



Inquests, investigations and how to navigate them

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only have a reason to suspect that the death was unnatural in order to initiate further investigation.

Inquests

Where the investigation proceeds, the Coroner will call an inquest. If, however, anyone is under investigation for an offence connected with the death, an inquest may be adjourned until later. Inquests take place as public court proceedings, overseen by the Coroner, who will set the bounds of the inquiry. There will be not normally be a jury unless the death resulted from an accident at work or occurred in state custody.

The purpose of an inquest is to establish:

- who the deceased was
- how, when and where the deceased came by his death
- the particulars to be registered concerning the death

Broadly speaking, there are two kinds of inquests. Enhanced inquests are held where a state agency is implicated in the death by arguably failing to meet its obligations under Article 2 of the European Convention on Human Rights to put in place general systems to protect life or to take steps to protect the life of vulnerable individuals who are at real and immediate risk of death.

Enhanced inquests will investigate the question of 'how' the deceased died more broadly, seeking to find out in what circumstances the deceased

A care home resident's death can cause untold distress. Coronial and subsequent investigations prolong the unease, draining staff morale. Difficulties become acute where managers and employees are underprepared, lacking knowledge of their role and rights in the inquest process.

An understanding of how inquests work is key to enabling providers to participate in a way that protects their reputation and the welfare of their staff and residents.

Section 1(2) of the Criminal Justice Act 2009 imposes a duty on the Coroner to investigate deaths that were violent or unnatural, or where the cause of death is unknown.

The preliminary investigation will involve the Coroner ordering a post-mortem and looking at evidence. Where the post-mortem or preliminary investigations establish the cause of death and there is no reason to suspect that the deceased died a violent or unnatural death, the investigation will end there. Otherwise, the coronial investigation will proceed to an inquest.

Unnatural deaths include cases where the deceased ostensibly died from a natural cause but there is reason to suspect the condition may have been triggered or accelerated by inappropriate treatment, including neglect or accident. A coroner need



came by his death. The day to day running of a care home, covering everything from standards of cleanliness to staff behaviour, can be scrutinised.

Private healthcare providers fulfilling certain roles can also trigger Article 2 inquests, for example, where they are being paid by the NHS to carry out an NHS function.

Where there is no enhanced obligation to investigate 'how' a person came by their death, 'how' is defined as 'by what means'. Given that in every case the Coroner's duty is to ensure the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity, the difference between the two kinds of inquest is not very significant.

Inquests can be emotionally charged. 'Interested persons', such as the deceased's family members or their lawyers, are allowed to request most documents and to question any witness during the hearing. Evidence given on oath by witnesses under cross-examination can later be used in

regulatory or criminal investigations. Where witnesses make admissions to criminal offences, the inquest can be stopped while prosecutions are undertaken. It is a criminal offence to give false evidence or to fail to comply with a coroner's notice to give evidence.

Subsequent investigations

While an inquest does not directly establish criminal or civil liability for a death, it can investigate what would be capable of forming the basis of criminal charges or civil actions.

Inquests can run parallel to the care provider's internal investigations and may be followed by regulatory or criminal probes. When generating paperwork during internal investigations, it is vital to maintain an awareness of the duty to disclose documents that may later be requested by the Coroner or investigators. Poorly drafted interview notes, for example, can lead to misunderstandings or even contain unintended admissions.

There is a delicate balance to be

drawn between cooperation and ensuring that requests for information are lawful and proportionate. Criminal investigators have wide powers to gather evidence. They can seize documents following an arrest, giving the provider little control over what is taken. They can also make voluntary requests or production orders. Legally privileged material is not required to be disclosed under a production order.

Determinations and Findings

Other than determining who the deceased was; how, when and where the deceased came by their death; and the details needed to register the death, where 'anything' revealed by the investigation gives rise to concern that 'circumstances creating a risk of other deaths will occur', a Coroner can make a report preventing future deaths. It is possible to oppose the making of these reports. Challenges to the Coroner's conclusions should be made as soon as possible and most challenges must be made within a three month limit.

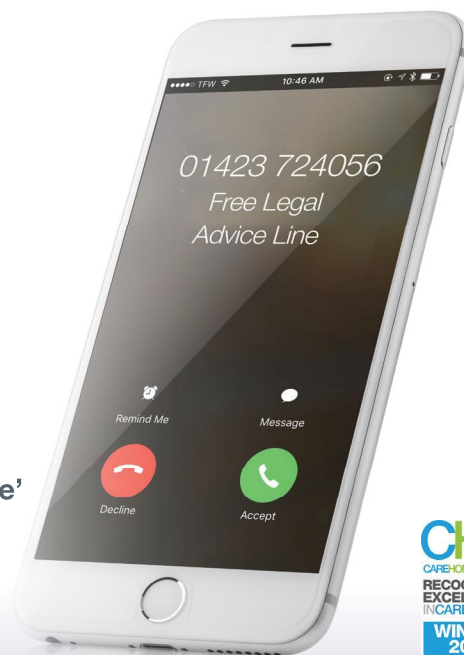
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