Conclusions

KEY MATERIALS

Legislation:

Birth and Deaths Registration Act 1953

Coroners and Justice Act 2009

Coroners (Inquest) Rules 2013

Chief Coroners Law Sheets:

No 1: Unlawful Killing

No. 2: Galbraith Plus

Chief Coroners Guidance:

No. 45: Still birth and live birth following termination of pregnancy

Introduction

1. Section 10 of the Coroners and Justice Act 2009 (the 2009 Act) under the heading 'Determinations and findings to be made', sets out what is to happen at the conclusion of an inquest. After hearing the evidence at an inquest the coroner (or jury) is required[1] to make and record 'findings' under s.5(1)(c) regarding the particulars required by Birth and Deaths Registration Act 1953 and 'determinations' regarding the four statutory questions under s.5(1)(a) and (b) (who the deceased was; how, when and where they came by their death)[2] as well as the medical cause of their death.

[1] By s.10 of the 2009 Act

[2] 'How' will have the expanded meaning of 'in what circumstances' if the Article 2 procedural duty are engaged under s.5(2) of the 2009 Act

2. The required 'findings' (more commonly called 'registration particulars') are the deceased's full name (including maiden surname of a woman who has married), date and place of birth, sex, date and place of death, their occupation and usual address.

3. Save where an inquest is being held in writing, both the determinations and the findings should be announced by the coroner (or jury foreperson if there is one) in open court.

4. These statutory findings are not to be confused with the wider 'findings of fact' set out by the coroner at the end of an inquest, adopting the three stage process that is described below, when arriving at an answer to 'how' the deceased came by their death.

The Record of Inquest

5. The findings and determinations along with the coroner's or jury's conclusion as to 'how' the death came about are recorded on the formal Record of Inquest form (ROI) found in the schedule to the Coroners (Inquests) Rules 2013 (the Inquest Rules).[3] It provides for a record to be made in the following form:

   Part 1. Name of the deceased (if known).

   Part 2. Medical cause of death.

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

   Part 4. Conclusion of the coroner/jury as to the death: (see notes (i) and (ii)).[4]

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

6. Interested persons (IPs) will often request and, in accordance with rule 13(2)(d) should be provided with, a copy of the ROI at the end of the inquest. Whilst rule 16 would allow a coroner to charge for a hard copy of the ROI once an inquest ends it is unlikely to be appropriate to expect the bereaved or indeed any other IP to pay a fee for this. No fee may be charged where a document is disclosed by email by a coroner to an IP.[5]

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[3] Form 2 in the schedule – see also Rule 34 Coroners (Inquests) Rules 2013. In most areas the version of Form 2 that is used will include other matters not formally prescribed in the schedule and will record the place the hearing was held, the hearing dates or date of the conclusion and the full name and status of the coroner.

[4] The conclusion referred to in part 4 was formerly known as the 'verdict' but the 2009 Act moved away from this term more suited to criminal proceedings.

[5] See reg.12(2) Coroners Allowances, Fees and Expenses Regulations 2013 ('the Fees Regs')

7. The ROI should be treated as a public document and so normally available for inspection by the public (including the media) at a coroner's office on request or a copy provided (usually by emailed pdf). A fixed statutory fee of £5 can be charged for hard copies of documents provided after the inquest.[6]

8. Where a coroner has sat with a jury there is no requirement for the jurors' full names to appear on the ROI, the jurors must however each sign the ROI. In the case of a majority conclusion, only those jurors agreeing should sign. The coroner is also required to sign the ROI once the jury has completed its inquiry.

9. If a copy of the ROI is requested by a member of the public or the press, the jurors' signatures should be redacted before a copy is provided. The same approach should be taken with copies of the ROI provided to IPs. If any objection to redaction is raised, the coroner should consider representations on the point. One of the factors that the coroner should consider where there has been a majority decision is the extent to which the signatures disclose information about the jury's deliberations.

10. Similarly, although details such as the address of the deceased will have been stated in open court at the end of the inquest, the redaction of their address from the ROI before it is distributed as a document will rarely be met by complaint if there is good reason for doing (such as sensitivity to those bereaved who still live at the same address).

11. The coroner should also complete a 'Certificate after Inquest' (Form 99(REV)A) at the conclusion of the inquest, a copy of which will be sent to the Registrar of Births and Deaths. Receipt of this form enables the registrar to register the death and issue a death certificate.

Completing the Record of Inquest

[6] See reg.12(3) of the Fees Regs: Where a document is disclosed by a coroner as a paper copy, a fee of £5 for a document of 10 pages or less shall be payable, with an additional 50p payable for each subsequent page.

12. Save where an inquest has been held in writing, the ROI should only be completed and signed by the coroner (and, if there is one, the jury) after the inquest conclusions have been announced in public.[7]

13. On the signing of the ROI the inquest and investigation are formally concluded and the coroner becomes *functus officio.* The coroner may still exercise their power under Paragraph 7 of Schedule 5 of the 2009 Act to make a report to prevent future deaths,[8] but as their investigation has now concluded and they have no power to hear any further evidence.

14. The ROI is set out in five parts that should be completed as follows:

Part 1: Name of the deceased (if known).

15. This will be the full name that the deceased was known by at their death, which may be different from their given name at birth.

16. Where the identity of the deceased is not known, it is acceptable to record 'unascertained' or 'unknown'.

17. The identity of a person under English law is not a matter of legal formality and anyone can choose to change the name they use and that others know them by.[9] Whilst many people will retain and use the name given to them at birth, there is no requirement in law to do so. In *Ganoun v Joshi*:[10] a judge of the High Court Chancery Division observed that "there was nothing improper in allowing the deceased to be buried under the name which he had always used since he had lived in the UK. Although it was not the name which he had been born with."

18. A person aged over 16 may choose to adopt a new name at any time in their life for any reason,[11] and a deceased's name need not correspond with their given name that appears on their birth certificate.

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[7] This is implicit in ss.5(1) and 10(1) of the 2009 Act and the Coroners (Inquest) Rules 2013. See 'The Record of Inquest' above regarding who signs the ROI.

