Scope of the Inquest

KEY MATERIALS

Legislation

Coroners and Justice Act 2009

Chief Coroner's Law Sheet:

No. 5: The Discretion of the Coroner

Introduction

1. On commencing any investigation it is essential to identify the strands of the inquiry that are to be pursued. Whilst the boundaries of the investigation may alter as the evidence develops, it is the coroner's responsibility alone to determine the scope of their inquiry. The formality with which this needs to be done will vary with the complexity of the case, however the coroner and any attending interested persons (IPs) should always have arrived at some understanding of what the limits of the particular inquiry will be before embarking on examination of the evidence in an inquest.

The meaning of 'scope'

2. By 'scope' all that is generally meant is a list of the topics regarding which the coroner, in their discretion, will call relevant evidence to be able to answer the four key statutory questions. As the coroner's investigatory powers only arise from the statutory duties under the Coroners and Justice Act 2009 (the Act) the scope of every investigation must be defined with reference to ss.5(1) & (2) and the constraints set out in ss.5(3) & 10(2) of the Act.

3. Scope therefore refers to the ambit, boundaries, parameters and extent of the investigation and inquest. The scope of the investigation and inquest comprises those

lines of inquiry or topics which the coroner considers to be relevant to answering the questions: who died, how, when and where did they come by their death?

4. The Court of Appeal has described scope as representing:

> a coroner's view about what is necessary, desirable, and proportionate by way of investigation to enable the statutory functions to be discharged. These are not hard-edged questions. The decision on scope, just as a decision on which witnesses to call, and the breadth of evidence adduced, is for the coroner. A court exercising supervisory jurisdiction can interfere with such a decision only if it is infected with a public law failing. It has long been the case that a court exercising supervisory jurisdiction will be slow to disturb a decision of this sort … and will do so only on what is described in omnibus terms as *Wednesbury* terms.[1]

The extent of an inquest's scope

5. Given the widely differing factual scenarios which coroners encounter, the scope of the inquiry will be uniquely defined by the circumstances of each case. Not only will decisions on scope be fact-sensitive but the scope of the inquiry will often evolve as further facts are uncovered. In straightforward situations with non-contentious deaths, the scope of the inquiry is generally confined to investigating the medical cause and/or mechanism of death and the immediate events surrounding the death.

6. However, the Court of Appeal have emphasised that even in a *Jamieson*[2] inquest it would be wrong to approach the question of 'how' the deceased came by their death based on whether the death would have occurred *'but for'* a particular act or omission. Causation in inquests is a broader concept, which encompasses acts or omissions which contribute more than trivially to a death. In a case where the actions of a public body were said to have contributed to a deterioration in the deceased's mental health the Court held that examining the extent to which acts or omissions contributed to the deceased's mental health deterioration, which in turn led them to take their own life,

[1] *Coroner for the Birmingham Inquests v Hambleton* [2018] EWCA Civ 2801, [2018] Inquest LR 239.
[2] *R v North Humberside and Scunthorpe Coroner exp. Jamieson* [1995] QB 1

was part of determining the 'substantial truth' of how the deceased died.[3] There should however be some evidence of a connection between the potentially causative occurrence and the death, mere speculation would be insufficient to expand an inquest's scope.[4]

7. In more complex deaths, and particularly in cases where Article 2 ECHR investigative obligations are engaged, scope may involve detailed and extensive consideration of several disparate factors that may have contributed to the death, including the role of state agencies and state agents in causing or failing to prevent the death and the adequacy of systems that should be in place to protect life.

8. When considering the question of scope, coroners should keep in mind Sir Thomas Bingham MR's description of the nature and purposes of inquests in the *Jamieson* case:[5]

> It is the duty of the coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedure to be followed. His decisions, like those of any other judicial officer, must be respected unless and until they are varied or overruled.

The discretion as to scope

9. The discretion of the coroner in setting the scope of the inquest is wide,[6] but not unlimited. The discretion must be exercised judicially in accordance with public law principles such as fairness, rationality, proportionality, and necessity.

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[3] *Dove v Assistant Coroner for Teesside* [2023] EWCA Civ 289.
[4] *Bell v HM Senior Coroner for South Yorkshire* [2023] EWHC (Administrative Court) 21 March 2023, [2023] 3 WLUK 342,
[5] *R v North Humberside and Scunthorpe Coroner exp. Jamieson* [1995] QB 1
[6] per Lord Mance in *R v Secretary of State for Defence exp. Smith* [2010] UKSC 29 at [208]: '*Everyone agrees that coroners have a considerable discretion as to the scope of their inquiry, although the verdict that they may deliver differs according to the type of inquest being held [Jamieson or Middleton]*'.

