CHIEF CORONER

GUIDANCE No.9

OPENING INQUESTS

Introduction[1]

1. This Guidance is intended to assist coroners on the new procedures for opening inquests under the Coroners and Justice Act 2009, the Coroners (Inquests) Rules 2013 and the Coroners (Investigations) Regulations 2013.

2. There has been considerable variation in practice between coroners across England and Wales in the opening of inquests.[2] The new procedures and this guidance are designed for greater openness and accessibility and with a view to providing more consistent practice.

3. Coroners have a duty to make these new procedures work and to create working arrangements in each coroner area in order to make them work.

Greater flexibility

4. Under the 2009 Act regime there is a greater flexibility for coroners. In the three stage process - (1) preliminary inquiries, no investigation, (2) investigation, no inquest, or (3) investigation, plus inquest[3] - coroners will be able more readily to come to a natural causes conclusion without the need for an inquest. There should therefore be a reduced number of inquests and a reduced number of openings.

5. Where a death is reported to the coroner, the coroner need not commence inquest proceedings in two situations. -

   (1) Where the coroner makes preliminary inquiries under section 1(7) of the 2009 Act, including (where necessary) a request for a post-mortem examination under section 14(1)(b), and concludes that he/she has no duty to investigate under section 1(1), there will be no inquest because there will be no investigation. There cannot be an inquest without an investigation: section 6.

   (2) Where the coroner decides to conduct an investigation into the death, the coroner may discontinue the investigation under the provisions of section 4 where applicable.

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[1] As always I am very grateful for the input of many coroners into this Guidance.
[2] See *Dorries* 2nd Edn., paragraph 7-16.
[3] See Annex A of *The Chief Coroner's Guide to the Coroners and Justice Act 2009.*

6. The statutory regime has another advantage. Coroners are allowed to release the body for burial or cremation, where appropriate (including clear identification), **without** having to open an inquest: regulation 21. This means that one significant aspect of opening an inquest, namely to allow for burial or cremation, is dispensed with. In turn this will usually mean that opening the inquest will be less urgent.

THE FORMAL REQUIREMENTS

(1) Timing of the opening

7. When a coroner is under a duty to conduct an investigation into a death (under section 1 of the 2009 Act), the coroner must, as part of the investigation, hold an inquest into the death: section 6, Coroners and Justice Act 2009. There will, however, be no inquest if the investigation is discontinued: section 4.

8. The coroner must open that inquest as soon as reasonably practicable after the date on which the coroner considers that the duty to hold an inquest applies: rule 5(1), Coroners (Inquests) Rules 2013.

(2) Notification of the opening

9. The family of the deceased should be notified of the time, date and place of the opening in all cases. Although there is no rule to this effect it is good practice and follows on from the duty to inform the deceased's next of kin or personal representative of the coroner's decision to begin an investigation: regulation 6, Coroners (Investigations) Regulations 2013.

10. It may also be good practice, where practicable, to notify others who appear at that stage to be likely to have an interest in the proceedings.

(3) Opening in public

11. The coroner must open an inquest in public: rule 11(1)[4]. Although the public, including the press, may not often attend, the hearing is a public hearing, constituting the formal commencement of the court proceedings, so the public are entitled to attend if they wish to.

12. In public means not just open to the public but arranged in such a way that a member of the public can drop in to see how an opening is conducted[5]. A coroner's office is never likely to pass this test. Subject to the following paragraph, a coroner who sits in private sits without jurisdiction, with the proceedings liable to be quashed[6].

13. If there would be unavoidable delay in applying rule 11(1), for example in some jurisdictions where no court or room used as a court is readily available, the coroner may open the inquest in private, so long as the coroner announces that the inquest was opened (and where and when) at the next inquest hearing held in public: rule 11(2).

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[4] There is nothing new about this provision: see *Jervis* 12th Edn. at paragraph 10-01.
[5] *Storer v British Gas plc* [2000] 1 WLR 1237 (CA).
[6] *Ibid.*; *McPherson v McPherson* [1936] AC 177.

14. However, coroners should not fall back on rule 11(2) as an easy excuse for not opening in public. Where court logistics are difficult, they should encourage the local authority to be more helpful in providing a court space. And in any event there should be less need for this procedure now that the body can be released without opening an inquest. It goes without saying that the principle of open justice is a long-standing and important tenet of constitutional law.

