APIL OCCUPATIONAL HEALTH GROUP MEETING

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CORONERS, INQUESTS AND INDUSTRIAL DISEASE

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Statistics:

From the Chief Coroner's Annual Report 2017/2018:

- Deaths in England and Wales: 500,000
- Cases reported to the Coroner: 229,700 (generally around 45%)
- Inquests: 31,519 (around 14% of all reported deaths)
- Much higher than most jurisdictions

- Industrial Disease conclusions: 10% of Inquests (Lexis Nexis): 1.4% of all reported deaths
- A small proportion of the Coroner's caseload

A Brief History of the Coroner:

- The office of Coroner, as it operates in the English legal system, is virtually unique.
- Although there are officers called "Coroners" in other countries – more akin to forensic pathologists.
- Even in Scotland – no Coroners

- Office of English Coroner dates back to the reign of Richard I (1194).
- Creation of officers called "custos placitorum coronae" – became known as "crowner" and later "coroner" – responsible for examining cases of sudden death

- Coroner has always been an independent officer – originally elected by Freemen of the county

- In medieval times the Coroner provided a source of revenue to the King – there were rigid procedures in place upon the finding of a body, failure to follow these resulted in a fine
- When a violent or unexpected death occurred the person responsible for finding the body was responsible for raising the "hue and cry" – this would bring the body to the attention of the Coroner, who would "ride out", discover where the body lay and gather a jury of men from the area
- The Coroner had to attend and make enquiries before the body could be buried

- The increasing complexities of society necessitated proper records of births and deaths, which led to the enactment of the Births and Deaths Registration Act 1836
- This statute provided that there could be no burial of a body without either a registrar's certificate or a Coroner's order, and required the Coroner to inform the registrar of the verdict of all inquests
- Legislation was also passed which gave Coroners the power to require a doctor to perform an examination on the body and/or attend Court to give evidence as to the cause of death

- The role of the modern Coroner is defined by statute.
- The first was the County Coroners Act 1860, followed by the Coroners Act 1887 – this statute introduced the concept of the Coroner investigating the cause and circumstances of a death – it also prohibited the previous practice of holding inquests in public houses!

- The Coroners (Amendment) Act 1926 introduced the requirement for Coroners to have a medical or legal qualification (Coroners appointed after enactment of the 2009 Act must be qualified lawyers, although a number are dual qualified)

- The Coroners Act 1980 brought about significant change
- Since medieval times the Coroner had been required to view the body, but this was no longer practical, and now the Coroner need only be made aware that there is a body lying within the area

- Then came The Coroners Act 1988 - a consolidating statute

- The current legislation which has governed Coronial law and practice since **25th July 2013** is contained in:
- **The Coroners and Justice Act 2009 [The Act]**
- **The Coroners (Investigations) Regulations 2013 [The Regulations]**
- **The Coroners (Inquests) Rules 2013 [The Rules]**
- **The Coroners Allowances, Fees and Expenses Regulations 2013 [The Fees Regulations]**

The Coroner in 2020:

The Coroner:

- An independent judicial officer, responsible to the Crown
- Independence is important because the Coroner will have to investigate cases involving the police, the NHS, the council, the government
- There is no national structure – which is the reason why there is such variability between Coroner areas and individual Coroners
- Coroner, Coroner's office and Court are funded by the local authority, which makes for differences in provision of services between areas

- The Coroner is not "employed" by the local authority (to retain independence)

- A 24/7 job – many areas operate an out of hours service for referrals, organ donation, out of England repatriations

The Chief Coroner:

- HHJ Mark Lucraft QC
- Role created by the Act
- Head of the Coroner system, but does not have "control" of individual Coroners
- Sets national standards, provides leadership and support
- Promotes consistency through publishing the Chief Coroner's Guidance and Law Sheets (a very useful source of information for practitioners attending inquests)
- Writes an Annual Report (available online)
- Reports upon timescales/delays – individual Senior Coroners provide annual reports to the Chief Coroner
- Approves new Coroner appointments
- Arranges training
- Monitors and publishes Regulation 28 reports (Prevention of Future Death (PFD) Reports)
- Appoints judges to hear some Inquests

