INQUEST
TRUTH, JUSTICE AND ACCOUNTABILITY

'A fantastic source of information, answering even the questions you didn't know to ask.'
Family member

THE INQUEST HANDBOOK: A GUIDE FOR BEREAVED FAMILIES, FRIENDS AND ADVISORS

INQUEST

WORKING FOR TRUTH, JUSTICE AND ACCOUNTABILITY

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At INQUEST we work hard to make all our written information as easy to read and understand as possible. This handbook does have legal terms and technical information that might be difficult to take in. If you are having any problems understanding information in the handbook, then please contact one of our caseworkers who can explain things more clearly; or speak to one of the other organisations listed in Section 8 who will also be able to help.

www.inquest.org.uk

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INQUEST is grateful to the Law Society, The Big Lottery Fund and to the family of Bobby and Christi Shepherd for the generous donation made in their memory that has assisted us in producing this guide.

The information was correct at time of printing in June 2016. The latest version of this guide will always be available to download from the INQUEST website.

Contents

How can this guide help you?

If someone you know has died, or you are helping someone you know deal with a death where an inquest is to be held, this guide will give you information about the inquest procedure and what will happen in the next few months. It is not intended to replace specialist advice from lawyers or the other organisations listed in Section 8, but to be in addition to that advice. This guide can help anyone who has to attend an inquest or is involved in counselling or advising people in that situation.

Preparing for an inquest can be a traumatic and bewildering experience in addition to the shock and distress caused by the death. Many people feel that the legal process and the procedures involved in trying to discover the truth about the circumstances of a death are the last thing they can cope with after the death of someone close. People may have regrets later if they did not get help or advice before the inquest.

This guide is intended to provide some help towards guiding bereaved people through the legal and emotional difficulties that can follow a sudden, violent or unnatural death. It is written in informal language in a question and answer format to make it easier to understand. It is not intended to be a complete guide to every aspect of the inquest procedure, but is written on the basis of more than three decades of experience of advising and supporting bereaved people. In particular circumstances suggestions will be made to seek advice and help from specific organisations that specialise in areas in which INQUEST has only limited experience. A list of further reading is included at the back of the guide in Section 8.

What is the inquest system?

The inquest system is not there to establish who was responsible for a death. Its purpose, put simply, is to answer four questions on behalf of the state:

- Who someone was.
- Where they died.
- When they died.
- How they came to their death.

It is important to understand the limitations of the inquest process from the start. Being clear about this can help you set realistic targets about what might be achieved at the inquest, and may help to reduce the subsequent frustration that is often felt by people.

The relevant law is the Coroners and Justice Act 2009, the Coroners (Inquests) Rules 2013 and the Coroners (Investigations) Regulations 2013. A small part of the Coroners Act 1988 remains in force, but will only apply in very limited circumstances.

I feel so relieved knowing someone is helping me. I could not do this on my own.

Charmaine Morris, mother of John York who died in prison

About INQUEST

What does INQUEST do?

INQUEST has provided free, confidential, specialist advice for over 35 years on deaths in custody or detention in England and Wales to the bereaved, community and voluntary groups and members of the INQUEST Lawyers Group. This includes deaths in prison, police custody or following police contact, immigration detention or mental health settings. It also works on other cases that involve multi-agency failings and/or raise wider issues of state and corporate accountability.

INQUEST's extensive case experience and associated policy work means it can provide helpful background – for example information about other deaths in similar circumstances, relevant policies and practices on the care of those detained and inquest conclusions. INQUEST has a unique overview of the investigation and inquest system and its treatment of bereaved people.

Influencing policy

INQUEST ensures that the collective experiences of bereaved families and the issues arising from deaths help to inform policy and parliamentary work to improve:

- The treatment of bereaved people.
- The investigation and inquest system.
- The way organisations implement change after inquests in order to prevent further deaths.
- State and corporate accountability.

Achievements

- Helping to shape reform of the inquest system through the Coroners and Justice Act 2009.
- Influencing the setting up of the Ministerial Council on Deaths in Custody.
- Influencing the establishment of the Harris Review into the deaths of 18-24-year-olds in prison.
- Working towards more independent investigations into deaths in mental health settings.
- Ensuring there are independent investigations into deaths in prison and involving the police.
- Creating greater political and public awareness of the needs of bereaved people facing all inquests.

You have clearly made yourselves a force to be reckoned with, a powerful instrument for good. In the process you have not only achieved real change in an aspect of our common life which would have commanded little attention or esteem were it not for your efforts, but you have at the same time offered enormous support to those bereaved people who long for a clear verdict on the death in custody of someone who means a great deal to them.

Dr Peter Selby, former President of the National Council for Independent Monitoring Boards

NOTES

SECTION 1: What happens after a sudden death and what is an inquest?

SECTION 1.1

What happens after a sudden death?

According to the Coroners and Justice Act 2009, where a person has died and their body is within a coroner's area, if the coroner suspects that the death was violent or unnatural, where the cause of death is unknown, or where the person died in custody or otherwise in state detention, the coroner has a duty to investigate the death.

The Chief Coroner (see below: ***What is a coroner?***) can also tell a coroner to hold an investigation into a death where a person is believed to have died in or near a coroner's area, but where the duty to conduct an investigation described above does not arise because the person's body is not in that area. For this to happen, the coroner must have reported the matter to the Chief Coroner.

A coroner may need to make enquiries to find out if there is a duty to investigate or whether the death is one where the Chief Coroner has the power to tell a coroner to hold an investigation.

In certain situations, a coroner's investigation into a death will lead to an inquest (see below: ***What is an inquest?***)

Are the procedures the same in all cases?

No. There are different investigations carried out and different legal avenues to pursue depending on the circumstances of the death. In Section 5 of the guide there are details on specific procedures following deaths in prison, in police custody or following police contact, in mental health settings, at work, or where medical care is involved. This will help you through the processes and also guide you to where you may be able to obtain more help. The guide also provides information about where to go for help in other circumstances. But the information in the guide will help anyone who has to attend an inquest in any circumstances.

Should I see a solicitor?

If you are worried about the circumstances of the death then you should consider seeking advice from a specialist solicitor as soon as possible (see Section 3).

The handbook is incredibly informative and helpful. I feel much more empowered now having spoken to you.

Mark Minkler, father of Czeslaw Minkler who died in a private care home under a DoLS

SECTION 1.2

What is an inquest?

An inquest is an investigation held in public to establish who the person was and where, when and how they died. It is a legal procedure presided over by a coroner in the public interest:

- To find out the medical cause of death.
- To draw attention to the existence of circumstances which, if nothing is done, might lead to further deaths.
- To advance medical knowledge.
- To preserve the legal interests of the deceased person's family or other interested parties.

What is a coroner?

The Chief Coroner is the national head of the coroner system in England and Wales. The Chief Coroner is appointed by the Lord Chief Justice in consultation with the Lord Chancellor.

The Chief Coroner is responsible for providing leadership, support and guidance to coroners, setting national standards including inquest rules, putting in place training and approving the appointment of coroners.

The Chief Coroner monitors investigations into the deaths of service personnel and recommendations made by coroners to prevent future deaths (see below: ***Can the coroner make recommendations to prevent a further death occurring in similar circumstances?***).

The Chief Coroner also keeps a register of all coroners' investigations lasting more than 12 months and has responsibility for taking steps to reduce unnecessary delay.

A senior coroner will be appointed by the local authority in which their court lies. The senior coroner is in charge of their coroner area. Working with the senior coroner for an area are full-time area coroners and part-time assistant coroners. Area coroners and assistant coroners are also appointed by the local authority.

All coroners are judicial office holders. Before the Coroners and Justice Act 2009, it was possible for qualified and experienced medical professionals, as well as legal professionals, to become coroners. Now, all newly appointed coroners must be qualified lawyers, meaning that they will be a solicitor, barrister or legal executive by profession, with at least five years' experience.

