

Note: both bullet points in text and using (a) (b) where sub-sections of a statute are cited is intentional

## Documentary Inquests And Inquests In Writing

### KEY MATERIALS

#### Legislation:

[Coroners and Justice Act 2009](#) s.6 s.9C

[Coroners \(Inquest\) Rules 2013](#) r.23

#### Chief Coroner's Guidance:

No 45 [Stillbirth, and Live Birth Following Termination of Pregnancy](#)

### Introduction

1. Many cases which coroners have a duty to investigate are uncontentious ones where the cause and the circumstances of the death are fully explained in the witness statements and reports that have been collected during the investigation. Such cases can be dealt with on the documents alone, as there is no need for any witness to be called to give live evidence.

### Summary inquest procedures

2. An inquest based on documents alone may be conducted either privately under s.9C of the Coroners and Justice Act 2009 (the Act) as an 'inquest in writing' or under [rule 23](#) of the Coroners (Inquests) Rules 2013 (the Rules) as a 'documentary inquest' held in open court. In both cases the determinations and conclusions will be reached after considering only the available documents and without any need for oral evidence.
3. The main difference between these two summary procedures is that for a documentary inquest in court the relevant parts of the written evidence that form the basis of the coroner's findings will be read out in open court as will the coroner's factual findings, determinations and conclusion, whereas an inquest in writing will be conducted solely in writing without the need for a court hearing for the inquest. When conducting an inquest in

writing coroners will still need to open an inquest in the usual way, but no further court hearing will be required.

4. The use of a summary documentary procedure is recognised as a proper step which can often avoid the stressful attendance at an inquest for the bereaved.<sup>1</sup> It will require fewer court resources and avoid any unnecessary delay in completing the coronial process. A further valid consideration when deciding to conduct an inquest by means of these summary procedures is avoiding the inconvenience and emotional impact upon a witness of being required to give oral evidence when their written statement provides all the relevant and necessary evidence they can give, and their account is not in dispute.

#### **Pre-conditions for holding an inquest in writing**

5. Holding an inquest in writing will often be an effective and proportionate way to conduct an inquest in straightforward cases where the necessary evidence is available to ascertain the matters to be ascertained under [s.5](#) of the Act and the facts, determinations and conclusion are unlikely to be in dispute.
6. Section [9C\(2\)](#) of the Act specifies that an inquest in writing may only be held where the coroner decides that a public hearing is unnecessary, and a coroner is not to decide that such a hearing is unnecessary unless:
  - (a) the coroner has invited representations from each interested person (IP) known to the coroner;
  - (b) no IP has represented on reasonable grounds that a hearing should take place;
  - (c) it appears to the coroner that there is no real prospect of disagreement among the IPs as to the determinations or findings that the inquest could or should make, and;
  - (d) it appears to the coroner that no public interest would be served by holding a hearing.
7. This means that if an IP represents on reasonable grounds that a hearing should take place (for example because a particular piece of evidence needs testing, or there is a reason why

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<sup>1</sup> [Mueller v HM Area Coroner for Manchester West](#) [2017] EWHC 3000, [2017] Inquest LR 283, at §25

the content of a particular document should be read out in open court), or if the public interest requires a public hearing, the inquest should not be held in writing.

### **Pre-conditions for holding a documentary inquest**

8. Holding a documentary inquest in open court is likely to be appropriate when, after opening the inquest:
  - the evidence that has been obtained establishes the cause and circumstances of the death;
  - no IP disputes that evidence and the bereaved raise no concerns about the circumstances of the death or regarding any care provided to the deceased,
  - however, the coroner is nevertheless of the view that in the interests of justice (including consideration of the views of the bereaved and the public interest) a hearing in open court is appropriate.
9. [Rule 23](#) permits written evidence to be admitted at a documentary inquest if the coroner is satisfied that:
  - (a) it is not possible for the maker of the written evidence to give evidence at the inquest hearing at all, or within a reasonable time;
  - (b) there is a good and sufficient reason why the maker of the written evidence should not attend the inquest hearing;
  - (c) there is a good and sufficient reason to believe that the maker of the written evidence will not attend the inquest hearing; or
  - (d) the written evidence (including evidence in admission form) is unlikely to be disputed.
10. In some cases the bereaved will still choose to attend or they may request to observe the hearing on a remote video platform if that facility is available. Even where such inquests are not attended by anyone, they are public hearings and, just as any other type of inquest held in a courtroom, must be recorded to comply with [rule 26](#).

