Death in Custody – A Coroner's Perspective

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The Inquest – A ‘Fact Finding’ Exercise

- Introducing the Coroner and their Role – !WARNING!
- (Very) recent history of the Coronial service
- The Purpose & Course of the Inquest process
- How is a Death in Custody different?
- How is the investigation managed?
- The Inquest hearing
- Good Preparation and Liaison with the Coroner’s service
- Questions

Statistics – Main Points

- Last full (calendar) year, 2022 (England & Wales)
- 36% of all deaths were reported to Coroners – 208,400
- PMEs in 43% of cases reported (but wide regional variations)
- 534 deaths in state detention (down from 580 in 2021) driven by a 20% fall in prison deaths
- 36,300 inquests opened – 17%, an 11% increase on 2021 – likely a result of dealing with backlog of cases, post worst of pandemic
- Most Coronial areas – inquests in around 10-20% of cases
- NOTE: Mandatory cases
- Documentary/Rule 23 and ‘Inquests In Writing’

Recent History

- Practice & procedure substantially altered by Coroners & Justice Act 2009 (‘the Act’)
- Relevant Part of the Act - in force 25 July 2013
- Structural changes – Chief Coroner: Guidance on key areas of practice
- Who are we? - Senior, Area and Assistant Coroners
- Introduction of Rules & Regulations in 2013, in order to:
  - Promote uniformity, generally
  - Provide for key material to ‘interested persons’, e.g. bereaved families
  - Rules to assist in managing cases, witnesses and documents.

Aims & Purpose of the Inquest

- Answer the statutory four questions – Section 5: who was the deceased and how, when and where did s/he die?
- Ascertain the medical cause of death ('the COD')
- Make findings, based only upon the evidence heard/seen as part of the investigation and the Inquest
- Utilise those findings to reach a conclusion
- Conclusion may be short-form (e.g. 'Accident', Drug related' or 'Suicide') or narrative, which may be a fuller account of how the death occurred and, in some cases, may use judgmental language
- Record the particulars required for the death to be registered.

Section 10 of the Act

- Determinations and findings to be made
- A determination may not be framed in such a way as to appear to determine any question of—
- (a) criminal liability on the part of a named person, or
- (b) civil liability.
- If a Coroner does find or hear evidence, during the course of an investigation Inquest that tends to implicate a witness (or any another person) the Inquest may be stopped and the issue reported to the police to investigate or re-investigate – Rare.

Deaths in Custody - Numbers

- Deaths in Prisons make up the largest proportion – approximately 57% of 2021/22 figures
- Deaths of persons detained under the Mental Health Act fell in 2021/22, compared to 2020/21 - remained the second largest category, at almost 40%
- Remainder for 2021/22 year consisted of deaths in police custody, cells and immigration detention centres

Deaths in Custody – Case Management

- Must be an Inquest when the deceased has died while in custody or otherwise in state detention
- Must be an Inquest with a Coroner AND jury when a death in custody or state detention was ‘a violent or unnatural one’ or where the COD is unknown – Section 7(2)(a) of the Act
- Where COD is a natural one, Inquest MAY be completed documentarily, that is without the need for witnesses to attend to give live evidence and be questioned
- If documentary Inquest, will be with consent/agreement of bereaved family (and other interested persons, e.g. relevant Trust).

Article 2, ECHR and the DIC Inquest

- ‘Unnatural’ deaths in state custody will engage Article 2 of the European Convention on Human Rights (‘ECHR’)
- “Everyone’s right to life shall be protected by law”
- Where Article 2 engaged, the ‘how’ question is enhanced – Inquest must examine ‘by what means and in what circumstances’
- In practice, leads to more in-depth scrutiny of the facts surrounding the death and the causal chain of events
- Necessarily the root causes examined, individual/systemic shortcomings (if any)
- PFD reporting considered, as in all Inquests.

Practicalities of the Investigation

- Death occurs and is reported to Coroner
- COD known/proposed, or PME if not
- Coronial investigation commences
- Inquest is Opened
- Coroner should review regularly, provide instructions to obtain reports (e.g. from psychiatrist(s) and other health care professionals), statements and records
- Pre-Inquest Review Hearing ('PIRH') to examine scope, issues, further and necessary disclosure, witness requirements, timetable etc
- Inquest

Preparation & Good Practice

- Trust will (likely) provide guidance, assistance and practical support
- Ingredients/Contents of a ‘good’ report
- Patient’s/Deceased’s background in outline, diagnosis(es), some reference to clinical records, summary of care provided
- Neutral account of the events proximate to death, if known
- If required as a witness: know content of statement/report well and ensure detail and accuracy; stick to expertise only, supposition and assumption unhelpful; NOT on trial - should not be an adversarial process.
- Try to observe an Inquest, or part of an Inquest
- If wanted, request feedback, or give it.

Questions ?