15. Coroners should also be reminded that an opening is a formal hearing and should be conducted appropriately.

(4) Recording of opening

16. The opening of an inquest should be recorded and the recording kept. Strictly speaking, an opening does not appear to be an 'inquest hearing' within the meaning of the rules, so that the requirement to record an inquest hearing and keep it under rule 26 may not apply. But an opening is a hearing, a public hearing, and good practice requires the hearing to be recorded, wherever the opening takes place. The recording will stand as an accurate record of what evidence was given and what precisely was said.

17. This also applies to openings which are opened in private; they are still hearings and should be recorded.

18. Recordings should be made by a court recording device - see Chief Coroner's *Guidance No.4: Recordings*.

(5) Identification and other evidence

19. The coroner will receive evidence of identification of the deceased, either oral evidence on oath or in written form complying with rule 23. Identification is an important first stage towards the inquest 'determination' as to who the deceased was: sections 5(1)(a), 10(1)(a). Identification will include as a minimum, where known, the name, age and address of the deceased.

20. In most cases there will be no need for the family to attend to give evidence of identification.

21. Identification evidence taken at the opening need not be repeated at the final hearing (although it can be referred to).

22. The coroner may also hear brief evidence of the general circumstances of the death, the finding of the body, whether a post-mortem examination has taken place and the provisional medical cause of death (if known). But care should be taken not to give the impression at an opening or pre-inquest review (PIR) hearing that a final conclusion has been reached on any issue[7]. The final hearing should not be prejudiced by any unnecessary or unwise comment at any prior hearing.

23. The evidence is best given orally on oath by a coroner's officer but may also be taken in formal written statement form.

[7] *R (Coker) v HM Coroner for Inner South District of Greater London* [2006] EWHC 614 (Admin), [11].

24. Where there is a police investigation, brief evidence (oral or in writing, as above) may be received from a police officer about its progress.

25. After hearing evidence the coroner will give directions including, where possible, a date for the next hearing (rule 5(2)), either a PIR hearing or the final inquest hearing: see below.

(6) Setting date for inquest

26. At the opening hearing the coroner must, where possible, either set the date for the inquest or for a PIR hearing: rule 5(2).[8]

27. The date for the inquest must normally be set within six months of the date on which the coroner is made aware of the death. This is because the coroner has a duty where possible to complete the inquest within six months: rule 8.

28. Where it will not be possible to set the date within six months for some good reason, such as delay likely to be caused by police or Health and Safety Executive or Prisons and Probation Ombudsman investigation, there is still a duty on the coroner to complete the inquest as soon as is reasonably practicable after the date of notification of the death: rule 8.

29. If there is likely to be such a delay, the coroner should fix a date within a reasonable time for a PIR hearing (see rule 6). In a complex or difficult case there may be more than one PIR hearing before the inquest.

30. Whenever a coroner sets a date for a PIR hearing, the coroner should state what it is intended should be achieved at that hearing, if necessary by giving directions which should be confirmed subsequently in writing. It may be necessary to draft an agenda for a PIR hearing or invite written submissions from interested persons in advance of the hearing. Or it may only be necessary to state that the review hearing will try and fix a date for the inquest or report on progress of any other relevant investigation. See Chief Coroner's Guidance No.22 *Pre-Inquest Review Hearings.*

31. In any event coroners are reminded of the duty in all cases to complete the inquest as soon as is reasonably practicable (rule 8) and that unnecessary delay may cause additional anguish and distress.

32. The importance of setting dates of hearings cannot be over-emphasised. More complaints are made by families about the failure to set dates than any other topic. Uncertainty causes distress. Not setting a date frequently causes unnecessary delay.

33. In Article 2 cases there is 'a requirement of promptness and reasonable expedition' in the investigation.[9]

34. Coroners are also reminded that they must notify the Chief Coroner of any investigation (and inquest) not completed within 12 months of the date of being made aware of the body within the coroner's area: section 16 and regulation 26,

[8] As long ago as 1865 it was doubted whether a coroner had the power to adjourn without fixing a date: *R v Margate Coroner* (1865) 11 LT 707 *per* Blackburn J (see Halsbury's Laws 4th Edn., paragraph 999).
[9] *Jordan v UK* (2001) 37 EHRR 913, [108].

although this only applies to deaths reported after 25 July 2013. If a need to report an inquest which has not been concluded arises, the Chief Coroner will want to know as a minimum:

(a) the factual dates of the case
(b) the nature of the investigation
(c) the reason for the delay, and
(d) the likely date of completion.

