CHIEF CORONER

GUIDANCE No.17

CONCLUSIONS: SHORT-FORM AND NARRATIVE

INTRODUCTION

1. The purpose of this guidance is to assist coroners in the use of short-form and narrative conclusions and with a view to achieving greater consistency across England and Wales.[1]

2. This guidance is not intended to cover all possible aspects of conclusions. It provides a suggested approach, consistent with case law, to making public findings and conclusions clear, accessible and complete. This will benefit all who attend inquests and will assist the important process of recording for statistical purposes.

The statutory framework and Record of Inquest

3. Section 10 of the Coroners and Justice Act 2009 (the 2009 Act) requires the coroner (or the jury if there is one) to make a 'determination' of the matters to be ascertained by the investigation and make 'findings' for registration purposes. The matters to be ascertained by the investigation into a person's death are: who the deceased was; and how, when and where the deceased came by his or her death (section 5). The findings for registration purposes are the particulars required by the Births and Deaths Registration Act 1953. The requirement for both is emphasised by Rule 34 of the Coroners (Inquests) Rules 2013 (the 2013 Rules).

4. The section 10 'determination' and 'findings' must be recorded on the Record of Inquest (there is a copy in the Annex below).

5. The Record of Inquest will be signed by the coroner and, if there is a jury, by those jurors who agree with it.

6. The Record of Inquest should normally be treated as a public document. Most if not all of the details on it will have been read out in open court, and it may be provided to any person unless they are not 'in the opinion of the coroner … a proper person to have possession of it',[2] which should be rare.

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[1] I am indebted to the coroners who have provided valuable input into this Guidance.
[2] See Regulation 27(2) of the Coroners (Investigations) Regulations 2013.

7. The Record of Inquest should normally be made available for inspection by the public (including the media) at a coroner's office on request. In the publicly available copy, the signatures of jurors should be redacted. Similarly, other details, such as the address of the deceased, may be redacted where there is good reason for doing so. Details should not be redacted unless the public interest requires it.

THE THREE STAGES

8. The coroner (or the jury, if there is one) is required, having heard the evidence, and in addition to deciding the medical cause of death, to arrive at a conclusion by way of a three-stage process.

(1) **To make findings of fact based upon the evidence.**

Where the coroner sits alone, the key findings of fact should be stated orally in open court, preferably (during or) after the evidence has been summarised (but not written on the Record of Inquest).

Where there is a jury, they need to be directed to make findings of fact for themselves based upon the evidence they have heard. They will not normally record these findings of fact publicly except insofar as they form part of the answer to 'how', or part of a narrative conclusion.

(2) **To distil from the findings of fact 'how' the deceased came by his or her death and to record that briefly on the Record of Inquest in Box 3.**

Normally, the answer to 'how' will be a brief one sentence summary taken from the findings of fact in (1) above.

In most cases, 'how' means 'by what means' (and not 'in what broad circumstances').[3] This will usually be a description of the mechanism of death. However, in Article 2 cases 'how' means 'by what means and in what circumstances'[4] (see the 'Article 2 Inquests' section below).

Examples of 'how' in Box 3 are:

- 'by hanging from an exposed beam using a ligature made from a bedsheet' (with the conclusion of 'suicide' entered in Box 4);
- 'by drowning while swimming from his small fishing boat in the open sea' (with the conclusion of 'misadventure' entered in Box 4);
- 'from injuries caused in a motor collision while a backseat passenger in her father's car' (with the conclusion of 'road traffic collision' entered in Box 4);
- 'from trauma consistent with an un-witnessed fall downstairs' (with the conclusion of 'accident' entered in Box 4);
- 'by exposure to asbestos fibres during the course of his occupation as a plumber' (with the conclusion of 'industrial disease' entered in Box 4).

To these words will be added the date and place of death where known and, where necessary, any further words which briefly explain how the deceased came by his/her death. (Box 3)

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[3] *R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson [1995] QB 1.*

[4] section 5(2) of the 2009 Act; *R (Middleton) v HM Coroner for West Somerset [2004] 2 AC 182.*

For example, in a case of bad driving falling short of manslaughter: 'The unknown driver left the scene without stopping. He had been travelling at high speed down an ill-lit narrow street, knocking into parked cars, before he struck and knocked down the deceased who was walking along the side of the road, causing the injuries from which he died. (Box 3) I shall therefore record the formal conclusion [under the law/as required by law] as accident OR road traffic collision.' (Box 4)

Coroners, in their judicial discretion, will use their own form of words. These should be brief, neutral and clear. They must not include opinion other than on matters which are the subject of statutory determination (section 5(3), the 2009 Act) and they must not appear to determine any question of criminal liability on the part of a named person or civil liability (section 10(2)).