## **Cases suitable for documentary inquests and inquests in writing**

11. Examples of cases where inquests in writing or documentary inquests might be held include:

- industrial disease cases, where there is an in-life histological diagnosis and a clear work history of exposure to the likely cause of the disease;
- deaths following witnessed and unwitnessed falls, where no issue arises regarding the quality of care provided at the time of the fall or in respect of any subsequent hospital care;
- deaths from drug overdose, where there is no reason to suspect deliberate self-harm and no concern regarding the involvement of a third party, or the role of addiction services or other healthcare providers;
- self-inflicted deaths in the community where the events and intent are clear, and no actions of a third party (including any public body) give rise to concern;
- cases where the medical cause of death remains unascertained, but there is no reason to suspect an unnatural cause or a death in state detention;
- Inquests following a lawful termination of pregnancy under the Abortion Act 1967.<sup>2</sup>

## **Considerations before holding a documentary inquest or an inquest in writing**

12. Coroners should only hold a documentary inquest or an inquest in writing where they are satisfied that a sufficient inquiry into the evidence can and will take place. A hurried or insufficient inquiry in the face of family concerns may lead to the inquest being quashed.<sup>3</sup>
13. If there is likely to be an inquest in writing or a documentary inquest the coroner should ensure that there is effective communication with the bereaved and all other IPs giving them the opportunity to propose that live evidence is heard. In many cases suitable for an inquest in writing or a documentary inquest the only IPs will be the bereaved. However, where other persons or organisations are entitled to be an IP it should never be assumed

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<sup>2</sup> See also §20 below.

<sup>3</sup> [Rushbrooke v HM Coroner for West London](#) [2020] EWHC 1612 (Admin), [2020] Inquest LR 99.

that they will be neutral as to the nature of the hearing, so they too must be contacted and their views sought on adopting the proposed summary procedure.

14. In all cases proceeding as documentary inquests or inquests in writing it is important to ensure that the IPs have the opportunity, if they wish, to review all of the relevant documentary evidence before agreeing with the proposal for a summary procedure. Those communicating with IPs should not explicitly suggest or inadvertently imply to the bereaved, who may be feeling vulnerable and dealing with an unfamiliar situation, that they have no option but to accept these summary forms of inquest.
15. A contemporaneous record should be kept of communications between the coroner's office and IPs prior to the inquest. Where initial discussions take place orally it is important that what has been discussed between a coroner's officer and an IP is followed up with a communication in writing. This can ensure clarity and allow for any misunderstandings to be identified and corrected before the summary inquest is held.
16. The IPs should be notified that the coroner is considering holding an inquest on the documents, as there is clear evidence of who the deceased is, when and where he or she died and how the death came about, and there appears to be no real prospect of disagreement as to the determination, findings or conclusion that the inquest should make. IPs should be told that if they are not content for the inquest to be held in the way proposed, they should write to the coroner requesting a hearing (where an inquest in writing had been proposed) or that oral evidence is called (where a documentary inquest had been proposed) and explain why they believe this is needed. A suggested template letter to inform the IPs of the proposal for an inquest in writing and of the anticipated inquest findings is found (here) [link to Appendix 4.1 Letter to bereaved before IIW](#)
17. Although not required to do so, in most cases it will be appropriate for the coroner to make IPs aware of the determination, findings and conclusion they anticipate reaching at the inquest to check whether there is any disagreement with those findings. In so doing, coroners should make it clear that any views they express are provisional. In that way the bereaved are properly involved in the process and will fully understand the likely outcome.