[8] See Chapter 16

[9] See Hale J (as she then was) in Buchanan v Milton [1999] EWHC B9 (Fam), [1999] 2 FLR 844: "In English law a person's name is that by which he himself chooses to be known."

[10] [2020] EWHC 2743(Ch). A case dealing with burial rights over a body where the deceased had for immigration reasons, adopted a new name and date of birth on his arrival in the UK 15 years before his death.

[11] A child under 16 or subject to certain care or residence orders will require someone with parental responsibility to consent to a change of name.

19. Whilst some of those who adopt a new name will execute a deed poll, a deed poll is not required to change one's name, it is simply a legal document that is accepted by organisations such as banks as proof of the decision to change one's name. A deed poll is documentary evidence of the choice of a new name, but it does not create any 'legal name' as no such thing exists.[12]

20. Contentious issues regarding someone's name may arise when the evidence indicates that a person has changed their name during their lifetime but the bereaved wish the coroner to register the death using the name given to them at birth.

21. The coroner or jury must determine the deceased's name and record this on the ROI as established, on the balance of probabilities, from the available evidence. Whether or not the deceased's name at death was different from their given name at birth will simply be a matter of evidence.

22. Just as coroners will not usually ask to see a marriage certificate before accepting the oral or written evidence of others that someone was married, similarly it is open to the coroner to accept the oral or written evidence of others as to what name a person had chosen to be known by at their death without requiring documentary evidence of this. Documentary evidence may assist in making the determination, but a coroner is not required to have seen such evidence to establish the name a deceased was choosing to use at their death.[13] Coroners should remember, however, that a marriage or civil partnership does not automatically create a new name, it is simply a custom and practice that some people will adopt their spouse/partner's family name on marriage. There is no requirement of law that anyone must do so.

23. Where a trans person has obtained a Gender Recognition Certificate (GRC) under the Gender Recognition Act 2004 this does not create a new name, nor create any right to use a new name, as no such right is needed for a person aged over 16. The GRC will have been issued in the name the person was choosing to use when they applied for the

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[12] Similarly there is no legal step to take if adopting a new name on marriage/civil partnership it is simply a matter of personal choice. Not all newly-weds will decide to adopt their partner's name. Producing a marriage or civil partnership certificate alongside an assertion that one has changed one's family will usually be accepted by organisations such as banks as evidence of a person having made the choice to adopt a new family name .

[13] Although documentary evidence such a driving licence, bank statement or passport may be available if requested.

GRC. However, coroners should note that to reveal the earlier name of a person with a GRC could amount to a criminal offence under s.22 GRA 2004, if by doing so one reveals their trans status.

24. Although it is permissible to record in part 1 of the ROI and for the registration particulars that the deceased person had used two names, for example '*Edward Wayne, formerly known as Tommy Wayne*', there is no requirement in law to record a person's given name or earlier name. Indeed, if there is evidence that they have chosen to no longer use their earlier name it may appear disrespectful to do so.

25. However, there may be occasions when the bereaved will wish for previous or alternative names used by the deceased to be recorded on the ROI and Form 99(REV)A, particularly when the deceased has recently adopted a new name and for some official purposes, such as executors accessing the deceased's bank accounts and pensions, a formal record of the deceased's earlier names on a death certificate may make matters simpler for the bereaved when dealing with probate. Such a request, if reasonable, may be acceded to.[14,15]

Part 2: Medical cause of death.

26. Whilst this will often reflect the medical cause of death provided by a pathologist or other medical practitioner, it is for the coroner (or jury) to make this determination. The cause of death therefore remains provisional until confirmed at the inquest. There is no obligation on the coroner or jury to accept the cause of death given by any medical witness if the evidence, when taken as a whole, suggests a different formulation. Indeed, given the tendency of some doctors to populate part 2 of a Medical Certificate of Cause of Death (MCCD) with *any* co-morbidity from which the deceased suffered,

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[14] See also *Ganoun v Joshi* [2020] EWHC 2743 (Ch) where, following the burial of the deceased in the UK under a name he had adopted on coming to the UK, the High Court agreed to made a declaration regarding the deceased's identity and his birth name to assist his Algerian family when seeking a visa to visit his grave. The High Court application was made three weeks after the death in a road traffic collision and so predated the inquest in that case. The Coroner was named as an interested party but played no part in the proceedings. However it is suggested that, had the death been registered following the inquest by stating both names then a declaration would not have been necessary.

[15] Should it come to light after an inquest that the deceased was formerly known by other names, the register of deaths can be updated if supporting documents and a letter are sent by a coroner to General Registry Office outlining clearly the names which were formerly used by the deceased and requesting that authority is granted for the Registrars to add the additional names to the register of deaths. Registrars can accommodate up to 5 names on RON (their software programme) as well as a maiden name, these can then all be added to the final re-issued death certificate.

regardless of its causative relevance to their death, careful scrutiny of any MCCD and the medical evidence will often be warranted. The conditions mentioned in part 2 must be known or suspected to have contributed to the death, not merely be other conditions which were present at the time of death.

Part 3: How, when and where the deceased came by their death.

27. Here the coroner or jury must set out how, when and where the death occurred. In most inquests the question of 'how' will mean 'by what means'. The answer to 'how' the deceased died may well go wider than the medical cause of death and encompass a description of the mechanism of death.

28. Examples of 'how' in Part 3 are:

- 'by hanging from an exposed beam using a ligature made from a bedsheet' (with the conclusion of 'suicide' entered in Part 4);
- 'by drowning while swimming from his small fishing boat in the open sea' (with the conclusion of 'misadventure' entered in Part 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 Part 4);
- 'from trauma consistent with an un-witnessed fall downstairs' (with the conclusion of 'accident' entered in Part 4);
- 'by exposure to asbestos fibres during the course of his occupation as a plumber' (with the conclusion of 'industrial disease' entered in Part 4).

29. 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.