Coronial Areas:

- The country is divided into Coronial areas (often along county lines)
- There are a reducing number of areas (mergers are being encouraged), with the aim of promoting consistency
- Number of areas reduced from 110 in July 2013 to 80 in the 2017/18 Chief Coroner's Report
- Each area has a Senior Coroner (usually full time)
- Larger areas also have 1 or more Area Coroners (often full time)
- Areas have different numbers of Assistant Coroners (zero hours contract, minimum 15 days pa)
- Some Assistant Coroners work regularly, others more sporadically, and will often work in more than 1 area

- CPS lawyers are allowed to sit as Assistant Coroners for a certain number of days each year at no cost to the local authority
- Appraisal Scheme to encourage consistency

Coroner's Officers:

- The interface between the Coroner and the family, doctors, hospital, police, other Interested Persons
- They are not lawyers – some are former/serving Police officers
- They work up the cases referred to the Coroner, obtain evidence as directed by the Coroner and prepare forms for authorisation by the Coroner (there are lots of different forms! – Form A, Form B, Interim Death Certificate, Cremation paperwork, Burial Order, Out of England Forms, Transfer Forms, Record of Inquest, Form 99)
- The Coroner's Officers are your point of contact – you should always feel free to call and speak to them, but please don't badger them or write to them as you would to solicitors representing another party in litigation
- In some areas Coroner's officers also act as Court Officers

The Trigger for Coronial Investigation:

- The Coroner is made aware of a body in the jurisdiction
- There is reason to suspect that the person died an unnatural death or the cause of death is unknown, or the person died in custody or otherwise in state detention

Referrals to the Coroner:

- From the police, doctors (GP and hospital), registrars, CQC
- Berkshire gets around 2000 referrals pa
- Made electronically
- Governed by **The Notifications of Death Regulations 2019 (in force since 1st October 2019)**
- There is MOJ Guidance and Chief Coroner Guidance (Number 31)
- This represents the first national guidance (previously varied by area)

Circumstances in which the duty to notify arises

3.*—(1) The circumstances are—*

(a)the registered medical practitioner suspects that that the person's death was due to—

(i)poisoning, including by an otherwise benign substance;

(ii)exposure to or contact with a toxic substance;

(iii)the use of a medicinal product, controlled drug or psychoactive substance;

(iv)violence;

(v)trauma or injury;

(vi)self-harm;

(vii)neglect, including self-neglect;

(viii)the person undergoing a treatment or procedure of a medical or similar nature; or

(ix)an injury or disease attributable to any employment held by the person during the person's lifetime;

(b)the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);

(c)the registered medical practitioner—

(i)is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person; but

(ii)despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown;

*(d)the registered medical practitioner suspects that the person died while in custody or otherwise in state detention(**3**);*

(e)the registered medical practitioner reasonably believes that there is no attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person;

(f)the registered medical practitioner reasonably believes that—

(i)an attending medical practitioner is required to sign a certificate of cause of death in relation to the deceased person; but

(ii)the attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death;

(g)the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.

The Medical Examiner:

- Now in place in most hospitals (plan to roll out in the community in future)
- They are designated senior doctors
- Ensure cases are appropriately referred to the Coroner
- Ensure that the content of the medical cause of death certificate is as accurate as possible
- Ensure that any clinical governance issues are passed onto the relevant responsible body
- National Medical Examiner is Dr. Alan Fletcher, a Consultant in Emergency Medicine at Sheffield Teaching Hospitals NHS Foundation Trust – oversees operation of the ME system

Post Mortem:

- Nationally 37% of referrals in 2017/18 – varies by area
- Not "one size fits all" – forensic, standard, external, scan, CBRN, paediatric, special
- If Coroner is offered a cause of death by a GP/hospital doctor and considers death to be natural - no PM - Form 100A (Coroner can accept a cause of death offered by a doctor on best knowledge and belief)
- If PM returns a natural cause of death, and no issues with care etc which may have rendered the "medically" natural death "legally" unnatural – Form 100B
- If PM returns an unnatural cause of death or unknown cause of death then an Inquest is necessary
- In some cases the referring doctor offers an unnatural cause of death which can be accepted without PM – proceed straight to Inquest

Format of Cause of Death:

Doctors often struggle with this!

I(a) *immediate disease or condition leading directly to death (eg myocardial infarction) – not mode of dying (eg cardiac arrest)*

(b) *any other disease which led to the immediate cause of death (eg coronary atheroma)*

(c)

II *other significant conditions which have contributed to death, but are not related to the disease or condition causing it (eg diabetes mellitus) – not every disease or condition the deceased ever suffered from!*

Inquest:

- Opened in open Court – short administrative hearing
- There can be one or more Pre Inquest Review hearings in more complex cases (like CMCs)
- Can be heard by the Coroner alone
- Section 7 of the Act sets out when a jury is required
- This includes where death is due to a notifiable disease (under RIDDOR) – only if the deceased was still in the relevant employment at the time of death (CJA 2009 section 7(2)(c))

Interested Persons:

- Categorised in section 47 of the Act
- Includes family, PRs of the estate, a person who may by any act or omission have caused or contributed to the death of the deceased, or whose employer or agent may have done so, life insurer

Purpose and Remit:

- Section 5 of the Act
- The 4 statutory questions who, when, where and how?
- The question of "how" generally means by what means (except in Art 2 Inquests when it is expanded to mean how and in what circumstances)
- The medical cause of death
- Conclusion (used to be called a verdict)
- The Coroner/jury is not allowed to step outside this remit (section 5(3) of the Act)
- An Inquest is not a trial
- An Inquest is not an Inquiry
- The determination may not be framed in such a way as to determine any question of criminal liability on the part of a named person or civil liability (section 10(2) of the Act)

Evidence/Disclosure:

- Coroners are not bound by the strict rules of evidence and can allow hearsay evidence (subject to weight)
- Evidence can be and often is read (under Rule 23) if it is not challenged or controversial and there are no additional questions for the witness
- How evidence is given and what evidence is called is at the discretion of the Coroner
- The Coroner (through the officers) collates the evidence
- Disclosure of evidence is governed principally by Rule 13 and 15 of the Rules – Rule 13 states that subject to certain exceptions in Rule 15 where an Interested Person asks for disclosure of a document held by the Coroner, the Coroner must provide the document, a copy or inspection
- Some Coroners wait to be asked, some routinely offer
- There is no requirement for the Coroner to disclose "unused" material
- The Coroner decides which evidence is relevant to the Inquest
- The Coroner takes the evidence and other Interested Persons have the right to ask questions and give evidence themselves, by statement or in person

Conclusion:

- See Chief Coroner's Guidance Number 17
- Short Form or Narrative
- Short Form includes:
    - Natural causes
    - Accident/misadventure
    - Suicide
    - Drug/Alcohol related
    - Industrial disease
    - Road traffic collision
    - Stillbirth

- Unlawful/lawful killing
- Open

- The standard of proof (not burden of proof) is on the balance of probabilities, except for unlawful killing (beyond reasonable doubt), and Open, which has no standard of proof, and is a fall back conclusion when the standard of proof required for all other short form conclusions is not satisfied.
- Narrative conclusions must be brief, factual and neutral

Timeframe:

- Rule 8 of the Rules required an Inquest to be completed within 6 months of the date the Coroner is made aware of the death or as soon as practicable thereafter
- Average 21 weeks according to the Chief Coroner's annual report 2017/18

