# System Comparison: Fatal Accident Inquiries and Coroners' Service of England and Wales

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# Similarities and Differences

- Both are death investigation services, separate to civil and criminal jurisdictions to establish facts, make findings and learn lessons in the hope of preventing further deaths.
- In both systems investigations may result in a judicial hearing .
- Main differences between the services are the more extensive use of discretion in Fatal Accident Inquiries, and the use of the final conclusion in inquests.

# Statistics Scotland

- Scotland 2022: ( 01/04/2022- 31/03/2023)
- Population 5 436 600 in 2022
- Deaths 2022, 16 853
- 43 Fatal Accident Inquiries heard in court ( 1: 126 432.5 of pop; 1: 391 deaths )
- 20  FAIs making recommendations requiring a response ( 1:2.3 FAIs)
- 27 such recommendations

# Statistics England and Wales

- England and Wales (01/01/2022- 31/12/2022)
- Population 60 236 400  in 2022
- Deaths 2022, 577 160
- 35 600 Inquests heard in court ( 1: 1692 of pop, 1: 16 deaths )
- 403 Prevent Future Death Reports. ( 1:88 inquests)

# Scotland's Hearings

- Fatal Accident Investigations are presided over by a Sheriff
- The Crown Office Prosecutor Fiscal Service investigates the death, then hands over to the Sheriff to preside on the case in court.
- COPF calls and examines the evidence.
- Interested parties may also call and examine their own witnesses
- At the end of the hearing, the Sheriff will record their findings as a Determination which is published by the Scottish Courts and Tribunals Service on their website.

# Coronial Hearings

- Once a death is reported to the coroner's area, that same coroner's service ( and often the same coroner) oversees the investigation, and if a court hearing is required, hears the inquest.
- The coroner hearing the inquest decides the witness list and exhibits and calls and examines the evidence and either with or without a jury sums up and records their findings on a document known as the Record of Inquest.
- The Record of Inquest is a public document, and fully disclosable, but is not published

# What is a Coroner

- An independent judicial office holder
- Statutory duty to investigate certain types of deaths
- The jurisdiction is INQUISITORIAL
- There is no system of appeal
- Coronial decisions are subject to judicial review by the High Court

# What do Coroners do?

- We have a statutory duty to **investigate** deaths of bodies that lay within our geographical areas when we have *reason to suspect that-*

*a) the death was violent or unnatural,*

*b) the cause of death is unknown, or*

*c) the deceased died while in custody or otherwise in state detention.*

- *Then coroner must as soon as practicable open an investigation into the circumstances of the death. (Section 1 of the Coroner's and Justice Act 2009 (the Act))*
- *Investigations may be discontinued if deaths turn out natural and proceed to inquest if not, remain unknown or DIC or at hands of the State.*

# Coronial Powers

Our powers are based on the:

- *Coroners and Justice Act 2009,*
- *Coroners (Inquests) Rules 2013,*
- *Coroners (Investigations) Regulations 2013* and
- Common Law.

We are also assisted by Guidance from the Chief Coroner and MOUs.

# Case Management by the Coroner

- Each case is overseen by the coroner, who directs and manages case investigation and compilation of evidence by a named coroner's officer.
- On our behalf, the police may investigate and seize evidence
- Government agencies have a duty to assist, including the military, the agencies, the NHS, social services etc.
- Doctors have specific duties under the GMC regulations etc.

# Coronial Jurisdictions

- A Coroner's jurisdiction is geographically based, usually along county or local authority lines, around 85 in total. FAIs Sheriffdoms!
- At Inner West London, I cover 4 London Boroughs, Westminster, Kensington and Chelsea, Wandsworth and Merton
- In 2022 around 2200 reported deaths pa, around 12% of which ended up at inquest (355 actually opened in 2022).
- 60% are reported by doctors, most of the rest by the police, 2% from the registrar.
- Prison governors have a duty to report all deaths in their prisons to the coroner.

# Reporting by Doctors

- There is now a statutory duty on a doctor to report a death to a coroner, under the Notification of Deaths Regulations 2019.
- NB: (1) notification must be done as soon reasonably practicable by a senior doctor with knowledge of the care of the deceased.
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- (2) In exceptional circumstances notification may be done orally, but such oral notification must be confirmed as soon as reasonably practicable in writing.
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- (3) The doctor must provide to the coroner any information that the doctor considers relevant and may provide any other information.
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- (4) the use of email/written notification does not preclude further discussion if required between the doctor and the coroner’s service. Such discussion should however be properly documented.

