where possible, set dates for any future hearings and give directions for the production of post-mortem and other expert or factual reports within a timescale (rule 5).

Disclosure

In one of the most welcome changes, part 3 of the Coroners Rules 2013 should radically transform pre-inquest disclosure. Under these new provisions a coroner must normally disclose relevant documents to an interested person, on request, at any stage of the investigation process. Previously, there was no legislative means to compel advance disclosure; it was simply left to the coroner's discretion. It is now effectively accepted that advance disclosure is necessary to ensure a sufficient inquiry, but problems may continue to arise and much does depend on the specific coroner.

The documents that should be disclosed (as set out in rule 13) are:

- any post-mortem examination report
- any other report provided to the coroner
- any recording of the inquest
- any other document which the coroner considers relevant.

Relevance is a question for the coroner. The duty of disclosure as set out above means that all relevant evidence should be disclosed to an interested person in advance of, or during, an inquest (regardless of whether it is an article 2 inquest).

What is relevant depends on the scope of the inquest and you will want to consider whether article 2 is engaged. *R(D) v Secretary of State* decided that, for an inquiry to comply with article 2, the representatives of the family must be given reasonable access to all relevant evidence in advance ([2006] WCA Civ 143). Material will also be relevant if it addresses the issue of what has changed as a result of the death (if anything) as, whether or not it is an article 2 inquest, a coroner has to consider whether to make a report to prevent future deaths.

"Document" is defined in rule 2 as "any medium in which information of any description is recorded or stored". This includes photographs and CCTV footage. Disclosure should be by electronic means wherever possible. If it is not possible to send documents to an interested person, then the coroner should allow such persons to inspect them. Documents may be redacted where appropriate (rule 14).

A coroner may refuse to provide a document or a copy where (as set out in rule 15):

- there is a statutory or legal prohibition on disclosure (for example police reports)
- the consent of any author or copyright owner cannot reasonably be obtained
- the request is unreasonable
- the document relates to contemplated or commenced criminal proceedings
- the coroner considers the document irrelevant.

This last restriction can cause difficulties, especially if only part of a document is disclosed.

One basis on which disclosure of some or all of a document could be refused is where the information is covered by public interest immunity (PII) (Schedule 5, paragraph 2(2)). The starting point is whether the evidence is relevant. At an inquest this is broader than in civil proceedings and includes learning lessons and assuaging public anxiety. For a PII application to succeed there must be a risk of serious harm to an important public interest. The court must then disclose the information unless the public interest in non-disclosure outweighs the public interest in the open administration of justice. The resolution of the balancing exercise, and the weight to be given to the public interest in concealment, are matters for the coroner. In the first instance, disclosure should be made to the coroner alone, who should examine the documents before making a decision. There is a great deal of authority emphasising the fundamental importance of open justice and disclosure at inquests. PII is the last resort and there may be a practical solution to enable full and effective investigations, even whilst public interest requires the withholding of some material.

A coroner must disclose documents as soon as reasonably practicable (rule 13(1)). This allows coroners some leeway if an interested person is likely to make a number of requests in succession. A coroner would be entitled to wait, but not unreasonably, until a bundle of documents could be disclosed together.

Disclosure is usually addressed at pre-inquest reviews (if not before) and/or in written submissions. You may find yourself making repeated requests and unfortunately not receiving fast responses. It is advisable to check with other interested parties what documentation they have.

In drafting submissions, refer to the rules and the Chief Coroner's Guidance. Mention that non-disclosure may mean a longer inquest since it is likely to increase lines of inquiry and lead to adjournments. It is particularly important if you are representing the family as,

although an inquest is not going to provide closure, you will wish to ensure that at least they do not feel that anything is being hidden from them and that a lot of their questions have been answered.

A good place to start when thinking about material of which you want to obtain is any initial inquiry e.g. police report, MOD service inquiry. Often internal, PPO or IPCC inquiries will be conducted in tandem with any investigation carried out on behalf of the coroner. There is a presumption that such inquiry reports should be disclosed to the coroner and to interested persons. Traditionally a police report was regarded as confidential but there is now a clear presumption in favour of disclosing it. There may be some cases where the report is not relevant and there will be specific claims of confidentiality applying to parts of it, but there can be no justification for a clear-cut rule against disclosure.

Such reports can form the basis of the witness list and are likely to refer to other documentation, which you can request. Another party should be entitled to the majority of the documents viewed and/or generated. If you think that any other witnesses/material/inquiries are necessary they can be suggested to the coroner.

A coroner will often depend on the police or prison service to conduct his or her inquiries and disclose to him/her relevant material relating to the death. They cannot disclose evidence they have not obtained so think about the material the coroner does not appear to have. The police have a duty to hand over all the material that touches upon a death to the coroner. The Macpherson Report recommended that there should be advance disclosure of evidence and documents to parties who have leave to appear at an inquest. The Home Office subsequently produced guidance to chief constables introducing a system of pre-inquest disclosure as a normal course of action.

A public authority which refuses to comply with a disclosure request could be judicially reviewed for an irrational decision. A coroner who refuses to make a request for disclosure and thereby fails to investigate fully may be liable to judicial review. Practitioners will want to ensure that coroners use their full powers under the CJA to compel those with relevant materials to provide for disclosure. Additionally, do not forget that you can produce your own witnesses and ask that their evidence be read or called.

The CJA gives a coroner power to summon witnesses and to compel the production of evidence by way of written notice. The coroner does not have the power to require anything that a person could not be required to provide to a civil court. The coroner also does not have the power to require evidence to be provided if this would be incompatible with EU law. The rules of law in relation to public interest immunity apply equally in relation to investigations or inquests.