## Single hearing inquests

18. There may be times where a coroner uses a fast-track procedure and an inquest is held and completed as a documentary inquest immediately after the inquest is opened. This process is sometimes known as a 'single hearing inquest'. Before this approach is adopted care should be taken to ensure that the bereaved and other IPs have been offered appropriate advance disclosure and are aware of and have agreed to this fast-track procedure. Open justice will still require the fact that a single hearing inquest is to be held to be made public.
19. One category of case where a single hearing inquest may be particularly appropriate is where the death follows a lawful termination. The Chief Coroner's Guidance No 45 [Stillbirth, and Live Birth Following Termination of Pregnancy](#) advises that lawful termination of pregnancy under the Abortion Act 1967 can trigger the coroner's duty to investigate under s.1 of the Act. Any child who is born alive after any length of pregnancy and whose death is caused by prematurity following a termination of pregnancy, will have died an unnatural death. There is then a statutory requirement that an investigation and inquest takes place, no matter how brief that child's life has been.
20. Such cases are likely to be both sensitive and highly emotive and coroners may feel it would be appropriate to conduct any resultant inquest as a documentary single hearing inquest under rule 23, to avoid the family going through the stress of a prolonged process or an in-person hearing. To achieve this, it may be helpful to have a standard witness statement template that is used by local hospitals when reporting such deaths to the coroner. That statement can then provide, from the very outset of the investigation, all the necessary information to be admitted under rule 23 at a single hearing inquest. See [appendix 4.2](#)
21. A narrative conclusion that might be returned where there has been a live birth following termination is: 'X died from extreme prematurity after being born alive following a termination of pregnancy under section 1 of the Abortion Act 1967'.

### **Disclosure in advance of a documentary inquest**

22. In all cases where an inquest is held only on the basis of relevant documents a bundle of the relevant documentary evidence should be prepared in the usual way and made available to any IP who wishes to be provided with a copy in advance of the inquest. Disclosure by means of an electronic bundle, with any redactions made clear, will usually be most efficient in such cases.

### **Conducting an inquest in writing**

23. Where an inquest is to be held in writing there will still be a need to comply with the [rule 5\(1\)](#) requirement to open an inquest in public as soon as reasonably practicable; it is only the subsequent inquest that can then be a paper exercise undertaken outside a courtroom.
24. It should be remembered that the bereaved may still wish for a pen portrait of their loved one to be included in the inquest evidence being considered by the coroner even though there is to be no hearing in open court.
25. There are no additional statutory requirements in relation to the format of the coroner's determination, findings and conclusion by virtue of the inquest being held in writing. Coroners should follow the same process in reaching their decision that they would when conducting any type of inquest.
26. After the written inquest has been conducted all the IPs should be informed in writing of the coroner's determination, findings and conclusion, and the bereaved should be told how to obtain a copy of the death certificate.
27. As the coroner does not have to be in court when conducting a written inquest there will be flexibility to work on these inquests efficiently around other duties. An example of a possible ruling in an inquest in writing is provided at [Appendix 4.3](#).

### **Open justice in inquests in writing**

28. When an inquest takes place in writing, the public and press lose the ability to attend to hear the evidence that would, in all other types of inquest, be read out in open court.

Coroners therefore need to take steps to ensure that inquests in writing comply with the fundamental principle of open justice.

29. The first requirement is to ensure that the public and press can identify when an inquest in writing is going to take place. Information about upcoming inquests in writing should be published online in the same way as for other types of inquest, although no place, date or time need be provided. The coroner's website might state: 'During the week commencing [*date*] the following inquests will be dealt with in writing (i.e. without a hearing in court) [*insert details*]'.
30. It is important for this information to be published before an inquest in writing is conducted<sup>4</sup> to enable members of the public and press to make representations about the format of the inquest, and/or request a copy of the ruling and Record of Inquest, if they wish to do so.
31. The second requirement is to ensure that coroners' decisions are sufficiently transparent. It is the Chief Coroner's view that coroners should usually accede to requests for both the ruling and Record of Inquest, as the Record of Inquest should normally be treated as a public document (see the discussion here: [[link to conclusions chapter](#)]), and the ruling contains information that attendees would have heard in court if the mode of hearing had instead been a documentary inquest in court. Coroners will need a strong justification for refusing to provide copies of the ruling to the public and press, given the otherwise secretive nature of an inquest in writing. This does not, however, apply to requests for any underlying documents, which should be dealt with under [reg.27](#) in the usual way.