What is a coroner's officer?

Coroner's officers are the staff in the coroners' courts that bereaved families will have most contact with before the inquest. The role of coroner's officer is often filled by either a retired police officer or a serving one on secondment from a local police force. Coroner's officers who are not serving police officers are employed by the local authority.

When do inquests happen and who has the power to decide?

The Coroners and Justice Act 2009 sets out the duties of a coroner and in what circumstances he or she must hold an inquest and in what circumstances he or she has the choice to do so.

This can be summarised as:

- Where there is reasonable suspicion that the death was violent or unnatural.
- Where the cause of death is unknown.
- Where the person died in custody or otherwise in state detention.
- Where the Chief Coroner directs that there should be an investigation.

When will a doctor refer a death to a coroner?

A doctor must refer the death to the coroner:

- If a doctor is not able to issue a medical certificate as to the cause of death when called to see someone who has died; for example, because they are uncertain about the cause of death.
- If the death occurred during an operation or before recovery from the effects of an anaesthetic.
- If the cause of death is violent or unnatural.

Who else may report a death to a coroner?

- The police.
- A registrar of deaths, for instance if the cause of death appears to be due to industrial disease or poisoning.
- A member of the public.

If a death is reported to the coroner, is an investigation always held?

No. After initial examination of the evidence and any necessary enquiries being carried out, a coroner may decide that there is no duty to conduct an investigation into the death and that the case is not one that they think should be reported to the Chief Coroner. He or she will send details to the registrar confirming that the death is natural.

Why must an inquest be held?

Because the cause of death is uncertain or the death is considered "violent" or "unnatural".

There are a number of circumstances where it would be expected that an inquest would be held, including:

- No death certificate was issued because a doctor was not present at or before the death.
- No medical attention was given for an illness which occurred just before the death.
- No medical examination was made by the doctor issuing the death certificate during a period of 14 days before the death.
- Death during or immediately after an operation, or following administration of an anaesthetic.
- No known cause of death.
- Reasonable cause to suspect that a death was unnatural, due to violence, neglect, abortion or in suspicious circumstances.
- Death due to industrial disease or poisoning.
- Death occurred in prison; in police custody or following police contact; or during detention in a psychiatric hospital.

The vast majority of deaths are not referred to the coroner for an inquest. Of the average half-million registered deaths in any given year, about 230,000 are reported to coroners. There are inquests held into around 31,000, or about 13%, of such deaths each year, according to figures published in May 2014.[1]

What is an unnatural death?

One that was due to actions or omissions that led to a clear event which ultimately led to the person's death.

[1] Ministry of Justice Statistics bulletin *Coroners Statistics 2013 England and Wales* (www.gov.uk/government/uploads/system/uploads/attachment_data/file/311465/coroners-bulletin-2013.pdf).

Who has the right to ask questions at an inquest?

Interested persons, as set out in section 47 of the Coroners and Justice Act 2009. See Sections 3 and 8 of this guide on legal advice and definitions for explanations of who is an interested person.

If an operation is likely to have led to a person's death, is an inquest necessary?

Not if the cause of death is natural, e.g. if the death of an older person was due to a stroke or if the chance of a surgical operation's success was very low. However, it is often an area of dispute and you should seek legal advice if you do not accept the coroner's decision not to hold an inquest (see Section 3 on legal advice, and also the part of Section 5 on deaths following medical treatment).

If you think an inquest should be held, what should you do?

Representatives of the family should make their views or concerns known to the coroner as soon as possible after the death. They can contact the coroner's court by post, by ringing the court and talking to the coroner's officer, or in some cases by email. It is also a good idea to put any concerns you have to the coroner in writing. You should also consider getting legal advice as soon as possible.

Will there be a jury?

Not in the vast majority of inquests, but in certain cases the law says that the inquest must be held in front of a jury.

When the state has had care of the individual prior to their death, such as in prison or in police custody, the inquest is required to meet particular standards under article 2 of the European Convention on Human Rights, which sets legal standards to protect the right to life. These are referred to as article 2 inquests and will often be held in front of a jury (see below).

Section 7 of the Coroners and Justice Act 2009 says that an inquest must be held without a jury unless the coroner suspects that:

- The deceased died in custody or otherwise in state detention, and the death was violent or unnatural, or the cause of death is unknown.
- The death resulted from the action or omission of a police officer or a member of a service police force in the purported execution of their duty.
- The death was caused by a notifiable accident, poisoning or disease.

A coroner can also hold an inquest with a jury if he or she thinks that there is sufficient reason for holding an inquest with one.

Only a minority of the inquests held each year have a jury. For example, of 29,942 inquests opened in 2013, only 456 were held with a jury.[2]

[2] Ministry of Justice Statistics bulletin *Coroners Statistics 2013 England and Wales* (www.gov.uk/government/uploads/system/uploads/attachment_data/file/311465/coroners-bulletin-2013.pdf).

What is an article 2 inquest?

Article 2 of the European Convention on Human Rights, often referred to as the right to life, says that the state must not take someone's life except in very limited circumstances, and it imposes a duty on the state to protect life.

In some circumstances, article 2 means that the state has a duty to carry out an effective investigation into a death that involves the family of the deceased. The inquest is normally the way in which the state carries this out and inquests held in these circumstances are now referred to as article 2 inquests. This might mean that the article 2 inquest has to be more thorough than otherwise would be the case.

However, more recently the courts have said that even a normal, non-article 2 inquest must be as thorough as an article 2 inquest. It appears that the main difference will be the examination of "systemic failures" and the conclusions available, because at an article 2 inquest there is more scope for the coroner or jury to leave critical conclusions about what happened (see below: ***Conclusions***).

Examples of article 2 inquests include where state agents (such as police officers or nurses in psychiatric hospitals) or procedures were arguably at fault for the death, or whenever someone who was detained kills themselves or is killed by someone else. This is a complex area of law and if you have questions about whether this applies to your relative's death you should seek advice from a solicitor.

What is a death certificate?

A death certificate is a legal document that is sent to the registrar of births and deaths to record the details of a person who has died and the cause of death. When there is an inquest the coroner will issue an interim certificate when the body is released, but will not issue a final death certificate until after the inquest has concluded. An interim death certificate is necessary to enable the body to be released in order for a funeral to be held and for the administrative procedures that follow a death.

When will the inquest be held?

In most circumstances the inquest will be opened very soon after the death for the formal business of recording the person's identity. This is a very short procedure taking only a few minutes, and it may be held in the coroners' office and not in a courtroom. You have the right to attend this hearing. After that, the length of time before the full hearing depends very much on the geographical area where the inquest is taking place and the nature of and circumstances surrounding the death. Where there are other investigation procedures to go through it can be a number of years after the death before the inquest is held.

Where will the inquest be held?

In some places, particularly large metropolitan areas and cities, there will be a specific coroner's court. In London there are eight coroners' courts which each cover a group of boroughs. In smaller towns it may be held in the magistrate's court or possibly in a room in the town hall. Jury inquests have sometimes been held in a local crown court.

Will the inquest establish who is responsible for my friend or relative's death?

No. The main purpose of an inquest is to establish the cause of death. It cannot blame individuals for the death, or establish criminal or civil liability on the part of any named individual(s). Coroners will often say at the beginning of the inquest that their job and that of the jury (if there is one) is to establish the answers to four questions – who the deceased was, where they died, when they died and how.

But surely how they died includes who was responsible?

No. According to the law it is not the function of an inquest to blame particular individuals involved. The inquest might make criticisms about what happened, but cannot suggest that any individual is liable for someone's death. Many people are shocked and very disappointed to learn that the inquest cannot seek to establish who may be responsible for the death.

Will the inquest look into all the issues and circumstances of the death?