30. For example, in a case of bad driving falling short of manslaughter the coroner might record the following: '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. (Part 3) I shall therefore record the formal conclusion [under the law/as required by law] as accident OR road traffic collision.' (Part 4)

31. In an inquest that must also meet the state's procedural obligations under Article 2 European Convention of Human Rights (ECHR), often referred to as a '*Middleton* inquest', 'how' should be understood as 'by what means and in what circumstances'.[16] Where Article 2 obligations are not engaged, then the inquest is often referred to as a '*Jamieson* inquest'.[17]

Completing part 3 in a non-Article 2 'Jamieson inquest'.

32. The function of an inquest is to 'seek out and record as many of the facts concerning a death as the public interest requires'.[18] The question of 'how' will be answered by giving a brief, neutral but factual account of the death which fully encapsulates the essential facts.

33. In a *Jamieson* inquest the language used should be non-judgmental. Relevant acts or omissions that were probably causative of death should be recorded, using a neutral form of words.[19] There is also a power, but no duty, to record relevant acts or omissions that were not causative of the death (or were only possibly causative).[20] That discretion may appropriately be used if the ROI would be deficient were the matter not recorded, particularly where the act or omission is an integral part of the factual matrix.[21] However, language that appears to amount to a finding of civil liability, or criminal liability on the part of a named person, must not be included.[22]

[16] *R (Middleton) v HM Coroner for West Somerset* [2004] UKHL 10, [2004] 2 AC 182
[17] *R v HM Coroner for North Humberside and Scunthorpe, exp Jamieson* [1995] QB1.
[18] *R v South London Coroner ex parte Thompson* (1982) 126 SJ 625
[19] *R. v East Sussex Coroner exp. Homberg* (1994) 158 J.P 357
[20] *R(Lewis) v HM Coroner for Shropshire* [2009] EWCA 1403, [2010] 1 WLR 1836
[21] In *R(Worthington) v HM Senior Coroner for Cumbria* [2018] EWHC 3386 (Admin), the court held that the coroner had been right to conclude that it was appropriate to include in part 3 of the ROI references to the anal penetration occurring in the hours before a child's death because, although this did not cause her death, it was part of the background facts and essential to explain why she was in the unsafe sleeping environment which did lead to her death.
[22] Section 10(2) of the 2009 Act.

Completing part 3 in an Article 2 (Middleton) inquest.

34. The same principles as with a *Jamieson* inquest apply in a case where the state's Article 2 investigative obligations are engaged, save that any factual findings returned, whether recorded in part 3 or part 4 of the ROI, may be judgmental. Indeed, it would be 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'[23]

35. 'How' in s.5 of the 2009 Act is given a broader sense by s.5(2), meaning not simply 'by what means' but 'by what means and in what circumstances' the deceased person came by their death.

36. It is for the coroner, in the exercise of their discretion, to decide how best to record their findings, or best elicit the jury's conclusion[24]. The conclusion must address the central issue or issues in the case.[25] A brief short-form conclusion may be sufficient, but in other cases the conclusion will need to be longer, describing not only where and when the death took place and the cause or causes of death, but also any defects in systems which contributed to the death and any other factors which are relevant to the circumstances of the death.

37. Conclusions must not be framed such that they appear to determine any question of criminal or civil liability on the part of a named individual or go beyond the coroner's statutory remit.[26] However, when considering this prohibition in s.10(2) of the 2009 Act the word 'determine' is important. An apparently judgmental finding that there was a failure to act in a particular way does not 'appear to determine' a question of civil liability. Findings of fact, however robustly stated, are not prohibited. Therefore a determination may be recorded, using words such as 'serious failure' or 'inadequate' to describe omissions of care. Any assertion that there has been a breach of a duty of care or that there was negligence or 'carelessness' and related expressions should be

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[23] *R (Cash) v HM Coroner for Northamptonshire* [2007] EWHC 1354 (Admin) at [51]-[52].
[24] See Chapter 11 on Juries for advice on eliciting findings, determinations and conclusions from juries.
[25] *R (Middleton) v HM Coroner for West Somerset* [2004] 2 AC 182 at §35-§37, §45
[26] S.5 of the 2009 Act (matters to be ascertained) and s.10(2) of the 2009 Act (determinations and findings to be made).

avoided.[27] A conclusion such as that suggested in §45 in *Middleton* ('The deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so') is permissible even though it embodies a judgmental conclusion of a factual nature, directly relating to the circumstances of the death. It does not determine any issue of criminal or civil liability.

38. As in a *Jamieson* inquest, the coroner has the power (but not a duty) in an Article 2 inquest to include (or leave to the jury), circumstances which are possible (i.e. more than speculative) but not probable causes of death.[28] In *Tainton*[29] the court considered that, where the possibility of a violation of the deceased's Article 2 right to life could not be wholly excluded, it would leave the account of the circumstances of the death incomplete not to include possibly causative failings.

39. A conclusion may also (but does not have to) include factual findings on matters which are possible but not probable causes of death if those findings will assist a coroner in considering a report to prevent future deaths (PFD report)[30] after the inquest.

Part 4: Conclusion of the coroner/jury as to the death.

40. Part 4 of the ROI is where the coroner (or jury) will set out their conclusion as to the death. There is no requirement in law to use any particular formulation or particular number of words in a conclusion. In the Schedule to the Inquest Rules there is a list of what are described as 'short-form' conclusions 'that *may* be adopted' set out in note (i) to Form 2. This optional list includes nine conclusions, but these are not the only one or two word conclusions that might be used.[31] Where possible, however, coroners should conclude with one of these listed conclusions as this has the advantage of being simple, accessible, and clear for statistical purposes. In most cases using a conclusion from this list in combination with the answer to 'how' in Part 3, will be sufficient to

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[27] *R(Catherine Smith) v AD Coroner for Oxfordshire* [2008] EWHC 694 (Admin) at §45

[28] *R(Lewis) v HM Coroner for Shropshire* [2009] EWCA 1403, [2010] 1 WLR 1836

[29] *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin) at §73-74

[30] See Chapter 16

[31] Using the listed conclusion of: 'alcohol/drug related' will often meet with an objection from the bereaved and may need to be further refined as either 'alcohol related' or 'drug related'.