The CJA does not alter the powers of a coroner to summon witnesses, require evidence to be given or punish for contempt of court. Coroners have been advised not be too hasty to exercise these powers.

Offences include failure to comply with a notice requiring evidence to be given or produced, altering evidence, preventing evidence from being given, destroying or concealing documents, and giving false evidence.

Interested persons can request disclosure before, during or after an inquest. For requests after an inquest, the coroner can charge for disclosure.

Coroners must retain documents in connection with an investigation or post-mortem for 15 years or as directed by the Chief Coroner.

Hearings must be recorded and interested parties may be able to obtain a recording. A coroner is expected to limit its use and disclosure may not always be appropriate/parts may be redacted. Disclosure may be subject to costs. If not involved in the inquest itself, it should be possible for an organisation/person to apply to be designated an interested person after an inquest.

Decisions can be contested by judicial review or by application by, or under the authority of, the Attorney General to the High Court under the 1988 Act. The High Court will be able to order an "investigation" into a death (where the coroner has refused or neglected to hold an investigation or an inquest) or a fresh investigation where a coroner has already held one. The High Court will refer cases back to the coroner for the area concerned or another coroner within the area. However, the CJA will then allow the investigation to be transferred to a different coroner. A coroner can also be subject to a complaint to the judicial conduct investigations office.

Pre-inquest review hearings

Rule 6 of the Coroners (Inquests) Rules 2013 formally recognises that pre-inquest review hearings (PIRs) are often held before the main inquest hearing. Where possible, coroners should set out an agenda in advance of the hearing for all interested persons and, where appropriate, invite written submissions to be considered at the hearing. If an agenda is not provided, legal representatives should write to the coroner's officer to request one (referring to Peter Thornton QC's expectation for an agenda).

The CJA expands the list of interested persons, capturing, for example, the role of the Independent Police Complaints Commission in conducting and managing some investigations. In addition to the specific list of those that fall into the category of "interested person" under section 47 of the CJA, there is power for the coroner to determine that any other person is an interested person.

It is not intended that the coroner has to contact all family members listed in section 47(2)(a). The coroner needs one point of contact with the family (or more than one when the family is

divided) and with any other interested persons. In relation to families, Peter Thornton QC has emphasised that the family should be at the heart of the coroner's process.

Rule 11 requires coroners to hold all inquest hearings in public. However, a coroner may exclude the public from all or part of any inquest hearing on the grounds of national security. The coroner may also exclude the public from any part of a pre-inquest review hearing in the interests of justice.

Witnesses

Witnesses must give evidence under oath (or affirmation) unless he/she is a child under the age of 14, or a child who is over the age of 14 but considered by the coroner to be unable to understand the nature of an oath or affirmation, in which case he/she may be permitted to give unsworn evidence on promising to tell the truth. Witnesses may give evidence via video link or behind screens. The order of questioning is formalised under rule 21, starting with the coroner, any interested party and then the representative of the witness (if any).

Written evidence should be admissible where the coroner is satisfied that (as set out in rule 23):

- the maker of the written evidence cannot attend the inquest to give evidence at all, or within a reasonable time (perhaps due to severe disability)
- there is good reason why the maker of the written evidence should not attend (for instance being abroad or ill)
- there is good reason to believe that the maker of the written evidence will not attend
- the coroner considers the evidence is unlikely to be disputed.

The Chief Coroner has encouraged coroners to admit written evidence wherever possible, particularly where it is unlikely to be disputed.

Submissions & juries

No person is allowed to address the coroner or the jury as to the facts (rule 27).

A jury must be summoned if the deceased died in custody or state detention, and the death was violent or unnatural, or of unknown cause; where the death resulted from an act or omission of a police officer or member of a service police force (defined in section 48) in the purported execution of their duties; or where the death was caused by accident, poisoning or disease which must be reported to a government department or inspector (section 7). This includes, for example, certain deaths at work. Jury inquests are not required where the deceased died in custody but from natural causes. The coroner may hold an inquest with a jury where he or she thinks there is sufficient reason.

The coroner must direct the jury as to the law and provide the jury with a summary of the evidence (rule 33). A jury will be directed by the coroner to reach a unanimous conclusion (section 9). If the coroner thinks that the jury has deliberated for a reasonable time, he or she may accept a conclusion on which the minority consists of no more than two. If the required number of jurors does not agree, the coroner may discharge the jury and summon a fresh jury and the case will be heard again.

Conclusion of the inquest & post inquest

Conclusions (formerly verdicts) will be set out on the Record of an Inquest form. Two new additions are "alcohol/drug related" and "road traffic collision". Conclusions may not appear to determine any question of criminal liability on the part of a named person or civil liability (section 10(2)).

The coroner (or jury) must make a determination in respect of the section 5 questions: who the deceased was and how, when and where the deceased came by his/her death. For cases where Article 2 of the ECHR applies, the "how" becomes "in what circumstances".

A coroner is now under a *duty* to report actions to prevent future deaths ("other" deaths in the language of the CJA) to a person who may have the power to take such actions (paragraph 7 of Schedule 5). The coroner must make a report where the investigation gives rise to a concern that there is a risk of deaths in the future and that action should be taken to eliminate or reduce that risk (paragraph 7). The coroner may recommend that action should be taken, but not what that action should be: see the Chief Coroner's guidance.

Any person responding to a coroner's report of action to prevent future deaths must include a timetable for the action proposed to be taken (see regulations 28 and 29). All reports and responses must be sent to the Chief Coroner, who may publish these or summaries. The coroner may also send copies to anyone whom he or she thinks will find it useful. The time limit for responding to the coroner's report remains at 56 days, with the possibility of the coroner extending this.