As explained, the remit of the inquest is legally very narrow. It may be that there are many events in the days, weeks and even months before the death which you believe played a part in the death. It will depend on the circumstances of the death as to which evidence the coroner thinks is relevant. Individual coroners will have different approaches and some will allow more questions than others.

Will I be able to see the evidence and statements before the inquest?

If you are an interested person, part 3 of the Coroners (Inquests) Rules 2013 says that when you ask for disclosure of a document held by the coroner, the coroner must provide that document or a copy of that document, or allow you to look at the document as soon as possible. This includes any post-mortem reports, any other reports that the coroner has obtained during his or her investigation, the recording of any inquest hearing held in public and any other document that the coroner thinks is relevant to the inquest. You may receive disclosure in a paper copy, electronically or both.

The coroner may decide that you can only see certain parts of a document and that other parts have to be deleted, or that you may only be allowed to see certain pages of a longer document. If the coroner says that you can look at a document, the coroner can say that this must be at a set time and/or at a set place.

The coroner can refuse to let you see a document because the law says that he or she cannot disclose it; because consent cannot be obtained from the author or the person with legal rights to the document; if the request is unreasonable; if the document relates to criminal proceedings; or if the coroner thinks that the document is irrelevant to the investigation.

A coroner should not charge an interested person for any documents or copies of documents before or during an inquest, but may charge an administrative fee if you ask for documents or copies of documents after the inquest has finished.

What information will I be given about the inquest by the coroner's court?

You should receive two guides from the coroner's court called *A Guide to Coroner Services* and *A Guide to Coroner Investigations*. If you do not receive these, ask for a copy. They are also available online at www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide

In some areas coroner's officers give this information automatically, but in others they do not have copies of the leaflet. You should ask questions of the coroner's officers if there is anything that you are not clear about.

Is there general information available online that may be helpful?

The website www.gov.uk has some very useful information. Go to the section headed *Births, deaths, marriages and care* which has another section headed *Death and Bereavement* where you will find a range of helpful information. In addition, the Coroners' Courts Support Service has useful information about the inquest process and you can also download the guides mentioned above at www.coronerscourtssupport service.org.uk. See also the website details of the organisations listed in Section 8.

INQUEST Skills and Support Toolkit

Another useful resource is the INQUEST Skills and Support Toolkit. This is a resource for families and friends which can be accessed online or as a book. The toolkit encourages the development of specific skills and knowledge that give people the ability to participate more fully in the inquest process through a range of activities following a relative or friend's death. Some of the skills and areas covered by the toolkit include campaigns or writing to parliament, organising meetings or working with the media.

It also deals with the more practical skills needed to support wider family members after a sudden death, things like sorting out paperwork, writing to your children's schools, dealing with employers, speaking to officials linked to the inquest and meeting new people.

For more information, please visit the skills toolkit website at info.inquest.org.uk/toolkit or contact INQUEST for a printed copy.

The handbook is absolutely fantastic. It has everything you need in it.

Charmaine Morris, mother of John York who died in prison

SECTION 2: Your rights and the body of your relative

SECTION 2.1

1. Your rights and the body of your relative

Can I view the body?

Yes. Although there is no provision in the law relating to coroners' duties and responsibilities that says a coroner must assist or allow relatives to view the body, in reality most coroners will do so. In some rare circumstances, for instance where there are seriously disfiguring injuries, the coroner may suggest that the family should not view the body or that the way in which you view the body should be limited (for example, from behind a glass panel). It is up to you whether you take this advice and human rights legislation should support the right of a family to be able to view the body in most circumstances (schedule 8 of the Human Rights Act 1998 [the right to respect for private and family life] should give families a right to view the body of their relative).

You should ask the coroner's officer to arrange for you to see the body. If your request is not granted, you should take this up with the coroner directly and then consider contacting INQUEST or a specialist solicitor if you are still experiencing difficulties or need further advice.

Who does the body belong to?

Because the person died in circumstances in which it appears necessary to hold an investigation, the state, in the form of the coroner, has temporary control of the body and it cannot be released for the funeral without the permission of the coroner.

However, the Coroners (Investigations) Regulations 2013 say that the coroner must release the body "as soon as is reasonably practicable". If this does not happen within 28 days of the coroner being made aware that the body is in his or her area, the coroner should tell the next of kin or personal representative of the deceased the reason for the delay. The coroner will release the body to whoever they understand is the next of kin, so it is important that you contact the coroner if you think there could be any disagreement about this.

Who should identify the body?

A family member or close friend of the deceased should be entitled to identify the body. If the deceased's body is in some way unidentifiable by sight, the police or coroner's office may use, if it is available, information such as fingerprints, dental records or even DNA samples to confirm identification.

If you experience any problems with being allowed to identify your relative, you should try to take this up with the coroner directly and then consider contacting INQUEST or a specialist solicitor if you are still experiencing difficulties and need further advice. Again, human rights legislation should support the family's right to identify the body of their relative.

Does the coroner service recognise different cultural and religious beliefs and practices in relation to death?

It is important to inform the coroner about your beliefs and practices so that, within the legal framework, they can be sensitive to your needs.

Can I prepare the body for the funeral?

The coroner will release the body to the family when the coroner no longer needs the body for the purposes of the investigation.

If there is a post-mortem, when will the body be released for the funeral?

The body will usually be released when the coroner is satisfied that the medical procedures necessary for determining the medical cause of death have been completed. It is difficult to give an accurate timescale, but if there is a straightforward cause of death it will be completed a few days after the death.

If, however, there needs to be a second post-mortem this will inevitably cause some delay. If there are body tissue tests that need to be done, some families want to delay the funeral until their completion. Usually the coroner will allow the body to be released for the funeral before the test results have been received.

When can I make the funeral arrangements?

The funeral cannot take place until the coroner has agreed to release the body, but it may be helpful to contact a funeral director of your choice at an early stage. He or she will be able to give you practical help with the procedures involved. If you or your partner are on a low income, you may be entitled to financial assistance that would meet the cost of a simple funeral. You can get further details about this from your local JobCentre Plus office, or you can download a copy of the form SF200 from www.nidirect.gov.uk/apply-for-a-funeral-payment.

If the person died in prison, the Prison Service must offer to pay reasonable funeral expenses under a Prison Service Instruction called PSI 64/2011. See chapter 12 at www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.DOC.

What other arrangements do I need to make?

There are often lots of practical tasks that you will need to think about when someone has died. The Department for Work and Pensions publishes an information booklet titled *DWP28 What to do after a death in England and Wales*, which you can get at your local JobCentre Plus office or online at www.gov.uk/government/publications/what-to-do-after-a-death-in-england-or-wales-leaflet.

If you are on a low income you may be able to get various bereavement benefits, which are also explained in the booklet and online at www.gov.uk/browse/benefits/bereavement.

We were very impressed with your website and the information there. I think it's great that charities like INQUEST exist as there needs to be accountability.

Anna Ferris, sister of Nathan Ferris who was in a mental health setting at the time of his death

SECTION 2.2

Post-mortem examination

What is a post-mortem examination?

A post-mortem examination is a medical procedure where a body is examined to find out what caused the death. It is not a common procedure and is only conducted in some circumstances, for example when the cause of death is unnatural or unknown. The procedure involves extensive cutting of the body and removal of the internal organs for examination before replacing them in the abdominal cavity, not where they would have originally been located. Families should be aware that if they view a body after a post-mortem there may be marks which look like bruises which will have been caused by the post-mortem procedure. There can also be marks caused if there was an attempt to resuscitate the person prior to their death.

In some parts of the country and in some circumstances it may be possible to ask for a post-mortem to be conducted by using an MRI scan, so that the body does not have to be physically damaged. This is a very new method of undertaking post-mortems and there are mixed views about whether it is always a good idea. If you feel strongly about this, for example for religious reasons, you can ask the coroner if it is possible, but you will be expected to pay for it.