### **Conducting a documentary inquest hearing**

32. At a documentary inquest held in court, [rule 23\(2\)](#) requires that before admitting documentary evidence the coroner must clearly announce at the inquest hearing that IPs are entitled to copies of the relevant documentary evidence upon request and that they can object to the admission of any of the said evidence. To ensure compliance with that rule

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<sup>4</sup> If possible, this should be at least 7 days before the inquest is conducted, although there is no specified time frame in law.



coroners should make sure that, in advance of the inquest, the bereaved, and where appropriate other IPs, have been provided with sufficient information and told of their right to object.

33. Statements of witnesses often include relevant and non-relevant matters and may refer to other documents. The coroner should indicate to the IPs which statements and documents are to be read or summarised at the public hearing, and which parts (if any) of those statements or documents are not to be read. The bereaved should be alerted to the contents of any statement or document that may cause them concern. Equally where a coroner does not intend to include part of a statement or document, but the bereaved wish it to be included, then, subject to relevance, the coroner should have regard to their wishes.
34. The coroner will introduce the documentary inquest hearing by stating that the IPs are aware the inquest is proceeding based on documents alone and that the requirements of rule 23 have been complied with in advance.
35. The coroner or their officer will then proceed to read the witness statements or summaries of the relevant evidence admitted under rule 23.
36. The formal findings of fact with brief reasons for the determinations and conclusion arrived at should then be stated by the coroner.
37. Family members will, on occasion, request a recording of the documentary inquest sometime after its conclusion. Coroners may therefore feel that it is appropriate to express their condolences to the family at the end of the inquest, even when the family is absent from court.

### **Final letters from the deceased**

38. In a case where there is potential for a suicide conclusion, notes of intent or final letters may have been left by the deceased. [Rule 23\(3\)](#) requires that these *must* be admitted in evidence if their content is deemed relevant to the purposes of the inquest by the coroner. It has been suggested that it is ‘unarguable’<sup>5</sup> that the content of a final note that was written

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<sup>5</sup> *Mueller* op cit. at §26

contemporaneously with someone taking their own life will be relevant to the purposes of the inquest if it reveals the deceased's intent. If it does so it will be mandatory that it is admitted as evidence at the hearing.

39. The impact of this rule is that those parts of a final letter that are relevant to intent must be read out in public during a documentary inquest. When considering what is relevant information within a final letter, coroners should be particularly mindful that the duty of the coroner is to determine how someone has died and not why, and so may conduct appropriate redaction of those parts of the letter or note that are irrelevant to their task.
40. Wherever possible the bereaved should be alerted to the need to reveal contents of any statement or document that may cause them distress or concern. Where a coroner is considering redaction of a final note the bereaved should be made aware which parts may be made public and, subject to relevance, the coroner should have regard to their wishes.<sup>6</sup>
41. Final notes or statements left by means of text, WhatsApp messages, voice or video communications are also covered by rule 23(3), which explicitly refers to 'any document made by a deceased person', as by virtue of [rule 2](#) the definition of 'document' is a wide one, encompassing 'any medium in which information of any description is recorded and stored.'

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<sup>6</sup> *Mueller* op cit. at §31

### Appendix 4.3 - Example of a ruling in an inquest in writing

[Insert Heading]

The Interest Persons are: [provide details]

[The Interest Persons are in agreement] OR [Having received no representations on reasonable grounds that a hearing should take place, I have decided] that the Inquest into the death of [deceased's name] can be concluded under s9C Coroners and Justice Act 2009.

[Deceased's name] was identified as confirmed by [insert details, e.g. an identity statement of [name] dated [date]].

I have had regard to: [insert details of evidence considered, e.g. a post mortem report of [name] dated [date], Statements of [names] etc].

I make the following findings of fact: [insert details].

Based upon those facts, I make the determination, findings and conclusion set out in the Record of Inquest attached.

[I would like to express condolences to [deceased's name]'s family.]

[Signed and dated]

Copied to the Interested Persons