(3) **To record the conclusion, which must flow from and be consistent with (1) and (2) above, on the Record of Inquest in Box 4.**

CONCLUSIONS: The alternatives

9. There are two alternatives for conclusions which are sanctioned by the 2009 Act, the 2013 Rules and the common law: (1) a short-form conclusion; and (2) a narrative conclusion. It is also permissible to combine the two types of conclusion.

10. The conclusion must be entered on the Record of Inquest in Box 4.

11. There must always be sufficient evidence on a *Galbraith* plus basis for a conclusion.[5]

12. It is for the coroner to decide whether a short-form or a narrative conclusion is more appropriate to the case in question.

Submissions: conclusions and directions of law

13. In more complex cases, the coroner should invite submissions from interested persons on the following:

- the type of conclusion, short-form or narrative; and (where there is a jury)
- the short-form conclusions the coroner is considering leaving to the jury;
- what written directions will be given to the jury (including in what order the jury should consider the conclusions); and
- what questions (if any) may be asked of them.

After considering any submissions, the coroner should give a ruling about these matters, with short reasons.[6]

14. In jury cases, it is good practice for the coroner to give the jury a copy of the directions of law, as well as reading them out. This allows the jury to revisit the

[5] See Chief Coroner's Law Sheet No.2, Galbraith *Plus*.
[6] *R (Wilkinson) v HM Coroner for the Greater Manchester South District [2012] EWHC 2755* at [18]; *R v Inner South London Coroner, ex parte Douglas-Williams [1999] 1 All ER 344, 355.*

directions when they have retired, without having to rely on their memory or notes.

(1) SHORT-FORM CONCLUSIONS

15. Wherever possible coroners should conclude with a short-form conclusion. This has the advantage of being simple, accessible, and clear for statistical purposes.

16. The short-form conclusion should be one from the list of short-form conclusions in Note (i) in the Schedule to the 2013 Rules (https://www.legislation.gov.uk/uksi/2013/1616/schedule/made). The list is not exclusive,[7] but straying from the list will usually be unwise.

17. The short-form conclusion: 'alcohol/drug related' may be split into 'alcohol related' or 'drug related'.

18. Even in a complex case, a short-form conclusion in Box 4, in combination with the answer to 'how' in Box 3, will often be sufficient to 'seek out and record as many of the facts concerning the death as the public interest requires'.[8]

19. Where a short-form conclusion is left to a jury in a complex case, the coroner should normally help the jury: (i) identifying key questions of fact for them to decide, when they come to answer the 'how' question (Box 3); and (ii) providing written directions of law with assistance on their conclusion (Box 4).

20. The following is an example of a direction to a jury in a more complex case on 'how' the deceased came by his death (Box 3), as a precursor to their consideration of a short-form conclusion (Box 4):

    'Members of the jury, in dealing with the requirement in Box 3 of the Record of Inquest to decide how [the deceased] came by her death you might like to consider the following questions as part of your investigation into the death. [LIST QUESTIONS] There may be other questions which you consider important.

    I am not telling you what to say. What you find and how you express it is entirely a matter for you. I am merely helping you with the sort of words you might write under this heading if you so choose.

    In answering the question how she came by her death you must make findings of fact. The law says that you must not make recommendations or express opinions. And your findings of fact must, of course, not only be brief, neutral and clear but they must also be based upon the evidence which you have seen and heard in court, from witnesses and in documents and from the CCTV evidence.

    Once you have agreed the facts, then and only then should you move on to consider your conclusion under Box 4 of the Record of Inquest. Let me now direct you about the possible conclusions. [BOX 4 DIRECTIONS]'

[7] See *R v Inner South London Coroner, ex parte Kendall [1988] 1 WLR 1186*, relating to the old Form 22.
[8] Per Lord Lane in *R v South London Coroner, ex parte Thompson (1982) 126 SJ 625.*

(2) NARRATIVE CONCLUSIONS

21. As an 'alternative' to a short-form conclusion, the coroner (or the jury, if so directed by the coroner) may record a 'brief narrative conclusion' in Box 4. A narrative conclusion may also be used in addition to a short-form conclusion.