When does it happen?

A post-mortem is carried out as soon as possible after the death on behalf of the coroner as part of the investigation to establish the cause of death. It usually takes place within one or two days of the death.

The coroner is required to inform the relatives of the deceased of the date, time and place at which the examination is to be made if the relatives have told the coroner that they wish to be represented at the examination, unless it is impracticable to notify them or if it would cause unreasonable delay.

The relatives have the right to be represented at the post-mortem by a medical practitioner or other representative (see below). In reality this very rarely happens and many families are not aware of their rights until it is too late and the post-mortem has already taken place. You should be aware that if you do have a representative attend the post-mortem on your behalf, you may be responsible for any of their related costs. In some exceptional circumstances these costs could be met by legal aid funding. You will need to discuss this with a specialist solicitor to see if it would apply to your situation.

Where the police are investigating the death because they think a crime may have been committed, and when someone has been or may be charged with causing the death, the coroner may delay giving permission to bury the body so that the lawyers acting for the accused can arrange their own post-mortem. This can be very distressing for the family, but the coroner has a duty to protect the rights of the accused in this way. If someone is charged with an offence and there is to be a criminal trial there will not usually be a full inquest as well. The coroner can hold an inquest after a trial, but in practice this is very rare. If you think that there should be an inquest as well as a criminal trial, you will need to make sure the coroner knows your views and you may need to take legal advice.

Who may be present at the post-mortem examination?

The following people are entitled by law to be represented at the post-mortem examination or, if they are a medical practitioner, to be present themselves:

- The next of kin or personal representative of the deceased.
- Any other interested person who has told the coroner of their wish to be represented.
- The deceased's regular medical practitioner, if they have told the coroner that they wish to be represented.
- The hospital, if the deceased died in hospital.
- In cases involving accident or disease, an authority or an inspector or representative of an authority responsible for receiving reports connected to the type of accident or disease.
- A government department that has told the coroner that it wishes to be represented.
- The chief officer of police, if the chief officer has told the coroner that he or she wishes to be represented.
- A representative of the chief officer of police and any other person, including a trainee doctor, medical student or other medical practitioner may attend the examination, but only with the consent of the coroner.

Can I stop it?

Bereaved relatives do not have to give consent for a coroner's post-mortem examination to take place. However, if you feel strongly about this you should speak to the coroner. If the coroner decides that a post-mortem examination is necessary, the only means of stopping it is by a complicated legal procedure called a judicial review. It would be necessary to demonstrate that the coroner's decision was unreasonable, i.e. because the grounds for wanting a post-mortem were in some way insubstantial.

In reality, the post-mortem is often carried out very soon after the death and the family may not have sought advice that quickly, or they may not have been informed that it is taking place. The coroner will not release the body for the funeral until the procedures required have been carried out.

Who carries out a post-mortem examination?

A pathologist, who is a doctor specialising in this particular area. The coroner will appoint the pathologist.

Where will it take place?

Usually in the hospital where the person died or was taken immediately after death, or at the public mortuary linked to the coroner's court.

Will any samples be kept?

At the post-mortem examination the pathologist may need to carry out some specialist tests in order to discover the cause of death, or be asked to carry out specific examinations by the coroner.

Sometimes very small pieces of tissue are kept for the pathologist to examine under the microscope at a later date. In some cases it may be necessary to keep the whole or parts of the organs to undertake particular tests. You can ask for information about this from the coroner or pathologist. You can also discuss delaying the funeral until the tests are completed so that the organs or tissue can be returned.

The coroner must tell you if organs or other samples are being kept after the post-mortem. You should also be told how long they will be kept and you will need to decide whether you want to have them returned to you, whether you wish to donate them for research, or whether they should be disposed of when the coroner decides that they are no longer needed for the investigation.

Further information about this is available online from the Human Tissue Authority at www.hta.gov.uk/sites/default/files/Post-mortem_examination_-_your_choices_about_organs_and_tissue_FINAL_v3_0.pdf

Can I see the post-mortem report?

If you are an interested person, you can ask the coroner to disclose the post-mortem report to you. If you do this before or during the inquest, there will be no charge. The coroner can charge you an administrative fee if you ask him or her to disclose the post-mortem report after the inquest (see above: ***Will I be able to see the evidence and statements before the inquest?***).

Can I have a second post-mortem examination?

Yes, with the consent of the coroner. In practice this is very rarely denied. If it is denied it can be challenged by judicial review (see Section 8: ***Definitions***).

If you consider having a second post-mortem you must be aware of the need to have a solicitor to instruct the pathologist and also of the cost involved. It will probably delay the funeral. But if you are not happy with the information you have received about the cause of death and you have worries about the circumstances of the death, you should consider a second post-mortem. It is important to use a pathologist with specialist expertise and you will need to take advice on this. You also need to ensure that the body is properly preserved. After a few days a body will start to deteriorate and if it needs to be kept for longer, the body will be frozen in order to preserve it.

What is a toxicology report?

A toxicology report is a report done on blood and tissue to establish whether there were any toxic substances in the body which may have contributed to the death. The toxicology report will detail prescription drugs, illegal drugs, alcohol and any other chemical substances which the toxicologist has been instructed to test for. It will usually take 6-8 weeks for the toxicology report to be completed. You can ask for a copy of this with the post-mortem report.

What will the body look like after a post-mortem?

A body will begin to deteriorate and this will become obvious if it has to be kept for any time. This can be very distressing for family and friends, particularly if they want to have an open casket at the funeral or perform other rituals with the body. You will need to talk to your funeral director and take their advice about whether it is going to be possible to have an open casket.

A judicial review is a complex legal procedure where a judge can review decisions made by the coroner and decide whether they are appropriate and/or correct. It is held in the High Court and the application generally has to be made within three months of the decision you are challenging and as quickly as possible.

NOTES

SECTION 3: Legal advice

SECTION 3.1

Legal advice and how to fund it

The Coroners and Justice Act 2009 specifies who can be legally represented at an inquest. This includes family members and specifies which family members are automatically considered interested persons (see Section 8: ***Definitions***). This representation can be done either by a solicitor or a barrister. If you want to be represented by a barrister, they may have to be instructed by a solicitor on your behalf.

Should I contact a solicitor?

If you are concerned about the circumstances of the death then you should consider seeing a solicitor who has specialist experience as soon as possible (see the question below about funding for legal advice). Whilst you might have been told by the coroner, coroner's officer or other professionals that it is not necessary, we would strongly advise you to talk to one of the organisations listed in the guide about legal advice if you are worried about what has happened.

It is not always necessary to have a solicitor, but if you want to be legally represented at the inquest itself it is important to have specialist help. It can also help to have a solicitor to assist you in obtaining any paperwork related to your relative's death or the circumstances surrounding the death. If you are not sure if you have found the right solicitor, you must feel free to ask them questions about their experience and how much they know about the different processes.

There are some circumstances of death where we would strongly recommend contacting a specialist solicitor as soon as possible. Where someone dies whilst in the care of an institution (for example, a psychiatric hospital or prison) or following contact with those working for a public authority (the police, for instance) it is advisable to seek specialist legal advice immediately (see Section 5).

It is now possible to instruct a barrister directly to represent you at the inquest hearing without first instructing a solicitor. This can be a useful option if you are not eligible for public funding and the cost of a solicitor is prohibitive, or if you are having difficulty finding a solicitor who is able to take on your case. However, if you are considering this option, we advise you that speak to an INQUEST caseworker first. You can find more information on the Bar Council's website at www.barcouncil.org.uk/using-a-barrister/public-access.

How can I find a solicitor?

You can find a solicitor by contacting the relevant organisations listed at the back of the guide. They may be able to suggest someone who has some experience in preparing for inquests.

