F12 The Role of the English Coroner in Preventing Future Deaths in Similar Circumstances

A.R.W. Forrest, LLM, Office of HM Coroner, Unit 1, Gilbert Drive, Wyberton Fen, , Lincolnshire PE21 7TQ, UNITED KINGDOM*

After attending this presentation, attendees will gain an appreciation of how English statutory and case law have produced an environment in which the judicial inquiry into a death in an English Coroner's Court can lead to documented action to prevent future, and similar, fatalities.

This presentation will impact the forensic science community by showing that death investigation in a coronial system can lead to real benefits for the community beyond establishing the cause and manner of death.

English coroners investigate deaths by holding inquests when required by law. The process is expensive, time consuming, and may not provide all the answers the family of the deceased desire, since all the inquest record includes is the name of the deceased, cause of death, a brief description of cause of death, and a neutral conclusion.[1] How can this archaic process produce a lesson to help the living?[2]

In the past, juries were discouraged from adding riders to an inquest verdict which simply stated who the deceased was and when, where, and how the person died. Juries did still add riders, although they were not part of the verdict and were recorded in the margin of the inquisition; however, coroners had the discretion to record riders if it "might do a public good if it reaches a proper quarter."[3,4]

In 1936, the power of juries to attach a rider of blame to their verdict was abolished and the power to attach a rider of any sort was abolished in 1984. The coroner was then given permissive power to report matters (the continuation of which could be associated with future fatalities) to a person who could possibly do something about it.

In 2008, the coroner's position was strengthened by mandating that a report directed to the prevention of future fatalities after an inquest must be responded to within 56 days. The response had to indicate what action would be taken and if no action was to be taken, explain why not. A copy would be sent to the Lord Chancellor who would have the discretion to publish the report and the response. Making such a report was still a matter of discretion — or was it? The 1998 Human Rights Act incorporated the European Convention on Human Rights (ECHR), a post-World War II document written in 1950 in response to that war and the circumstances that led up to it, into English law. The ECHR thus became the nearest thing to a written constitution for the English that there is. Article 2 of the ECHR is the "right to life" part of the convention. Brussels Jurisprudence has held that Article 2 provides citizens an adjectival right to have their death "in the arms of the state" investigated and this investigation falls to the coroner, with an expanded remit to determine not only how the deceased died, but the circumstances in which he/she came to his/her death.[5] In a Court of Appeals case, there was *obiter* that in some inquests in which Article 2 of ECHR is engaged, the coroner had a duty to write a report in which the circumstances indicated that action might be taken to prevent future fatalities.

The Coroners and Justice Act 2009 requires the coroner to write reports that will be published, along with responses, when action may be taken to prevent future fatalities. This is a powerful tool for the doing good.

Examples of reports include those relating to notoriously dangerous roads, illicit cigarettes that are not self extinguishing, Novel Psychoactive Drugs which are not yet illicit, and the dangers of ignoring repeated chest infections, thus missing a diagnosis of Tuberculosis (TB), in patients being treated with tumor necrosis factor inhibitors.

The obligation in England and Wales for coroners to report deaths in which action may be taken to prevent future fatalities truly makes the Coroner's Court a place where the dead teach the living.

Reference(s):

1. The Coroners and Justice Act 2009, ss1-17.
2. Hawkes N. Why the delays in counting the dead? *BMJ*. 2014;349:g4305.
3. R v. Harding (1908), 1 Cr App Rep 219.
4. W B Purchase. *Jervis on Coroners, 8th Edition*, 1946; 110.
5. R .v HM Coroner for Western Somerset, Ex parte Middleton (2004) UKHL 10.

Coroners, Inquests, Learning Lessons

*Presenting Author