# Findings on the Record of Inquest

- *Who was the person who has died and how when and where the death arose, and the particulars necessary to record the medical cause of death.*
- *Neither the coroner nor the jury may express an opinion on any other matter.*
- *No determination should be framed in such a way as to appear to determine any question of criminal liability on the part of a named person or civil liability*
- *(The Act, Sections 5 and 10)*

# Fatal Accident Inquiries

- Legislation: Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 places duties on the procurator fiscal to investigate the circumstances of the death and arrange for an inquiry to be held.
- Act of Sederunt (Fatal Accident Inquiry Rules) 2017
- Inquiry to be conducted by the Sheriff, evidence led by the Procurator Fiscal.

# Purpose of the Fatal Accident Inquiry

- Section 1 (3)
- To establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances.
- On its face this is the same purpose as those inquests where Article 2 of the Human Rights Act is engaged, when the findings of ROI should include the circumstances in which the death took place.
- Like inquests not to establish criminal nor civil liability. Neither ROIs nor Determinations may used as evidence in a civil claim or criminal investigation.

# Mandatory and Discretionary Investigations

- For FAI, mandatory when someone died in legal custody or in an accident at work.
- In all other cases, a FAI  occurs if following investigation by the procurator fiscal, only if the death was sudden, suspicious or unexplained, or occured in circumstances giving rise to serious public concern AND in the public interest, for example when lessons may be learned from the death that may prevent future deaths occurring.
- Section 1 Coroners and Justice Act 2009, no discretion in relation to an inquest, if the death was arguably violent, unnatural, death or cause unknown, or occurred in custody or at the hands of the State.

# FAI Determinations

- When and where the death occurred
- When and where any accident resulting in the death occurred
- The cause or causes of the death
- The cause or causes of any accident resulting in the death
- Any precautions that could have been taken to to avoid the death
- Any defects in any system of working which contributed to the death or any accident resulting in the death
- Any other facts which are relevant to the circumstances of the death.

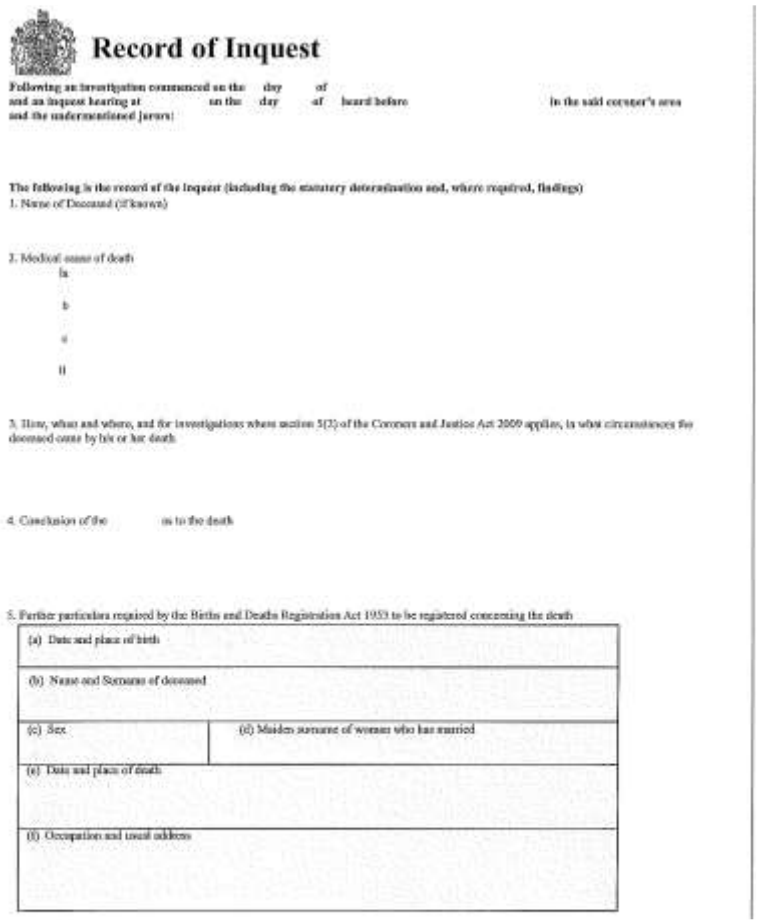
# Article 2 Compliant Inquests

- Who, was the person who has died, how, when and where and in what circumstances the death occurred, registration particulars and medical cause of cause.
- The final conclusion should be *“a judgemental conclusion of a factual nature, directly relating to the circumstances of the death”*
- *(R (Middleton) v HM Coroner for Western District of Somerset [2004] UKHL 10)*

# Conclusions in Article 2 Compliant Inquests Continued

- An inquest in performing its duty under Article 2 should make findings of fact on all the central matters in issue in the case
- This may even include matters which were admitted failures and non-causative in the death,
- matters that only possibly contributed to the death,
- matters not causative in the death if findings may go towards the writing of a Prevent Future Death report

# Record of Inquest



**Record of Inquest**

**Following an investigation commenced on the day of and an inquest hearing at on the day of heard before in the said coroner's area and the undermentioned jurors:**