It is important to find a solicitor with experience of inquests or of the circumstances in which your relative died. If you already have a solicitor you trust and have worked with before, then you can suggest that they contact the organisations listed for more specialist information. The solicitor should have an understanding of the importance of the inquest to you in finding out what happened.

Most solicitors do not have expertise in inquest preparation and some may give you inadequate advice or charge very high fees. Legal funding for inquests is complicated and a solicitor inexperienced in this work may not know how to help you get the limited funding that may be available.

What will my solicitor do before the inquest?

This depends on the nature of the death, but in all cases the solicitor should inform the coroner that they are acting for you and that you are an interested person or wish to be recognised as such at the inquest.

Your solicitor should:

- Be in regular contact with the coroner.
- Obtain the medical records of the deceased and police reports if available.
- Take statements from you and any other key witnesses.
- Consider the use of an expert.
- Arrange representation at the inquest itself.
- Advise you on what the conclusion means.

The statement you give to your solicitor should not only deal with the circumstances surrounding the death in considerable detail, but also set out clearly your concerns so that the coroner is in a position to consider them. You should also inform the solicitor of any other information that could be relevant.

If there is a formal investigation, for example by the Health and Safety Executive (HSE), the Independent Police Complaints Commission (IPCC), Prisons and Probation Ombudsman (PPO) or hospital trust (see Section 5), your solicitor will liaise with the investigator responsible, help you to ensure any concerns or questions you have are covered in the investigation, and help you to put together any comments on the draft report.

It is essential for your solicitor to keep in regular contact with the coroner's officer to keep your solicitor informed about the arrangements for the inquest including the date, venue, order in which the witnesses will be called and the nature of any exhibits to be presented in evidence.

How can I help the solicitor?

If there are several of you in your family it is useful for one of you to be the main person to work with the solicitor. You should write down as much of what you remember being told about your relative's death as soon as you can and any background information that you feel might be helpful and relevant to your solicitor's understanding of your relative and the circumstances of the death.

It may be difficult because you will be experiencing shock and distress about the death, but it is helpful to do this as soon as you feel able and give it to your solicitor. Requests can then be made to the coroner via the coroner's officer to call evidence that the family believe is relevant to the cause of death.

Do I need a barrister to represent me at the inquest?

A solicitor or a barrister can represent you at the inquest and ask questions of the witnesses on your behalf. Some solicitors have considerable skill and experience of representing people at hearings and some do not. Not all solicitors represent people in court, but this does not mean that they are any less capable at what they do in advising you. Usually the solicitor will instruct a barrister to represent you in the court itself.

It is best to discuss this with your solicitor and any of the organisations listed in this guide you have been in contact with. This is particularly relevant when there are lawyers acting for other interested persons and who will be representing them at the inquest.

If I have a barrister, will I meet them before the inquest?

It is best practice for you and your solicitor to have a meeting (called a conference in legal jargon) with your barrister before the inquest. You may also meet them if there is a pre-inquest hearing (see Section 4).

It is important that you let your barrister know what your concerns are and what questions you want to be asked. It is a good idea to write down any points that you want to raise with them before the meeting. You may be anxious that one or two meetings will not be long enough for them to understand your case, but they will have read the papers produced by the solicitor very carefully. What is important to remember is that you are instructing them and they are there to ask questions at the inquest on your behalf, so you should not be shy about raising particular points with them.

They will be able to advise you on whether these points can be raised through questions at the inquest. If they tell you that some of the things you are concerned about cannot be put to witnesses at the inquest, it may be because of the law related to inquests that only allows quite a narrow look at the circumstances surrounding the death. You should feel free to ask your solicitor and barrister to explain why they don't think that some of your concerns can be raised at the inquest. The best time to do that is in conferences before the hearing, rather than while it is taking place.

How much does it cost?

Unfortunately, there is no automatic public funding for a family's legal costs at an inquest, and what help you get depends on your circumstances and the particular nature of the death. In some circumstances and where your income and savings or other assets are below a certain amount, you should be eligible for Legal Help. This pays for a solicitor's initial advice and most of the preparation that is necessary before an inquest.

There is no automatic public funding for representation at an inquest hearing (which is when your barrister or solicitor attends an inquest hearing to speak on your behalf). There are some circumstances when this representation will be paid for by the state under a system called exceptional funding.

There is the possibility in some circumstances of also taking a compensation claim in a county court or at the High Court (not the coroner's court). In those cases public funding may be available, depending on your means. Alternatively, it might be possible to fund your legal representation through legal expenses insurance or a conditional fee agreement (also known as "no win, no fee"). You will need to ask the solicitor to explain the legal costs very carefully to you.

If you are in any doubt about what the solicitor tells you about how to fund your case, get a second opinion or speak to one of the organisations listed in this guide.

It is so good we have INQUEST and lawyers helping us with unwavering commitment, professionalism and care.

Barbara Montgomery, mother of James Herbert who died in police custody

Sometimes when families are not eligible for public funding, these organisations may be able to find experienced solicitors and barristers who, depending on the circumstances, may be prepared to charge a low fixed fee or in some cases act for you for free.

What is exceptional funding?

The Lord Chancellor has the power to grant legal funding for representation by a solicitor or barrister at the inquest in circumstances that the Lord Chancellor believes to be exceptional. The Lord Chancellor has issued guidance setting out when funding will be granted.

In broad terms, the guidance says that exceptional funding will be granted where required by article 2 of the European Convention on Human Rights. Funding can also be granted where advocacy is necessary because of the wider public interest of the issues arising at the inquest.

When considering whether to grant exceptional funding, the Lord Chancellor will also consider the family's financial circumstances. However, the Lord Chancellor can grant exceptional funding even where family members would not normally be financially eligible for legal aid. If exceptional funding is granted, family members may be required to make a contribution.

Exceptional funding should be made available where someone has died whilst in the care of the state. This would apply where someone dies in prison or police custody, whilst detained under the Mental Health Act 1983 or whilst subject to an order depriving them of their liberty. In addition, exceptional funding should be made available where someone dies following police contact or where an individual has been killed by state agents. It may be more difficult to obtain exceptional funding for deaths from "natural causes" in state detention or for deaths in hospital.

However, each application for exceptional funding must be considered on the basis of the individual facts of the case. You should suggest to your solicitor that they discuss this with INQUEST if they are considering an application and are not familiar with the process.

You need to be aware that the process of applying for funding is complex and the forms that you will need to fill in for your solicitor to make the application to the Legal Aid Agency are very detailed and that families often find the process of applying for legal aid to be intrusive and stressful. In order to establish whether your family is financially eligible for exceptional funding, it will be necessary for the various next of kin to the deceased to provide their financial details. Each family member will need to provide very detailed information about their financial affairs. Your solicitor should be able to guide you through the process and respond to any queries you may have.

In some cases coroners may be willing to write a letter in support of a funding application. This will assist with the funding application, but does not necessarily mean that funding will be granted.

SECTION 4: The Inquest

SECTION 4.1

Before the inquest

Who decides who will give evidence?

It is up to the coroner to decide who will give evidence. You can suggest witnesses who may be helpful and important to the coroner yourself or through your solicitor. If you have a solicitor, it is important that he or she lets the coroner know as soon as possible that they are instructed by you to prepare for the inquest, and that they keep in regular contact with the coroner. Some coroners are more open to suggestions on which witnesses to call than others. In the end it is the coroner who makes the decision, although it may be possible to challenge the coroner through other legal processes if the decision is unreasonable.

Many coroners will release a witness list of who they propose to call to give evidence in advance of the inquest. A coroner will either call a witness to give evidence at the hearing or will arrange for their statement to be read at the inquest without the need for them to attend under rule 23 of the Coroners (Inquests) Rules 2013. If you object to a statement being read, then it usually should not be and the witness should be called to appear at the inquest in person.

What is a pre-inquest hearing or review?