(7) Further directions

35. In addition to fixing a date the coroner should give directions, when feasible, including a timetable for the provision of reports and statements, particularly those of a medical nature. In the normal course of events, with the duty to hear and complete inquests within six months, the coroner should direct that specific reports and statements should be provided within three weeks (except where further reports from toxicologists etc are required).

36. The coroner's court is a court of record and the coroner is entitled to give reasonable directions for the good and fair management of the proceedings. This applies to openings and PIR hearings. This aspect of the coroner's duty to investigate is particularly important in an inquisitorial process where the ultimate aim is to make objective determinations and findings in the public interest.

37. In this context, at openings, coroners should not normally use the power to require evidence to be produced under Schedule 5 of the 2009 Act. Schedule 5 should not in any event be used too freely. It is something to be used when other methods of request have failed, bearing in mind that the notice to produce under Schedule 5 must include the possible penal consequences for non-compliance (see Schedule 6). Summonses, the equivalent in civil and criminal courts, are not used routinely. As is stated in the Chief Coroner's Guide to the 2009 Act:

> Coroners should not be too hasty to exercise these powers. They should only be used where necessary and where other methods have failed. Much can be achieved by agreement with, for example, local hospitals, on regular procedures for the production of witness statements, medical notes and reports.[10]

38. It is better for the senior coroner to discuss the provision of statements, reports and notes with pathologists, local hospitals and GPs, for example, so that there is a good understanding of what is required by the coroner (and expected by the Chief Coroner).

39. Schedule 5 might, however, be used when a direction given (above) is ignored or frequently ignored. The procedure for obtaining a witness summons from the High Court or county court for the production of documents still exists but may be unnecessary in the light of Schedule 5.

(8) Notifying the public

40. The coroner must make the details of all final inquest hearings publicly available in advance: rule 9(3). Those details must include the date, time and place of the inquest: rule 9(3).

[10] Paragraph 133.

41. The coroner must publish, preferably on a website (part of the local authority website or, better still, a separate website), and where possible at least seven days in advance of the hearing: the date, time and place of the inquest (rule 9(3)); the name of the coroner (where known); if jury inquest; the name and age of the deceased, and the date and place of death (hospital or town). It is not appropriate for the notice to include the medical cause of death, brief circumstances of the death or the likely conclusion of the inquest.

42. Where possible the same practice should apply to each opening (but not if it will cause delay) and PIR hearings. If the hearing is in public and the public (including the press) have a right to attend, that right is of no value unless notice of the hearing is made publicly available in advance.

43. Where coroners have no access to a website in order to publicise cases, they should at the very least post a notice of forthcoming cases outside the court on a regular basis. Where possible, this should include openings and PIR hearings. Some coroners also make it known publicly that they will open inquests at a certain venue on fixed days during the week at fixed times.

44. Some coroners also use the good practice of using an email list of local hospitals, police, press, funeral directors etc who are regularly updated with forthcoming cases.

Effect of opening

45. Proceedings become 'active' for contempt of court purposes: see paragraph 12 of Schedule 1, Contempt of Court Act 1981.

46. At the close of the opening hearing, the case is adjourned to the stated date.

47. Once opened, an inquest must be concluded.

HH JUDGE PETER THORNTON QC
CHIEF CORONER

23 October 2013
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ANNEX

SUMMARY OF OPENING PROCEDURES: GOOD PRACTICE

1. Where duty to investigate, inquest must be opened and later held (unless investigation discontinued).

2. Notify the family in advance of the opening hearing.

3. Notify others, where possible.

4. Open the inquest as soon as possible.

5. Open in public (unless the exception applies).

6. Record the opening hearing.

7. Receive evidence including identification.

8. Set date for inquest (or review hearing).

9. Give directions on timetable for reports etc.

10. Publish notice of all hearings, including openings (where possible).