22. Where a narrative conclusion includes clearly the answers to 'how, when and where', it is best to record the mechanism of death under 'how' in Box 3 and the wider narrative conclusion in Box 4.

23. Narrative conclusions may be used in both Article 2 and non-Article 2 cases.[9] In a non-Article 2 case, a narrative conclusion should be a brief, neutral, factual statement; it should not express any judgment or opinion.[10] For example, in a clinical death, a narrative conclusion might state that the deceased died from recognised complications of a necessary surgical procedure. By contrast, a conclusion in an Article 2 case may be judgmental: see 'Article 2 Inquests' below.

24. The difference in some cases may be slight and not much more than a matter of words. For example, in a non-Article 2 case judgmental words such as 'missed opportunities' or 'inadequate failures' should probably be avoided. But rather than, for example, saying that 'There was a missed opportunity when the registrar failed to seek advice from the consultant', the coroner could say just as effectively: 'The evidence leads me to find that the registrar did not seek advice from the consultant who was nearby and available at the time and the registrar knew that. The registrar acted on his own.'

25. The higher courts have repeatedly emphasised the need for brevity in a narrative conclusion. A sentence or two, or a single short paragraph, will be sufficient. Longer narrative conclusions are neither clear nor accessible and should not be given.

26. Narrative conclusions are not to be confused with findings of fact in the three-stage process. If the three-stage process is properly followed, there will often be no need for a narrative conclusion.

27. In general, a narrative conclusion should be used only where the three-stage process (culminating in a short-form conclusion) is insufficient. For example, a short-form conclusion may be insufficient where the jury would wish to express a conclusion in a prison death case on a major issue such as procedures leading to two persons sharing a cell together.[11]

28. Narrative conclusions must be directed to the issues which are central to the cause of death. The coroner does not have to state a conclusion on every issue raised.[12]

29. Where a jury is invited to write a narrative, the coroner will usually identify the issues or areas of fact which the jury needs to address, guiding them with examples of possible narrative conclusions.

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[9] *R (Longfield Care Homes) v HM Coroner for Blackburn [2004] EWCH 2467 (Admin),* [28]-[31].
[10] *Jamieson*, note 3, general conclusion (6); see also *R (Hurst) v London Northern District Coroner [2007] 2 AC 189.*
[11] *Middleton,* note 4, at [31], referring to the major issue in *Amin*.
[12] *R (Allen) v HM Coroner for Inner North London [2009] EWCA Civ 623,* at [33].

30. Alternatively, the coroner may choose to provide the jury with written questions in the form of a questionnaire. In such cases, the questions and answers will stand as the narrative conclusion. They will become part of the Record of Inquest and will be read out in public. Questionnaires should not be lengthy.[13]

31. Although coroners will use their own words (when sitting without a jury), in the exercise of their judicial discretion, the following is an everyday example of a narrative conclusion: 'He/she died from a complication of necessary medical treatment OR of a necessary surgical procedure'.

ARTICLE 2 INQUESTS

32. In an Article 2 inquest, a short-form conclusion may be sufficient to enable the jury to express their conclusion on the central issues.[14] However, frequently a narrative conclusion will be required in order to satisfy the procedural requirement of Article 2, including, for example, a conclusion on the events leading up to the death, or on relevant procedures connected with the death.

33. The coroner has a power in an Article 2 inquest (but not a duty) to leave to the jury, for the purposes of a narrative conclusion, circumstances which are possible (i.e. more than speculative) but not probable causes of death.[15] A narrative conclusion may also (but does not have to) include factual findings on matters which are possible but not probable causes of death where those findings will assist a coroner in a Report to Prevent Future Deaths.[16]

34. A conclusion in an Article 2 inquest may be a 'judgmental conclusion of a factual nature [on the core factual issues], directly relating to the circumstances of death', without infringing either section 5(3) of the 2009 Act (limiting opinion) and section 10(2) (avoiding questions of criminal liability on the part of a named person or civil liability).[17]

35. It is unlawful to direct a jury in an Article 2 case in such a way that they are prevented from entering 'a judgmental conclusion of a factual nature'.[18]

36. Words denoting causation such as 'because' and 'contributed to' are permissible.[19] On the other hand, words which suggest civil liability such as 'negligence', 'breach of duty', breach of Article 2' and 'careless' are not permitted as they may breach Section 10(2) of the 2009 Act.