If the case is complicated, for example when there are lots of witnesses and other interested persons, there may be one or more pre-inquest hearings or reviews. These are hearings with the coroner and all the interested persons where plans are made for the practical arrangements, such as agreeing a date, deciding on which witnesses will be needed and how long the inquest is going to take. There are often legal arguments in these hearings, for example about how much information the inquest will consider and how wide the investigation will be – often called the scope of the inquest.

You can go along to these hearings, you may want your solicitor to deal with them for you, or you can decide not to go at all. Some (but not all) coroners will make sure that families are shown around the court facilities and given the information they need about the practical arrangements when they attend one of these hearings.

I felt like I was banging my head against a brick wall, not getting anywhere until I finally got in contact with INQUEST and secured the help of a good solicitor.

Rachel Sunter, daughter of Ian Sunter who died following contact with multiple agencies

When will I be told the date of the inquest?

You should be informed of the date of the inquest as soon as it is set. If there are any pre-inquest hearings the date should be agreed then. You will be able to tell your solicitor if there are any dates that would be difficult for you to attend and they can ask the coroner to take this into account. If a barrister is representing you, then your solicitor should ask the coroner to ensure that enough notice is given and also ensure that your barrister is available. Although this is good practice, not all coroners take this approach.

If the death raises complicated issues and involves investigations by other organisations, you may need to be prepared to wait many months, or in some circumstances years, before the inquest takes place. In some complex cases this can be as long as four or five years after the death.

Can I speak to the coroner?

It is more common that you will speak to the coroner's officer, although some coroners will speak directly to bereaved people or their solicitors.

What are the legal rules about what can be said in public before an inquest?

There is no strict rule forbidding you to speak in public about the inquest before it happens – in legal jargon it is not sub judice (see Section 8: ***Definitions***) – so simply reporting the matter is not contempt of court, neither is talking about the deceased's life before they died. However, you need to be very careful and seek advice from your solicitor or one of the organisations listed in this guide about what is sensible to say in public before the inquest as it could have a negative impact.

For example, if there is the possibility of someone being charged with a criminal offence, it is not usually a good idea to speak publicly about the facts or events involved in the death. If there is a prosecution, it might be argued that it was impossible to have a fair trial because of the publicity. If someone has been arrested and charged then it will become sub judice. If there are civil proceedings taking place, you also need to have good advice about what you can say and when you can say it.

SECTION 4.2

At the inquest

Will there be any private place to wait at the inquest?

The facilities in coroner's courts vary enormously. Unfortunately, there is not always a private place for friends and family to wait or to talk with their legal representatives. Some coroner's courts (or where a town hall or county court is used) have waiting and/or interview rooms and some coroners may consider making one available for the family and their lawyers, especially if the inquest is going to take some time. Ask the coroner's officer if you would like this to happen or ask your solicitor to do this for you. At other courts this is not the case and you need to be prepared for having to wait in the same place as the people involved in the death, which can obviously be very distressing.

What should I wear and bring with me to the inquest?

You should wear clothes you feel comfortable in. The coroner, lawyers and witnesses will be dressed formally, but do not feel you have to do the same. Lots of families like to bring a photograph of their loved one to the inquest and sometimes a coroner will allow a photograph to be shown to the jury, if there is one.

Will my expenses be paid?

If you are called to give evidence you may be paid some expenses for having to miss work to come to the inquest and also travelling expenses. This will only apply if you have been summoned to give evidence. If your relative died in prison, the Prison Service may agree to contribute to your expenses for attending, but this does not always happen. You should raise this with the coroner's office and/or your solicitor.

Who has the right to attend?

Anyone – an inquest is a public hearing. You may want to bring a friend or family members to support you during the inquest. Some coroner's courts and other venues where inquests are held are very small and therefore this limits the number of people who can attend.

How long will the inquest take?

This can vary significantly depending on the individual circumstances and the approach of the coroner. Many inquests last for just a few hours, sometimes less. However, if the person died in more complicated circumstances, particularly in article 2 cases (e.g. when someone has died in state custody), an inquest can take days or even weeks.

Will the press and public be there?

Because an inquest is a hearing in public, the press may attend and report on what has happened. Some families want there to be press attention, but some do not. You cannot stop the press from writing about the hearing, but they do have a code of ethics and should be sensitive to grieving families. If you want to know more about this or make a complaint about the press, there is more on the website of the Press Complaints Commission: www.pcc.org.uk (see also Section 7 on dealing with the media).

Can I leave the court if I want to during the inquest?

Yes, you can leave whenever you want (apart from if you are giving evidence at the time) and come back whenever you like. If you feel upset or angry with any of the evidence you may want to have a break or leave altogether. If you choose to do so, you should leave

quietly. Coroners are used to people coming in and out of the court. Some coroners will mention in open court when post-mortem evidence or other distressing evidence is coming up to allow you the opportunity to leave if you want to.

Will anything personal and private be said at the inquest about my friend or relative and their family?

The inquest is there to inquire into the circumstances of the death, and there may be evidence that the coroner considers relevant to the investigation that reveals private information about the person. If there are things which you do not think are relevant to the inquest, you can ask that they are not made public. The coroner will make the final decision about this.

Some coroners will be sympathetic and sensitive to your concerns, but others may be less understanding. However sympathetic the coroner is, they may feel that they have no choice but to reveal information if they think it is relevant to the death.

Will a "suicide note" be read out during the inquest?

It is unusual for a suicide note to be read out in full, but the coroner or others may quote from it if they think it is important in explaining what happened. You should have already been told of any final letter or note (sometimes known as the "suicide note") and given a chance to read it before the inquest.

What will happen at the inquest?

An inquest is not like a criminal trial. It is meant to find out facts, not to establish blame. Inquests are not supposed to be adversarial like criminal trials. The coroner and any legal representatives should treat witnesses, especially the bereaved, with care and respect, but this will depend on their experience and sensitivity.

The coroner will begin the inquest and if there is a jury its members will be required to take an oath. The coroner will explain to them what their duties are and that they are there to establish the answer to the questions: who the person was; where they died; when they died; and how they came by their death. The coroner will also usually explain the purpose of the inquest and that the inquest is not held to establish any criminal or civil liability, that it cannot blame individuals for the death, and that the coroner and/or the jury must not name anyone in delivering their conclusion (sections 5 and 10 of the Coroners and Justice Act 2009).

Evidence

The coroner will then call the witnesses. If a family member is giving evidence they will usually do so first. The coroner will normally begin by questioning the witnesses and talking them through the statement they have made. There will then be the opportunity for you or your legal representative as well as barristers representing any interested person to question the witnesses. If the witness is your witness (either yourself, another family member, a pathologist you employed or another expert) your barrister will usually be the last to ask questions. If you do not have a legal representative the coroner may decide to ask any questions you have on your behalf. The jury are also allowed to ask questions.

Sometimes witnesses will not actually attend the inquest, but their statements will be read out by the coroner. If you think it is important for a particular witness to attend to give their

evidence in person, then you must make sure the coroner knows this in advance of the hearing. In the end, it is the coroner's decision who will give evidence.

In some cases, the coroner will warn the witnesses that they do not have to answer questions if they feel their answer might incriminate them in a criminal offence.

Summing up

After all the witnesses have been questioned, the coroner sums up the evidence. Your barrister and any other legal representative do not have the right to sum up the evidence as they see it. Because there is no right to sum up, it is very important to ask the right questions during the inquest so that the jury (if there is one) understands what your concerns are. This is one of the reasons why it helps to have a barrister or solicitor representing you.

After the summing up, the coroner or jury will give their conclusion. If there is a jury, the coroner must explain to them which conclusions they can consider based on the evidence that has been heard. Your barrister and any legal representatives for other interested persons may ask to address the coroner on the law in relation to possible conclusions. The jury will be asked to leave the court until the legal submissions have been made. The coroner will then address the court on the conclusion, or if there is a jury they will retire and consider their conclusion (see below).