10. The touchstone guiding the exercise of that discretion is the statutory duty pursuant to s.5 to investigate *how* the deceased came to die. The coroner must investigate factors that probably caused or contributed to the death and has a discretion to consider matters that have possibly contributed to the death. However, the discretion does not extend to investigating matters that did not make any contribution to the death. Coroners are therefore entitled to exclude from their inquiry any issues they consider to be so remote from the cause of death that they could not even arguably be said to have contributed.[7]

11. In more complex inquests, the coroner will have formed a provisional view of the issues that are likely to fall within scope when the inquest is opened. It is not unusual for scope to be wide during the initial investigation but the topics to be explored to refine or narrow during the inquest, not everything then investigated will necessarily be reflected within the final determinations. Indeed, a helpful analogy put forward in *Lewis*[8] was of the inquest process being visualised as a funnel: wide at its opening but narrowing as the evidence passes down it, so as to exclude non-causative factors from the eventual conclusion.

12. In many cases the scope of the inquest will extend beyond the answers required by s.10 of the Act. How far it extends is a matter of coronial discretion. As Simon Brown LJ said in *Dallaglio*:[9]

> The inquiry is almost bound to stretch wider than strictly required for the purposes of a verdict. How much wider is pre-eminently a matter for the coroner whose rulings upon the question will only exceptionally be susceptible to judicial review.

13. However, the Senior Courts have discouraged coroners from investigating broad matters of public policy, funding and resource allocation.[10] For example, in *Speck*,[11] the court held that it would be 'wrong in principle' to go into issues of policy and resources in respect of the decision whether to allocate NHS funding to provide a health-based 'place of safety' although there could still be an investigation of the decision to take the deceased to a police station instead of a hospital.

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[7] *R (Speck) v HM Coroner for the District of York* [2016] 4 WLR 15, [2016] Inquest LR 38
[8] *Lewis*: Op cit at §26
[9] *R v Inner West London Coroner exp. Dallaglio* [1994] 4 All ER
[10] *Scholes v SoS for Home Department* [2006] EWCA Civ 1343, [206] Inquest LR 1
[11] *R (Speck) v HM Coroner for York* [2016] EWHC 6, [2016] Inquest LR 38

Article 2 ECHR and scope

14. Section 5(2) of the Act provides that where Article 2 ECHR is engaged, the statutory question 'how' is extended to 'by what means and in what circumstances'.

15. In an Article 2 inquest the scope of the inquiry should reflect 'the central issue or issues' at the heart of the case (such as where and when the death took place; the cause or causes of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death: see *Middleton*[12] at §36).

16. Even where the Article 2 investigative obligation is engaged and s.5(2) of the Act applies, this does not trigger an obligation to investigate every single aspect of the case to the standards required by Article 2. The obligation imposed by s5(2) requires an investigation 'where necessary' to ensure compliance with the Convention. A coroner's ruling on the engagement of Article 2 obligations should identify the specific issues that have given rise to the need to conduct an enhanced Article 2 inquiry. That determination will provide a guide to the extent of the enhanced inquiry and the matters that fall within its scope.[13]

17. Because of the wide discretion afforded to coroners, even an inquest where Article 2 procedural obligations are not engaged may investigate the broader circumstances of the death if the touchstone of possible causation is met. This has led the Supreme Court to comment that there can be little difference between the investigatory breadth of the two types of inquest, although the conclusion that will be delivered may differ.[14]

Reports to prevent future deaths and scope

18. The coroner's primary focus will be upon identifying and formulating the answers to the four statutory questions, but coroners should also have regard to their duty under

[12] *R v HM Coroner for Western Somerset exp. Middleton* [2004] UKHL 10, [2004] Inquest LR 17
[13] *R(Gorani) v HM Assistant Coroner for Inner West London* [2022] EWHC 1680 (Admin)
[14] *R v Secretary of State for Defence exp. Smith* [2010] UKSC 29, [2010] Inquest LR 119, per Lord Mance at §208

paragraph 7, Schedule 5 of the Act, and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 (the Regs) to make a report to prevent future deaths (a PFD report).[15] Where Article 2 obligations arise the PFD report may be part of satisfying the Article 2 requirements.[16]

19. However, although the duty to make a report may be an important aspect of the outcome of an investigation, it is essentially ancillary to the primary purpose of an inquest which is to make the statutory determinations, findings and conclusions relating to the death.