‘seek out and record’ as many of the facts concerning the death as the public interest requires.

41. The term ‘narrative conclusion’ is also introduced as a note to Form 2[32] to describe a longer and more descriptive conclusion being returned.[33] Although a longer narrative may be used in both Article 2 and non-Article 2 cases, the higher courts have repeatedly emphasised the need for brevity in conclusions. A sentence or two, or a single short paragraph, will often be sufficient. Longer conclusions are neither clear nor accessible and these tend to only be required in significant and complex Article 2 inquests where there is a need to record determinations about a number of issues which are central to the cause of death.

Three stage process for reaching a conclusion

42. In order to correctly arrive at the conclusion in part 4, the coroner (or the jury) should adopt a ‘three stage process’:

    (1) *Make findings of fact based upon the evidence.* Where a coroner is sitting alone these should be stated orally in court and can be as brief or as detailed as the case requires. Where relevant facts are in dispute the coroner should usually give reasons why some facts have been accepted and/or rejected in favour of others. In a complex case, it may be appropriate to record the findings of fact in a short judgment. If sitting with a jury, the coroner will best assist the jury by identifying any key issues of fact the jury will want to consider when coming to their determinations. The jury 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) *Distil from the findings of fact made, ‘how’ the deceased came by his/her death which is to be recorded in part 3.*

    (3) *Record the conclusion as to the death in part 4, which must flow from, and be consistent with points (1) and (2) above.* The conclusion recorded should

[32] Note (ii) Sch Form 2 Coroners (Inquest) Rules 2013

[33] See §86-93 below.

logically flow from part 2 (the medical cause of death) to part 3 and 4 so that it is clear how the coroner (or jury) has reached their decision in respect of the final conclusion.

Level of confidence / standard of proof

43. It is perhaps inconsistent with the task facing a coroner to speak of a standard of proof in an inquisitorial jurisdiction, where no person must prove or disprove a case. The phrase 'level of confidence' might be considered a better descriptor. Following the decision of the Supreme Court in *Maughan*[34] the level of confidence required for all factual findings and conclusions at inquests is the same as the civil standard – on the balance of probabilities.

Causation

44. In *Tainton*[35] the court observed that the level of confidence to be applied to matters of fact and for causation is the balance of probabilities,[36] and this should not be confused with the *threshold* for causation of death. The threshold that must be reached for causation of death to be established, is that the event or conduct said to have caused the death must have more than minimally, negligibly or trivially contributed to death. Putting these two concepts together, the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death.[37] Put even more simply - did the action or omission probably contribute to the death in a more than minimal way?

Accidental death or misadventure

[34] *R (Maughan) v HM Senior Coroner for Oxfordshire* [2020] UKSC 46
[35] *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin) at §41
[36] Since *Maughan* this is the case for all conclusions including suicide and unlawful killing
[37] *R v HM Coroner for Birmingham and Solihull, exp Benton* [1997] 8 MEDLR 362

45. The term ‘accidental death’ is generally considered to be where an unexpected event, which was neither intended nor envisaged, has resulted in death. A conclusion of ‘accident’ or ‘accidental death’ can encompass a number of scenarios and has no bearing upon any future civil claim as it is neutral in terms of liability. A conclusion of ‘accident’ is often taken by the public to mean that no-one was to blame for the death but that is a significant misunderstanding that may need explaining to unrepresented families.

46. Whilst it is arguable that there is no difference between the terms accident and misadventure, the latter may be considered as the appropriate conclusion when a death occurs due to bad luck rather than from a human error. It is sometimes used when a deliberate human act (undertaken either by the deceased or another) unexpectedly, and unintentionally, goes wrong. For example ‘medical misadventure’ might be the conclusion when a recognised complication of an elective surgical procedure has come about with fatal consequences. For statistical purposes, misadventure will be combined with accidental death.

Alcohol / Drug related death

47. This conclusion recognises that alcohol and/or drugs has been the ultimate cause of death without passing any comment upon the deceased’s wider alcohol or drug use. Hence it can cover a number of scenarios including for example where:
    a. the deceased died as a result of drug or alcohol use which was accidental or experimental;
    b. the deceased died as a result of prolonged alcohol or drug use, having been a habitual user or having a physiological addiction (such as a death of an alcoholic from liver failure);
    c. a combination of the above two scenarios, where, for example, the deceased (who habitually abused drugs or alcohol) completes a detox programme but then relapses – consuming a quantity of alcohol or drugs that his/her body can no longer tolerate.

48. The conclusion does not necessarily reflect that the death was from a drug/alcohol overdose but simply that it was 'drug/alcohol related'. An alternative approach, given the role of either drugs or alcohol in the death will often be clearly recorded in the medical cause of death, may be to reflect what actually occurred by using a conclusion such as accident in scenarios (a) and (c) above.

Industrial Disease

49. There is no statutory definition for the term 'industrial disease' but it is generally understood to refer to a death that has resulted from a disease or infection contracted during and because of the deceased's employment. Schedule 1 of the Social Security (Industrial Injuries) (Prescribed Diseases) Regulations 1985 sets out a list of diseases/injuries and associated occupations where the disease will be presumed, unless the contrary is proved, to be due to the nature of one's employment for the purposes of claiming disability benefits. This schedule includes diseases such as mesothelioma and asbestos-related pulmonary fibrosis and it may provide a useful guide to some conditions that might be considered as an industrial disease.

50. However this list is not prescriptive for coroners who may not rely on a presumption, but will require evidence of an industrial-related cause of a fatal condition.[38] In *R v South Glamorgan Coroner ex p BP Chemicals Ltd*[39] the Divisional Court held that 'industrial disease' as a conclusion has no 'particular refined meaning' and concluded that the death of an office worker employed near a plant manufacturing a substance known to cause angiosarcoma, qualified as an 'industrial disease'.