**The following is the record of the inquest (including the statutory determination and, where required, findings)**

1. Name of Deceased (if known)

2. Medical cause of death

1a

b

c

II

3. How, when and where, and (for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

4. Conclusion of the as to the death

5. Further particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death

| | |
|---|---|
| (a) Date and place of birth | |
| (b) Name and Surname of deceased | |
| (c) Sex | (d) Maiden surname of woman who has married |
| (e) Date and place of death | |
| (f) Occupation and usual address | |

# Final Conclusions on the Record of Inquest

- Is recorded in box 4 on the Record of Inquest
- **Short form:**
  - Unlawful killing.
  - Suicide.
  - Lawful killing.
  - Natural causes.
  - Industrial Disease.
  - Drug Related
  - Alcohol Related
  - Accident/ Misadventure
  - Open Verdicts

# Neglect

- Term of art
- A **gross failure** to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself and that failure has led to or contributed to the death
- There must be a direct causal connection with the death and it must contribute to the death.

# Neglect not Negligence

- Neglect should be distinguished from civil negligence, which is a much wider concept of failure to exercise a duty of care towards a person to whom it is owed.
- A gross failure is a total and complete failure- “plain as a pike staff”.
- At the material time *(Jamieson),* not a value based judgement with the benefit of hindsight.
- The test for this is now clearly objective post the case of *Clegg ( R v HM Coroner for Wiltshire ex p Clegg (1996) 161 JP 52*
- Omissions capable of being neglect
- Failures to provide any effective medical treatment could amount to gross failure *(Clegg)*

# Neglect continued

- Neglect may also be returned by adding together acts or omissions by different individuals and /or system failure so that in combination they form “*a total picture that amounts to neglect”*
- *“a continuous sequence of shortcomings”*
- It may be added as a rider

# Determinations and Guidance in Relation to Written Inquests

- From 28th June 2022, section 9 c Coroners and Justice Act inquests now may take place in writing.
- Chief Coroner's Guidance Number 29, Inquests in Writing and Rule 23 Evidence:
- Make findings of fact based based upon the evidence
- Distil from these findings how the person came to die
- State the conclusion

- ( similar to Determinations?)

# Comparison of Rules

- Both inquisitorial
- All evidence on oath in Inquest, may be on oath in FAI.
- Participants/ interested persons
- Witnesses may decline answer questions tending to self -incriminate
- Joint Minute of Agreement in FAI
- Vulnerable witness protection
- FAI in public, but Sheriff may order proceedings, or any part of them to be heard in private.

# Comparison of Rules continued

- Inquest must be in public, unless interests of national security not to.
- PIRH – public may be excluded if in interests of justice or national security.
- FAI no juries since 1976!
- Inquests: with a jury if died whilst in custody or otherwise in state detention AND
- That the cause of death was violent or unnatural or unknown, or arose from an act or omission of a police officer in the action of their duty, or death caused by a notifiable accident, poisoning or disease
- Juries 7 to 11 members

# Comparison of Rules continued

- Inquests- no address as to the facts- IPs can only address the coroner in relation to the law
- **Suspending investigations and inquiries** – Inquests: homicide offences to court, public inquiries, discretion. FAI: criminal proceedings, H&S inquiries, Gas Act, public inquiry, Energy Act inquiries.
- **Deaths abroad**: if violent, unnatural, cause unknown etc in England and Wales, inquest if body in jurisdiction irrespective where cause of death occurred……
- In Scotland- more discretion inquiry if investigation not sufficiently established the circumstances, real prospect those circumstances would be established in an inquiry AND in the public interest

# Prevent Future Death Reports

- Prevent Future Death Reports Inquests
- Duty to make reports to the relevant authorities to encourage them to take action to prevent future deaths. *(Regulation 28) either during investigations or when all evidence has been heard.*
- Recipients must send a written response to the coroner
- Coroner must copy the report and response to interested persons to the inquest and the Chief Coroner
- The Chief Coroner will usually publish the report and response or summary of them
- The coroner and the Chief Coroner may also copy the report and responses to any other person or organisation with an interest

# FAI Recommendations

- Such recommendations as the Sheriff deems appropriate:
- Taking of reasonable precautions
- Making improvements to any system of working
- The introduction of a system of working
- The taking of any other steps

[which might reasonably prevent deaths in other similar circumstances]

Addressed to participants, or body or office holder appearing to the sheriff to have an interest in the prevention pf deaths in similar circumstances. Ust respond in writing.

Much wider powers that PFDs

# Why do we do it?

- Help prevent such a death occurring again

*"in this country…effect has been given to [the duty to investigate] for centuries by requiring such deaths to be publicly investigated before an independent judicial tribunal with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear; to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relatives may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."*

Lord Bingham in *R (Amin) v SSHD [2004] 1AC 653 at paragraph 31*

# What can we learn from each other?