It is vital to understand that the inquest is not like an ordinary court of law. The coroner is prohibited from deciding any issues of civil or criminal liability on the part of a named individual. The inquest is purely a fact-finding hearing.

If there is a jury, the coroner must explain to them which conclusions they can consider based on the evidence that has been heard. Your barrister and any legal representatives for other interested persons may ask to address the coroner on the law in relation to possible conclusions.

SECTION 4.3

Conclusions

What conclusions can the inquest return?

There are a number of conclusions that can be given including:

- Natural causes.
- Industrial disease.
- Dependence on drugs/non-dependent abuse of drugs.
- Want of attention at birth.
- Suicide/killed him or herself whilst the balance of his or her mind was disturbed.
- Accident or misadventure (which means almost the same thing).
- Disaster which is the subject of a public inquiry.
- Attempted or self-induced abortion.
- Lawful killing.
- Unlawful killing.
- Open conclusion – this means that the cause of death cannot be established and doubt remains as to how the deceased came to their death.
- Stillbirth.
- Narrative conclusion.

In some cases the words "contributed to by neglect" can be added, but the law is very limited on when this can be applied and neglect does not mean the same in law as it does in everyday language. "Systemic neglect" can also be considered in some circumstances where evidence showed that insufficient action was taken to prevent a death.

All of these conclusions have to be established to the test within the balance of probabilities, except for suicide and unlawful killing, which have to be proved beyond reasonable doubt.

When does the coroner use the conclusion "killed him or herself"?

When it is believed, on the basis of the factual evidence, that the person genuinely intended to kill him or herself. For this conclusion to be returned there has to be clear evidence, for example a suicide note, which shows beyond reasonable doubt that it was definitely the person's intention to take their own life. If they did something that resulted in their death but there is not enough evidence that they intended to die, then this conclusion cannot be returned.

What conclusion is used if there is insufficient evidence that somebody had intended to kill themselves?

Typically, misadventure, accidental death or an open conclusion.

Would the conclusion "killed him or herself" have to be supported by a suicide note?

No, but that is a piece of evidence which could show intent.

What do accidental death and misadventure mean?

Accidental death means that the person died as a result of actions by themselves or others that had unintended consequences.

Misadventure is similar to accidental death, but means that the deceased or others were carrying out an intended action (for example a planned surgical operation) but there was an unintended outcome (in this example, the death of the patient).

What does an open conclusion mean?

This means that there is not enough evidence to return any other conclusion.

What does unlawful killing mean?

This conclusion means that the person was killed by an "unlawful act" by someone or some others or as the result of their "gross negligence". These are both legal terms that are clearly defined in the criminal law. Unlawful killing is a very rare conclusion.

If I think an institution (such as a prison or hospital) has neglected my relative, will that be included in the conclusion?

There is a real difference between the meaning of "neglect" in common speech and what that means in law. This is a complicated area and you should discuss this with your solicitor or one of the organisations at the end of the guide. As indicated above, it is rare for the words "contributed to by neglect" to be added to one of the conclusions already mentioned. The conclusion cannot state that any individual is guilty of neglect.

What is a narrative conclusion?

In some circumstances, particularly in inquests that are more complex and/or where article 2 of the European Convention on Human Rights applies (see Section 2: ***What is an inquest?***), the jury can be asked to provide a narrative conclusion or the coroner might give a narrative conclusion. This allows the jury or coroner to expand on their conclusion and give a longer explanation of what they think the main or important issues are. A narrative conclusion might also involve the coroner providing the jury with written questions in the form of a questionnaire and these questions and answers will form the narrative conclusion. They will become part of the record of the inquest and will be read out in public. If you are legally represented, it is important to discuss this with your solicitor or barrister.

A narrative conclusion can be a very powerful way of exposing any problems or mistakes that have been made, even though it will still not name any individuals as being to blame. If there are any disputes about what happened factually which are important, the narrative can include the jury or coroner's decision on those facts. The jury or coroner should record any failings if these caused or contributed to the death.

Can the coroner make recommendations to prevent a further death occurring in similar circumstances?

The coroner has an important role in trying to prevent further deaths. Under paragraph 7 of schedule 5 of the Coroners and Justice Act 2009, where a coroner has been conducting an investigation and the investigation reveals a concern that circumstances creating a risk of death will occur or will continue to exist in the future, the coroner must report the matter to any person or authority that has the power to take action to prevent future deaths. This is referred to as "action to prevent other deaths". The coroner is the only person entitled to make recommendations.

However, some coroners will allow lawyers to suggest things they think should be considered under his or her powers under paragraph 7 of schedule 5 of the Coroners and Justice Act 2009.

The report must be provided to every interested person who should receive it, in the coroner's opinion; the Local Safeguarding Children Board (where the coroner believes the deceased was under 18); and to any other person who the coroner believes may find it useful or of interest.

Can the jury make any recommendations?

No. But as explained above, in some circumstances they can write a narrative conclusion including their concerns as long as they do not criticise a named individual.

Can the coroner's recommendations be enforced and will I find out what response they received?

The recommendations cannot be enforced. However, any person or authority who receives a recommendation from a coroner under this power must provide a written response within 56 days of the date on which the report was sent, but the coroner can extend this time period. The response must set out the action that has been taken or will be taken or explain why no action is proposed.

The report and the response must be provided to every interested person who should receive it, in the coroner's opinion; the Local Safeguarding Children Board (where the coroner believes the deceased was under 18); and to any other person who the coroner believes may find it useful or of interest.

A copy of the coroner's report and the response must be sent to the Chief Coroner. The Chief Coroner may publish the report and/or the response or distribute it further, although the person responding to the report can make representations about publication to the coroner who made the report.

How does the inquest finish?

The coroner and jury (if there is one) sign a document, form 2 of the schedule to the Coroners (Inquests) Rules 2013, known as the record of the inquest. This document gives the findings of the inquest, which records the answers to the questions: who the person was; where they died; when they died; and how, i.e. the medical cause of death and in what circumstances, if the inquest is an article 2 inquest.

You should be given a copy of this form.

SECTION 4.4

After the inquest – further action

What happens after the inquest?

The coroner will send any details required by the registrar of deaths to them and will also write to any relevant authorities under his or her powers to take action to prevent other deaths if he or she thinks that is appropriate (see above). The coroner's officer will explain how to get a copy of the death certificate, for which you will have to pay a small fee. If it has not already been done, he or she will also send a burial order, a cremation certificate or permission to send the body abroad.

Can any other legal claim be brought after the inquest?

If the family want to make a financial (civil) claim they should seek advice from a solicitor if they have not already done so. The solicitor will be able to advise them whether there are good grounds for a civil claim. This is much more likely to be successful when there has been a strong conclusion at the inquest – and for this reason it is usually better to get advice about this before the inquest takes place. There are also time limits to making claims; for example, if you make a claim under the Human Rights Act 1998 it generally must be made within 12 months of the death, so early advice from a solicitor is very important.

There may be other avenues to pursue, but these are very limited and again you should discuss this with a solicitor or one of the relevant organisations listed in Section 8.

What can I do if I am unhappy with the conduct of the inquest and the conclusion?

You have very limited options for taking action after the inquest. There is no right of appeal. If you are concerned either about the conclusion or the way that the inquest was run, you should talk to your legal representative or one of the organisations listed in Section 8. There are some ways to challenge an inquest, but these involve complicated legal processes which can take months or years to complete and require specialist knowledge of the law; so if you have not taken legal advice before, you need to do so now. There may also be difficulties in funding any challenge and so again, you will need good advice.

We have set below out some of the ways you can seek to address any problems, but each case is unique and you definitely need to seek advice.

If a coroner has refused to hold an inquest, can her/his decision be overruled?

Yes. It can be challenged by judicial review or by the Attorney General (see below).

What is a judicial review?