51. The term 'industrial disease' might also be interpreted as encompassing 'employment-related' diseases. As such it can be used not only to describe pathological reactions to chemicals, but also to describe direct infections from biological agents in the workplace (such as those who were exposed to, contracted and died from COVID-19 whilst working in a healthcare role).

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[38] See also *Wandsworth Borough Council, R (on the application of) v HM Senior Coroner For Inner West London* [2021] EWHC 801 regarding identifying the source of the pathogen and establishing causation.
[39] 151 JP 799

52. Where the deceased has worked in several places when the disease could have been contracted, it is not necessary for the coroner to state in their conclusion which one of their employment situations has led to the disease, as long as the coroner is satisfied from the evidence that it was one of them.[40]

53. The employer (or ex-employer) of the deceased is usually entitled to be considered an IP at an inquest if industrial disease may be the outcome. As industrial diseases can take decades to manifest, it may not always possible to notify a previous employer, particularly where the business no longer exists.

Lawful / Unlawful killing

54. The coroner (or jury) can return a short form conclusion of lawful killing if satisfied on a balance of probabilities, that the death of the deceased was as a result of an action justified in law. A lawful killing is one which is still deliberate and may, for example, arise where acting in self-defence is argued. Guidance on the directions to be given to the jury where self-defence has been raised can be found in *Duggan*.[41]

55. A conclusion of unlawful killing can be considered by the coroner (or jury) if a death was due to murder, manslaughter (whether unlawful act manslaughter, gross negligence manslaughter or corporate manslaughter) or infanticide. Each of the elements of the relevant offence needs to be established to the civil standard.[42] A conclusion of unlawful killing does not extend to the criminal offences of causing death by dangerous or careless driving[43] or offences under the Health and Safety Act 1974 which have resulted in a death. Further guidance can be found in the Chief Coroner's Law Sheet No. 1.

56. In summing up in an inquest where unlawful killing is a potential conclusion, the coroner should direct the jury clearly as to the elements of the criminal offence that need to be established and what they have to find as facts to justify the conclusion. A

[40] There must, however, be some evidence identifying the source of the illness if it is to be specified in any conclusion. See *Wandsworth Borough Council, R (on the application of) v HM Senior Coroner For Inner West London* [2021] EWHC 801

[41] *R (Duggan) v North London Assistant Coroner* [2017] EWCA Civ 142

[42] *R (Maughan) v HM Senior Coroner for Oxfordshire*, [2020] UKSC

[43] *R (Wilkinson) v HM Coroner for Greater Manchester South District* [2012] EWHC 2755 (Admin)

reasoned decision will be expected of the coroner if unlawful killing has been raised but is not, in the coroner's judgment, a conclusion properly open on the facts of the case.

57. Although it may be plain and obvious from the circumstances and the evidence who is regarded as responsible for an unlawful killing, it would be a breach of s.10(2) of the 2009 Act for that person or persons name to appear on the ROI.

Natural causes

58. Whilst there is no statutory definition of 'natural causes', many coroners will consider this to be the normal progression of a natural illness or disease, which runs its full course and results in death, without any significant human intervention. A death from natural causes may be deemed 'unnatural' for the purposes of engaging the coroner's duty of investigation under s.1 of the 2009 Act where it is a *'wholly unexpected death from natural causes which would not have occurred but for some culpable human failure'.*[44] But this does not mean that the coroner or jury must conclude that the death was not from a naturally occurring cause, rather it is an indication that one might wish to return a brief narrative conclusion that sets out how a preventable death, albeit from a natural cause, was not prevented. A finding of 'natural causes' is not in any way a finding that there was no fault.[45]

Road traffic collision

59. The conclusion of 'road traffic collision' distinguishes those deaths that arise from collisions involving vehicles on a public road from other accidental events involving vehicles. The conclusion will be appropriate where the deceased suffered fatal injuries, whether as driver, passenger or pedestrian in a public highway. If the collision occurs on private land or involved railway stock, this conclusion would not be appropriate. Where the death arises from a road traffic collision, a conclusion of 'unlawful killing' would not generally be appropriate[46] unless the necessary elements required for gross

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[44] *R v Inner North London Coroner ex p Touche* [2001] QB 1206
[45] *R v HM Coroner for Birmingham and Solihull, exp Benton* [1997] 8 MEDLR 362.
[46] *R (Wilkinson) v HM Coroner for South Manchester* [2012]

negligence manslaughter are satisfied, or where a vehicle is used as a weapon of assault and deliberately driven at a person who dies.[47]

Stillbirth

60. Coroners do not have a statutory power to investigate a stillbirth as in the absence of independent life there has not, legally, been either a life nor a death to investigate.[48]

61. The definition of a 'stillbirth' is set out in s.41 of the Births and Deaths Registration Act 1953; *'A stillborn child is one that issued from its mother after the 24th week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life.'* However there is no formal definition as to what constitutes 'signs of life'. Phenomena that are generally accepted as being signs of life include (but are not limited to): breathing, crying, or sustained gasps; a heartbeat; a pulsing umbilical cord; or making definite movement of voluntary muscles. Coroners may be assisted by obtaining a medical opinion.

62. There may be situations where it is unclear whether a baby did show any signs of life outside the womb. In such cases the issue of whether this was a stillbirth must be resolved, either through preliminary inquiries conducted pursuant to s.1(7) of the 2009 Act or as a preliminary point at an inquest.[49]

63. Coroners should refer to Chief Coroner guidance No 45: Still birth and live birth following termination of pregnancy[50], which sets out how coroners should approach such cases, and the subsequent reporting requirements.

64. If the evidence at inquest reveals that a child was born alive then the conclusion should be formulated in the usual way.