20. The statutory obligation to make a PFD report arises where the evidence obtained during an investigation or inquest gives rise to a relevant concern. But there is no obligation to positively seek out evidence that might reveal such a concern. As such, coroners should be cautious of requests to widen an inquest's scope to obtain evidence that is unrelated to the particular death in question, just because it may provide a foundation for a PFD report. In *Dillon*[17] the Divisional court emphasised that, as PFD reports are ancillary to a coronial investigation, they do not concern the rights of any IP and no person has a right to be heard or to call any evidence that relates only to whether a PFD report should be made.

Determining the scope of the inquest

21. Before finally determining the scope of a complex inquiry, the coroner should invite representations from the IPs. Where a pre-inquest review hearing is held, giving advance notice to IPs of the coroner's provisional view of the inquest's scope will enable focused representations to be made. Where any dispute remains, a coroner's ruling on scope (whether *ex tempore* or in writing) should include reasons and enable IPs to understand why their submissions have or have not been accepted.

[15] See Chapter xxx of this Bench Book.
[16] *R (Lewis) v HM Coroner for the Mid and North Division of the County of Shropshire* [2009] EWCA Civ 1403, [2009] Inquest LR 294.
[17] *R(Dillon) v HMAC Rutland and N. Leicestershire* [2022] EWHC 3186 (Admin) at §43

22. One example of a reasoned ruling on scope is that of His Honour Peter Thornton QC in the Birmingham Bombing 1974 Inquests here.[18]

23. There are occasions during inquests when answers to questions of witnesses give rise to a further potential line of inquiry that had not previously been anticipated. This may require a reconsideration of the investigatory scope during an inquest hearing. It is a matter for the coroner as to whether pursuing that line of inquiry is necessary in order to satisfy the s.5 statutory duty. Before redefining scope, the coroner should invite representations from the IPs and provide reasons for the determination of whether the new line of inquiry falls within their inquiry's scope.

Recording the inquest's scope

24. In a straightforward or non-contentious inquest it is helpful and invariably sufficient for the coroner to set out the ambit of the inquiry orally in the introductory comments at the outset of the inquest hearing.

25. In inquests with multiple IPs or substantial Article 2 cases, it is good practice for the coroner to formally record the scope of the inquiry in a document that is made available to all participants well in advance of the inquest commencing. This allows for easy reference of the coroner and all IPs to the scope document should an issue of relevance arise during the hearing. An example is given in appendix 7.1.

26. It is sometimes helpful to also explicitly record matters that fall outside the scope of inquest to provide clarity for all IPs. For example stating on the scope document: 'The inquest will not be addressing: (i) post-incident procedures (ii) family and victim support after the incident.'

27. In high profile cases the media may ask to be provided with the document setting out the inquest's scope. The principles of open justice would usually support acceding to that request.

[18] This is the ruling that was unsuccessfully challenged in *Coroner for the Birmingham Inquests v Hambleton* [2018] EWCA Civ 2801, [2018] Inquest LR 239, and of which the Court of Appeal stated" 'In our judgment the coroner's statement of "the meaning of scope", in paragraphs [18] and following of his ruling was correct.'

Questioning on issues that are outside of scope

28. Irrespective of the adequacy of the coroner's explanation of the purpose and scope of the inquest, coroners frequently encounter the situation in which an IP (particularly when unrepresented) wishes to pursue a line of questioning which falls outside scope. In those circumstances the coroner should normally invite the IP to explain why they consider the question to be relevant with reference to the scope document.

29. Strict application of r.19(2) would *require* a coroner to disallow any question put to a witness which the coroner considers irrelevant. Coroners should approach these situations using pragmatism and common sense as there may be circumstances when the coroner takes the view that a question, which in strict terms may not fall within scope, should be allowed. For instance, it may serve another purpose such as helping the bereaved understand something that is important to them. In the event that the coroner decides that a particular line of questioning should not be allowed, the rationale for this should be explained and it will often be helpful to make reference to the inquest's scope when giving the reasons.