INDUSTRIAL DISEASE CASES

- All cases where there is reason to suspect that the deceased has died from an industrial disease should be reported to the Coroner
- Industrial disease is not defined in the Act and does not have a refined meaning
- The family/PRs will be an Interested Person in the Inquest (section 47 of the Act)

- There is variation in how Coroners approach the issue of whether to order a PM
- I generally do not require a PM if there is an in life diagnosis made on biopsy - I would require evidence by way of clinic letters to establish the diagnosis
- If the in life diagnosis is woolly – eg a diagnosis of mesothelioma cannot be ruled out, I would request a PM (I do not regard this wording as satisfying the standard of proof on the balance of probabilities)
- If there is no in life diagnosis on biopsy I will authorise a PM with histology
- The question of whether to authorise a PM is not just resource driven – the Coroner must do only what is necessary and proportionate to ascertain the medical cause of death at the risk of breaching the family's Article 8 rights – it is not the function of the Coroner to provide evidence to support litigation
- I would always listen to what a family says about the issue of a PM before making a decision
- The ultimate decision about whether the authorise a PM is a Coronial one
- The family can always organise (and pay for) their own PM

- If the Coroner suggests that a death is from natural causes in a case where industrial disease is suspected by a family then it is always worth writing to the Coroner (perhaps with the support of APIL) to set out why there is reason to suspect an unnatural death – it is a low threshold

- Many Coroners, myself included, mostly hold paper inquests into industrial disease deaths, but if the family has particular reason to challenge any of the evidence which it is proposed to read under R23 then make the Coroner aware, and ask for the decision to be reviewed

- Let the Coroner know if there is/has been a civil claim or a statutory award

- The evidence which the Coroner will collate in an industrial disease case is likely to include:
    - GP summary records
    - Cause of death letter or Post Mortem report
    - In life statement of the deceased or statement from family with evidence of occupational exposure
    - Medical records, at least clinic letters to support in life diagnosis on biopsy and exposure
    - HMRC employment records

- If the Coroner does not offer disclosure to the family, request it (they are entitled to it under Rule 13)

- I do not mention the name of the exposing employer(s) in Inquests (otherwise they would be entitled to status as Interested Person(s)). Generally employers/insurers play no part in the Inquest process and do not contact the Coroner
- The identity or number of exposers is irrelevant to the Inquest

- Families should not require representation at Inquests in occupational disease cases (and generally the employer is not present or represented). Funding for family legal representation at Inquests remains an issue

- It is not necessary for the deceased to have worked in a prescribed occupation or for the disease to be a prescribed disease under the Social Security Regulations
- The disease must be of a type which is occupationally induced
- The disease must have caused or contributed to death – a conclusion of industrial disease will not be appropriate in a case where the deceased dies with the disease, but not from it (eg he is diagnosed with mesothelioma and falls downstairs suffering a fatal subdural haemorrhage the next day) – it is necessary for the industrial disease to have made a more than minimal contribution to death on the balance of probability
- Should a conclusion of industrial disease be returned in cases of domestic or environmental exposure to asbestos? I would say “yes” because the source of the asbestos is industrial and otherwise the statistics relating to deaths from asbestos related disease would be skewed

- There can be occupational disease inquests which also have to consider issues arising out of poor medical care, and whether missed opportunities to diagnose disease or failures to treat symptoms have caused or contributed to death. If such factors cause or contribute to death then the Coroner should record them, and may well return a narrative conclusion reflecting the causality of both the industrial disease and the missed opportunities or failures/errors in treatment

And Finally……

The MOJ has recently (28th January 2020) published a new version of "A Guide to Coroner Services for Bereaved People"

It uses plain English and is accurate, informative and easy to use

Please recommend it to your clients as it demystifies the coronial service

It is available in hard copy in all Coroner's offices and online as a PDF at:

https://www.gov.uk.government/publications/guide-to-coroner-services-and-coronerinvestigations-a-short-guide through GOV.UK