[47] See para 3 Chief Coroner Law Sheet No. 1: Unlawful Killing.
[48] See: Attorney General's Reference (No.3 of 1994) [1998] A.C. 245. Although, the government have consulted on extending the role of coroners to enable investigations into stillbirth from 37 weeks' gestation. See 'Consultation on coronial investigation of stillbirths, Ministry of Justice', CP 16, 26 March 2019.
[49] *R (T) v HM Senior Coroner for West Yorkshire)* [2017] EWCA Civ 318
[50] Link: https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-45-stillbirth-and-live-birth-following-termination-of-pregnancy/

65. If, however, it is found that the death was a stillbirth, the coroner can record the relevant facts regarding how the still birth occurred neutrally in part 3 of the ROI[51] and use the short-form conclusion of 'stillbirth' in part 4. The coroner should also complete a 'Coroner's Certificate after Inquest (Still-Born Child)' form[52] to send to the registrar.

66. Article 2 considerations may not apply if a death is established as a stillbirth, as it is arguable that a foetus is not a 'person' with the 'right to life' for the purposes of Article 2. However, although the European Court of Human Rights has reviewed this question in *Vo v France*[53] it did not need to rule on whether the unborn child was a person for the purposes of Article 2 in that case as, on the question before it, the interests of the foetus and its mother overlapped.

Suicide

67. A coroner or jury may return a conclusion of suicide where, on the balance of probabilities:[54]
    a. the deceased died from a deliberate act initiated by themselves ('the act') and;
    b. the deceased intended that their actions would cause their death ('the intention').

68. Suicide must never be presumed,[55] and if not established on the evidence, the coroner should explain why.[56] A conclusion of suicide should not be avoided (or returned) simply to reflect the wishes of the family. 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.[57]

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[51] For example: *'Baby Smith was delivered at Barchester Hospital on 30 July 2023. She was stillborn due to the effects of a hypoxic brain injury sustained when her umbilical cord became tightly wrapped around her neck and was compressed. Her heartbeat had been detected 30 minutes before her birth'.*
[52] A copy of this form is annexed to Chief Coroner Guidance 45.

[53] *Vo v France - 53924/00 [2004] ECHR 326*
[54] *R (Maughan) v HM Senior Coroner for Oxfordshire* [2020] UKSC 46
[55] *R v City of London Coroner exp Barber* [1975] 1 WLR 1310; *Jenkins v HM Coroner for Bridgend and Glamorgan Valleys* [2012] EWHC 3175
[56] *R v Essex Coroner exp Hopper*, unreported 13 May 1988, cited in *Maughan* at §54
[57] 'The job of the judges is to apply the law, not to indulge their personal preferences': Lord Bingham in *The Rule of Law* (2010).

69. An accurate recording of a conclusion of suicide is important for statistical purposes, therefore where the two necessary elements for a suicide conclusion are met, coroners are encouraged to use the term suicide. The Office of National Statistics (ONS) will record a death as intentional self-harm (the official basis of suicide statistics) based on:

    a. a short form conclusion of 'suicide' or
    b. a narrative conclusion – provided the narrative contains a clear statement that the death arose from an act that was intentionally self-inflicted, even if not shown to be intended to cause death.

70. In absence of any clear statement of intentional self-harm (where for example, the terminology is unclear and ambiguous) the ONS will record the death as 'accidental'. It is vital therefore, that coroners use clear and unambiguous terminology when returning a narrative conclusion to ensure that suicide is not under-reported.[58]

71. It is not appropriate to use the phrase 'commit/committed suicide' on the ROI or indeed in the course of an inquest, as this terminology might suggest a criminal act. Similarly saying 'successful suicide attempt' may distress the bereaved. The words 'died by suicide' are generally more acceptable.[59]

Alternative conclusions after fatal self-harm

72. There may be occasions where there is little question that the deceased undertook the fatal act, but the coroner (or jury) is not satisfied that the deceased probably intended to die. In such cases, a coroner may consider:

    a. a narrative conclusion stating that the death was from a self-inflicted act but there was no suicidal intent, or that it is not possible to discern intent;
    b. an accidental death conclusion, but only if satisfied that the deceased probably did *not* intend to die; *or*

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[58] See Chief Coroners Newsletter dated 19th June 2017 for further discussion.

[59] see also the Equal Treatment Bench Book which provides important guidance on the language judges and coroners should use in court.

c. an open conclusion, where none of the above apply. But to assist ONS purposes in this situation part 3 of the ROI should set out succinctly what facts were found, where reasonable so to do.

Open conclusion

73. Where there is insufficient evidence to record one of the other short form conclusions, perhaps because the available evidence fails to meet the required level of confidence, an 'open conclusion' may be considered and recorded. This does not mean that the conclusion will be re-visited at a later date if further evidence becomes available – an 'open' conclusion is a final conclusion in its own right. The coroner (or jury) should consider returning an open conclusion only when no other conclusion is available or can be established on the balance of probabilities[60]. It is not a conclusion to be returned by a jury simply because they cannot reach agreement between themselves.

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

75. Returning a 'open' conclusion does not suggest in any way a failure on the part of the coroner (or jury) in being unable to reach a substantive conclusion. 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.

76. An 'open' conclusion is the only inquest finding that requires no level of confidence to be established: it is a finding made by the coroner (or jury) that there is insufficient cogent evidence to return any other conclusion. Paragraph 3 of the ROI must still be completed in relation to '*how'* the deceased died to explain so far as possible what did happen.

[60] This includes where the coroner (or jury) is unable to be reach any conclusion on the balance of probabilities between two competing conclusions: *Re Tabarn* [1998] EWHC Admin 8, at [50]

77. 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

78. Neglect (as opposed to self-neglect) has a restricted meaning according to the case law and should not be considered as a primary cause of death. A finding of neglect is not in itself a conclusion, but may form part of the conclusion in part 4 where a gross failure to provide basic care or attention has caused or contributed to the death.[61] Neglect is not to be confused with the civil tort of negligence (breach of duty of care) or gross negligence. Neglect has a narrower and limited meaning as defined in *Jamieson:*[62]

> (9) Neglect in this context means 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. Failure to provide medical attention for a dependent person whose position is such as to show that he obviously needs it may amount to neglect.