MISCELLANEOUS

Level of certainty

37. The level of certainty required when reaching conclusions at an inquest (whether those conclusions are short-form or narrative) is the same as the civil standard of proof, namely the balance of probabilities.[20]

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[13] *Scholes v SSHD [2006] EWCA Civ 1343* at [70].
[14] *McCann v United Kingdom* (1995*) 21 EHRR 97; Hurst*, note 10, at [48].
[15] *R(Lewis) v HM Coroner for the Mid and North Division of Shropshire [2010] 1 WLR 1836* as cited in *R (LePage) v HM Assistant Deputy Coroner for Inner South London [2012] EWHC 1485* at [45].
[16] *Lewis,* note 15, at [27].
[17] *Middleton*, note 4, at [37].
[18] *R (Cash) v HM Coroner for Northamptonshire [2007] EWHC 1354 (Admin)* at [51]-[52].
[19] *Middleton,* note 4 at [45]; *Lewis*, note 15 at [25].
[20] *R (on the application of Maughan) v HM Senior Coroner for Oxfordshire [2020] UKSC 46.*

Particular short-form conclusions

38. Guidance will not be provided here on all short-form conclusions, only on some.

Lawful/unlawful killing

39. For the conclusion of lawful killing see the decision of the High Court in *Duggan*.[21]

40. For the conclusion of unlawful killing see the Chief Coroner's Law Sheet No.1.

Suicide

41. It is not proposed in this guidance to set out the law relating to the short-form conclusion of suicide, but two points need to be made in the context of conclusions.

42. First, the conclusion of suicide should not be avoided by coroners simply out of sympathy for the bereaved family, or for any other reason. It is the coroner's judicial duty, when suicide is proved on the evidence, to record the conclusion of suicide according to the law and the findings which justify it. It would be wrong, for example, to record an 'open' conclusion when the evidence is clear.[22]

43. Secondly, coroners should make express reference in each case of possible suicide to the two elements which need to be proved: (i) [the deceased] took his/her own life; and (ii) [the deceased] intended to do so (or, put together, 'he/she intentionally took his/her own life'). Both elements must be proved on the balance of probabilities. Suicide must never be presumed.[23]

Accident

44. Some authorities have approved additional words in accident cases such as 'the deceased was killed when his car was run down by an express train on a level crossing', or 'the deceased was drowned when his sailing dinghy capsized in heavy seas'.[24] The phrase 'accidental death' may also be used[25].

45. This type of wording is not a narrative conclusion, but it may be used to answer the 'how' in Box 3, leaving the short-form conclusion of 'accident' to stand alone in Box 4.

Misadventure

46. Misadventure may be the right conclusion when a death arises from some deliberate human act which unexpectedly and unintentionally goes wrong.

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[21] *R (Duggan) v HM Assistant Deputy Coroner for the Northern District of North London [2014] EWHC 3343 (Admin).*
[22] 'The job of the judges is to apply the law, not to indulge their personal preferences': Lord Bingham in *The Rule of Law* (2010).
[23] *R v City of London Coroner, ex parte Barber [1975] 1 WLR 1310.*
[24] *Jamieson*, note 3.
[25] *Kendall*, note 7.

Open conclusion

47. Open conclusions are to be discouraged, save where strictly necessary.

48. An open conclusion is the conclusion that can be used when another short-form conclusion has not been proved.

49. Where an open conclusion is left to a jury with one or more other short-form conclusions, the coroner should tell them (a) not to use the conclusion because they disagree amongst themselves on the other short-form conclusion(s), and (b) if they do come to an open conclusion, not to consider that they will be criticised for it or that they have failed in their duty in any way.