79. The term 'neglect' therefore reflects a gross absence of care-giving where care is obviously required. It is not to be confused with simply making the wrong judgment about what type of, or how much, care was required for the deceased. Hence in a health care setting neglect will usually not be an appropriate term to reflect errors made in complex and sophisticated medical procedures.[63] Making the wrong clinical decision about what treatment a patient needs may be negligence, but will not amount to neglect. However, leaving a patient in obvious need unattended for an extended period may well amount to neglect. In a prison context, 'only in the most extreme

[61] *R v West London Coroner, exp. Gray* [1988] QB 467.
[62] *R v HM Coroner for North Humberside and Scunthorpe, exp Jamieson* [1995] QB1.
[63] *R (Davies) v Birmingham Deputy Coroner* [2003] EWCA Civ 1739

circumstances (going beyond ordinary negligence) could neglect be found to have contributed to the cause of death'.[64]

80. There must be a clear and direct causal connection between the conduct described as neglectful and the cause of death. It is sufficient to establish that the conduct made only a material contribution to death, it need not be the sole cause (the threshold being that of a more than minimal, trivial or negligible contribution), but it is still necessary to establish that the purported material contribution probably occurred.[65] If the action or omission in question only 'possibly' made a more than minimal contribution to the death this will not be sufficient to establish neglect.

81. When considering omissions, if there was a missed opportunity to render care which *might* have made a difference or there was a 'real possibility' of averting death or saving life this will not be enough to establish neglect.[66] It must be established that had adequate care been given it would probably have saved or prolonged life.

Narrative Conclusion

82. A 'narrative conclusion' is simply a number of words that make up a brief factual statement of how the deceased came by their death. In the last decade, the use of narrative conclusions in coroners' courts has steadily increased. Narrative conclusions should generally be used where using only the one or two words of a short-form conclusion is insufficient to 'record as many of the facts concerning the death as the public interest requires'.[67] 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.

83. Whilst 'narrative' and 'short form' conclusions are often spoken of as if they are two different types of finding, adopting such a binary distinction is somewhat artificial. All conclusions simply consist of words, some situations allow for more succinct use of

[64] *R (Middleton) v HM Coroner for West Somerset* [2004] 2 AC 182
[65] *R (Khan) v HM Coroner for West Hertfordshire* [2002] EWHC 302 (Admin)
[66] *R (Khan) (op cit)* at §43
[67] *R v South London Coroner, exp Thompson* (1982) 126 SJ 625

phraseology so one of the conclusions suggested in the footnote on Form 2 will suffice, in other cases more words will be required.

84. A narrative conclusion may include within it the wording of the more traditional short form conclusions where appropriate.[68]

85. What the coroner or jury record as a narrative conclusion is a matter of discretion and can range from a short paragraph summarising the key factual points to a more detailed account of the circumstances. The narrative need not be lengthy: as stated in *Middleton* it is simply 'the jury's factual conclusions briefly summarised'. A few sentences or one or two short paragraphs will generally be sufficient.[69] A narrative will more often be required in an Article 2 inquest where the use of only one or two words could not meet the Convention requirement to express a conclusion on the circumstances and events leading to the death.

86. A narrative conclusion may be useful where the death arises from more than one cause.[70] In a non-Article 2 *Jamieson* inquest, the narrative conclusion should be a brief, neutral factual statement, which should not express any judgment or opinion.[71] The coroner (or jury) may include factual information that is necessary to explain the circumstances surrounding the death, even if those factors were non-causative of death.[72]

87. In an Article 2 inquest it would be unlawful to direct a jury so as to prevent them from entering a 'judgmental conclusion of a factual nature'.[73] A narrative conclusion may, if appropriate, be judgmental when addressing the central issues in the case relating to the circumstances of the death.[74] Permitted judgmental words include 'inadequate', 'inappropriate', 'insufficient', 'lacking', 'unsuitable', 'failure', 'because' and 'contributed to' are permissible.[75] An example was given in *Middleton*:

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[68] Note (ii) Form 2: Record of Inquest
[69] See paras 34 & 35 Chief Coroner Guidance No. 17: Conclusions: Short Form and Narrative.
[70] *R (Longfield Care Homes) v HM Coroner for Blackburn* [2004] EWCH 2467 (Admin) para 28 – 31.
[71] *R v HM Coroner for North Humberside and Scunthorpe, exp Jamieson* [1995] QB1.
[72] *R (Worthington) v HM Senior Coroner for Cumbria* [2018] EWHC 3386 (Admin)
[73] *R (Cash) v HM Coroner for Northamptonshire* [2007] EWHC 1354 (Admin) at para 49
[74] *R (Middleton) v HM Coroner for West Somerset* [2004] 2 AC 182
[75] See para 52 Chief Coroner Guidance No. 17: Conclusions: Short Form and Narrative

'The deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so.'[76]

88. Coroners should also not lose sight of the fact that one of the purposes of an Article 2 investigation is 'that suspicion of deliberate wrongdoing (if unjustified) is allayed'.[77] A finding that assuages such an unjustified suspicion may be needed to address a central issues in the case and need to be recorded as one part of the circumstances of the death, in accordance with s.5(2) of the 2009 Act.

89. Where the narrative conclusion includes a description of those matters which are usually covered in paragraph 3 of the ROI: i.e. 'how, when and where' the deceased came by their death, the coroner or jury may simply choose to write in part 3 of the form 'see part 4'.

Dealing with admitted failings

90. Where, in an Article 2 inquest, an IP or organisation has admitted a failing or shortcoming in dealing with the deceased, it *may* be necessary to record this even where that failing cannot be established on the evidence to have caused the death.

91. In *Tainton*[78] the Divisional Court held that the coroner had ruled correctly, after hearing all the evidence, that an admitted failure to refer the deceased for medical treatment sooner should not be left to the jury as arguably causing or contributing to his death. Even in an Article 2 inquest, there was no general duty to direct a jury to record admitted failings forming part of the circumstances in which the death occurred if those failings were not causative of death. Nevertheless, the Divisional Court went on to say that the admitted failings in the prison health care in this case, which were only possibly causative, should have been entered in part 3 of the ROI 'as forming part of the narrative', as such a statement 'would have completed the incomplete account of

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[76] *R(Middleton) v West Somerset Coroner* [2004] UKHL 10 §45
[77] See *R(Amin) v SoS Home Dept* [2003] UKHL 51, per Lord Bingham at §31
[78] *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin) see §73

the circumstances … which the Record of Inquest contains … and would have been a fair reflection of the issues that the inquest had focused upon.'

92. In essence, as the account of how the deceased came to die would be inadequate in the absence of those admitted and possibly causative failings being recorded, then Article 2 required that they should appear on the ROI.

93. However it was subsequently said in the case of *Smith*[79] that where a coroner sits alone and has included the non-causative shortcomings as part of their publicly announced findings of fact, Article 2 did not mandate that they must also appear in the ROI. When taken alongside the decision in *Worthington,*[80] the relevant point is perhaps not the fact of whether the shortcoming is admitted or not, but whether the ROI being silent on an important part of the factual matrix complies with Article 2 ECHR.

94. A coroner sitting with a jury in an Article 2 case involving admitted failings by a state body may therefore wish to consider the following questions:

    a. *Is there evidence that the admitted failings probably made a material contribution to the death?*
    If there is and it would it be safe (on a *Galbraith* basis[81]) for a jury so to find, the matter should be left to the jury to find and record in paragraph 4 of the ROI if they do.

    b. *If not, is there evidence that the admitted failings could possibly have made a material contribution to the death?*
    If there is, the coroner has a discretion, not a duty, to leave this issue to the jury. That discretion must be exercised judicially, with brief reasons given. If the account of the death would nevertheless appear be incomplete without a formal record made of an admitted failing, then the jury should be directed to record the admitted failing briefly in Part 3 of the ROI and add the explanation that it is not established that the failing probably contributed to the death, but it may have done so.

[79] *R (Carole Smith) HM Assistant Coroner for North West Wales* [2020] EWHC 781 (Admin)
[80] *R(Worthington) v HM Senior Coroner for Cumbria* [2018] EWHC 3386 (Admin), and see discussion at §16 above.
[81] See 'Applying the *Galbraith* test' below.

c. *Is it not even theoretically possible that the admitted failing made a material contribution to death?*

If so, there is no discretion to leave the matter to the jury to record. An inquest is concerned only with what caused or may have caused or contributed to death, otherwise the link between the investigation and Article 2 is severed.[82]

Submissions regarding conclusions

95. Rule 27 of the Inquest Rules prohibits a person from addressing the coroner (or jury) in relation to the facts as who the deceased was, where, when and how he/she came by his death. IPs are however entitled to make representations to the coroner on which conclusions should be considered (or left to the jury) as this is a matter of law not fact.

96. Rule 27 is then perhaps best understood not as a ban on mentioning facts at all in legal submissions, but rather a prohibition on seeking to persuade the coroner in the course of any submissions as to what facts the coroner should find when alternative factual scenarios are available.

97. In more complex cases, the coroner should invite submissions from IPs on the following and, after considering any submissions, give a ruling on these matters, with short reasons:

- the type of conclusion that is most appropriate, short-form or narrative;
- the available short-form conclusions the coroner or jury must consider;
- what written directions will be given to any jury (including in what order the jury should consider the conclusions);
- whether a list of issues should be provided to the jury to guide them on the key matters they should seek to cover in any narrative.

Applying the *Galbraith*[83] test

[82] *R (Allen) v HMC for Inner North London* [2009] EWCA Civ 623, per Dyson LJ giving the judgment of the Court at para 40.

[83] *R v Galbraith* [1981] 2 ALL ER 1060: [1981] 1 WLR 1039

98. When sitting alone (or with a jury) the coroner must make a judgement based on the evidence received as to the conclusion(s) that ought to be available for consideration. This requires applying the two limbs of the 'Galbraith Plus' test.[84] The test comprises two questions as set out in Law Sheet No. 2 at paras 4 and 5:

   a. firstly, is there evidence on which a properly directed jury could reach a particular conclusion?[85]
   b. the second question (or 'second limb' of the test) is: would it be safe on the evidence for the jury to reach this conclusion?[86]

99. The second limb of this test will operate where there is some evidence that could arguably support the finding in one direction, but the overwhelming weight of evidence pointing in the other direction means the finding could not be safe. A Divisional Court has recently made it clear that 'it is not open to a coroner, in a case which passes the classic *Galbraith* test of evidential sufficiency, to withdraw a conclusion under the guise of lack of "safety" just because they might not agree with a particular outcome, however strongly.'[87]

Naming individuals on a Record of Inquest

100. In many cases, the identity of an individual who has some responsibility for the death will be obvious and known. As a matter of law there is no prohibition on naming an individual other than the deceased as part of the conclusion on a ROI unless to do so appears to determine criminal liability (e.g. in cases of unlawful killing).[88]

101. Where there have been shortcomings in the care of the deceased an individual involved, or their employer, may be named on the ROI without infringing s.10 of the 2009 Act.[89] However, it is generally the custom and practice not to do so. An inquest is only required to record answers to the statutory questions. When recording *how* the

[84] *R (Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire.*
[85] The test for a criminal matter in the Crown Court would be whether there was evidence on which a jury properly directed could properly convict.
[86] Again, as a criminal matter in the Crown Court, the test would be whether it would be safe on the evidence for the jury to convict?
[87] *R(Police Officer B50) v HM Coroner for East Yorkshire and Kingston Upon Hull* [2023] EWHC 81 (Admin)
[88] Section 10(2)(a) of the 2009 Act.
[89] *My Care (UK) Ltd v HM Coroner for Coventry* [2009] EWHC 3630 (Admin) [2009] Inquest LR 285, at §5.

deceased came by their death, the identity of a party whose conduct may be impugned is not a question that an inquest is required to record on the face of the ROI.[90]

[90] See also *Coroner for Birmingham Inquests (1974) v Hambleton* [2018] EWCA Civ 2081