50. Where the conclusion is an open one, Box 3 still needs to be completed, including 'how'.

51. An open conclusion, once entered and recorded, may not be revisited without the intervention of the High Court.

52. In some cases, a narrative conclusion will be preferable to an open conclusion. A narrative will give the coroner (or jury) the opportunity to state what findings are made and what are not. Or alternatively, the open conclusion can have extra words appended by way of explanation. For example, in a suspected suicide case, a coroner might write: 'The means by which the deceased came to be in the water could not be ascertained'.

Neglect

53. The following does no more than outline the concept of neglect in coroner law.

54. Neglect has a restricted meaning according to the case law and should not be considered as a primary cause of death.

55. A finding of neglect is not in itself a conclusion, but may form part of the conclusion in Box 4, either as words added to a short-form conclusion, or as part of a narrative conclusion.

56. Neglect is narrower in meaning than the duty of care in the law of negligence.[26] It is not to be equated with negligence or gross negligence. It is limited in a medical context to cases where there has been a gross failure to provide basic medical attention to someone in a dependent position. In broad terms there must be 'a sufficient level of fault' to justify a finding of neglect.[27]

57. In a medical context, it is not the role of an inquest to criticise every twist and turn of a patient's treatment. Neglect is not concerned with the correctness of complex and sophisticated medical procedures but rather the consequences of, for example, failing to make simple ('basic') checks.[28]

58. In prison death cases, 'only in the most extreme circumstances (going well beyond ordinary negligence) could neglect be properly found to have contributed to that cause of death'.[29]

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[26] See *R v HM Coroner for South Yorkshire, ex parte Stringer (1993) 17 BMLR 92.*
[27] *R (Khan) v HM Coroner for West Hertfordshire [2002] EWHC 302 (Admin)* at [44].
[28] *R (Nicholls) v HM Coroner for City of Liverpool [2001] EWHC Admin 922* at [45]-[58].
[29] *Middleton*, note 4, at [28], summarising *Jamieson,* note 3, at pp25-26.

59. There must be a clear and direct causal connection between the conduct described as neglect and the cause of death.[30] The conduct must have caused the death in the sense that it 'more than minimally, negligibly or trivially contributed to the death'.[31] The 'touchstone' is 'the opportunity of rendering care … which would have prevented death.[32] It is not enough to show that there was a missed opportunity to render care which might have made a difference; it must be shown that care should have been rendered and that it would have saved or prolonged life (not 'hastened' death).[33] [emphasis added]

60. Neglect must be shown on a balance of probabilities. A 'real possibility' is not enough[34].

61. The phrase 'aggravated by neglect' should not be used, nor should 'lack of care'. A better phrase might be that neglect (being the conduct which amounted to neglect) contributed to the cause of death.

All inquests

62. Coroners should at all times use moderate, neutral and well-tempered language, befitting the holder of a judicial office. Coroners should not make any other observations of any kind, however well-intentioned, outside the scope of a report on action to prevent future deaths under the provisions of paragraph 7 of Schedule 5 to the 2009 Act.[35] Such observations are an expression of opinion wider than is permissible (under section 5(3) of the 2009 Act) and are therefore unlawful and to no effect[36]

63. Juries may not give riders or otherwise make recommendations.[37]

HH JUDGE THOMAS TEAGUE QC
CHIEF CORONER

30 January 2015,
14 January 2016 revised,
7 September 2021 revised

[30] *Jamieson,* note 3, at point (12). See also *Khan*, note 27.
[31] *Khan*, note 27, at [25], [43].
[32] *R v HM Coroner for Coventry ex parte Chief Constable of Staffordshire (2000) 164 JP 665,* pp675-676.
[33] *Khan*, note 27, at [43].
[34] *Khan*, note 27 at [43].
[35] See Chief Coroner's Guidance No.5.
[36] See *R (Mowlem plc) v Avon Assistant Deputy Coroner [2005] EWHC 1359 (Admin)* and *R (Farah) v HM Coroner for Southampton and New Forest District of Hampshire [2005] EWHC 1359 (Admin)*.
[37] This practice was abolished by the Coroners (Amendment) Rules 1980. See also *Jamieson*, note 3, at p14.

ANNEX

Record of Inquest

Following an Inquest opened on and an Inquest hearing at heard before and the undermentioned jurors in the Coroner's Area for

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

I a
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 Coroner as to the death

5. Further particulars required by the Births and Death 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	

Signature of

Signatures of Jurors (if present)

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