It is a complex legal procedure where a judge can review decisions made by the coroner and decide whether they are appropriate and/or correct. It is held in the High Court and the application generally has to be made within three months of the decision you are challenging and as quickly as possible.

Judicial reviews have been used successfully to challenge various coroners' decisions, such as failing to call relevant witnesses or not directing the jury properly.

Is there any appeal against the conclusion of a coroner?

Not directly. But it is possible that if the High Court accepts that there has been fraud, rejection of evidence, irregularity of proceedings, an insufficiency of inquiry or if it is in the interests of justice, a new inquest can be ordered and the previous inquest overturned. The exercise of this power depends on the court's view that it would be necessary and desirable in the interests of justice.

Who can make an application to overturn an inquest or to make a coroner hold an inquest?

Any interested person, including the family of the deceased and any organisation or individual involved with them immediately before their death. Again, this is a complex legal process and you should get specialist advice very quickly because of the time limits.

Can a conclusion be overturned or amended if it appears that the coroner made an error in the interpretation of the law?

Yes, by judicial review (see above). It should be undertaken by a person with sufficient interest, e.g. the family of the deceased or a person who might be charged with causing the death. The Attorney General could also make an application and satisfy the High Court that an error in the interpretation of the law was a reason to overturn a conclusion.

Can a conclusion be overturned or amended if new evidence is found that was not available at the original inquest?

Yes, by the Attorney General making an application to the High Court. But the length of time that has passed will be taken into account as to whether it is in the public interest to order a new inquest. Applying to the Attorney General is a process similar to a judicial review and you should discuss this with your solicitor.

If evidence comes to light sometime after a death that suggests a death was unnatural or the cause of death uncertain, can an inquest still be held?

Yes, if the coroner agrees that there are reasonable grounds. The death certificate will be amended if new evidence reveals at the inquest that the original cause of death was wrong.

Can a body be exhumed if new evidence comes to light that suggests an inquest is necessary?

Yes, but in practice this is extremely rare. The coroner must issue a signed warrant addressed to the persons in charge of the burial ground. The exhumation is carried out at night or early in the morning. A funeral director or a member of the family carries out identification of the body.

Will anyone be prosecuted after the inquest?

This is exceedingly uncommon, but it is possible. If a death is caused by a criminal act, there should be a police investigation and the Crown Prosecution Service (CPS) or another prosecuting authority will decide whether there is enough evidence to press charges. If this is going to happen, it usually does so before an inquest takes place. However, if evidence or information comes to light during the inquest which might form the basis of a criminal prosecution, the CPS can be asked to reconsider their decision. In practice, this is very rare.

Can I get a transcript of the inquest?

Yes. Coroners are required to keep recordings of inquest hearings and the recording of any inquest hearing held in public should be provided to any interested person. You may receive disclosure as a paper copy, electronically or both. The difficulty is often the cost, as some coroners only keep the recording copy and so you may have to pay for these to be transcribed by a typist, which can be very expensive.

Can I make a general complaint about an inquest or how the coroner behaved?

If your complaint is about the behaviour of a coroner or other staff at the court (but not about legal decisions or procedure) and you have not been able to sort it out with the coroner directly, you can raise your complaint with:

- The Judicial Conduct Investigations Office (judicialconduct.judiciary.gov.uk).
- The Ministry of Justice Coroners Section.
- The local authority that funds the coroner.

If it wasn't for INQUEST and their lawyers my family would have been totally unaware of the huge stumbling blocks we were to face with the whole process of losing a loved one in state custody.

Marci Rigg, sister of Sean Rigg who died in police custody

SECTION 5: Particular circumstances of death – what else do you need to know?

This section covers deaths that occur in particular circumstances. It should be read alongside the more general sections of the guide.

SECTION 5.1

Deaths in police custody or following police contact

This section gives you specific information about the investigation of deaths that occur in police custody or following police contact. You should read this section with the general sections in the guide.

What is a death in police custody or following police contact?

It is when someone dies during or following contact with the police in the course of arrest, on the street, in a police van, by police shooting, during police pursuit, in a police station and deaths in hospitals of those who had previously been in police custody. The definition of "immediately following contact" is quite limited, and you may need further advice if you think that contact with the police prior to someone's death should be taken into account.

Will there always be an inquest?

A death in police custody or immediately following police contact is always referred to the coroner for an inquest to be opened. An inquest will usually take place if there has been some other contact with the police immediately before the death. If you believe that a death should have been referred to a coroner but has not, then you should take advice or contact INQUEST and your local coroner's office.

If there is a criminal prosecution arising from the investigation of the death, the coroner will decide whether there needs to be an inquest after the criminal trial is over.

In the majority of deaths in these circumstances there will be an article 2 inquest (see Section 1). When someone dies in custody or following contact with police officers there should be a thorough investigation involving the family, which must look at what happened and whether there were any individual or systemic failings that contributed to or caused the death.

Should I contact INQUEST?

Yes, INQUEST is the only independent organisation that works with families following a death in police custody or following police contact and can provide advice and support throughout the whole process and with help in finding a solicitor who can assist you. INQUEST's specialist advice service and its associated policy work means that it can provide helpful background – for example information about other deaths in similar circumstances, relevant policies and practices on the care of detainees in police custody, inquest conclusions, etc.

Will there be a post-mortem?

Yes. It is usual practice that there is a post-mortem done almost immediately – usually within 24 to 48 hours. This will be carried out by a Home Office pathologist instructed by the coroner. Sometimes two pathologists will be present at the initial post-mortem – one for the Chief Constable of the police force involved (or in London, the Metropolitan Police Commissioner) and one for the coroner. The police officers involved may also have a representative at the post-mortem.

Because the post-mortem happens very quickly following a death, families are often unaware that it is taking place, or have not had the chance to take advice. If you have any concerns about the way someone died, you may need to think about whether a second post-mortem should be carried out (see Section 2). This is particularly important in cases following the use of force by police officers, e.g. use of restraint or firearms.

What if I am too late for a second post-mortem?

If it is not possible to hold a second post-mortem because the funeral has already taken place, it is still possible to get an independent pathologist to review and comment on the original post-mortem.

Should I contact a solicitor?

Yes – these are complex and difficult situations and you will need good advice. You should contact INQUEST, who will either work with your own solicitor to help if they have not dealt with a death in police custody before or put you in touch with a solicitor who has specialist experience. You will need to talk to the solicitor at the beginning about legal funding. Your solicitor should take a detailed statement from you about what you know about the circumstances of the death and your concerns. If you have not found a solicitor immediately, you should keep a note of all the information relevant to the death so that you can make a statement to your solicitor when you have one.

Will the Independent Police Complaints Commission (IPCC) be involved?

Yes. The IPCC (www.ipcc.gov.uk) is the public authority with responsibility for the investigation of deaths in this area. Where any death follows police contact and that contact may have caused or contributed to the death, the police are under a duty to refer the matter as soon as possible to the IPCC.

This includes:

- Fatal police shootings.
- Deaths in police custody.
- Deaths during contact with the police or immediately afterwards where a link between the contact and the death can be established.
- Road traffic deaths where there has been a police vehicle involved.

The IPCC may undertake an independent investigation itself, or it can manage a police investigation. Other investigations will be carried out by the police. If you are unhappy with the decision as to who investigates you can raise the matter directly with the IPCC or take legal advice.

In all cases there will be a named IPCC commissioner who has overall responsibility for the investigation. In an independent investigation the commissioner will appoint an IPCC investigator to carry out the investigation, supported by other IPCC staff.

What sort of an investigation will the IPCC conduct?

IPCC investigators should take evidence from people involved in the events leading up to the death. They should examine all relevant documentary evidence, for example custody records and medical records, as well as looking at any CCTV footage and examining other physical evidence. The evidence gathered during the course of this inquiry forms the basis of the investigator's report that then goes to the commissioner along with the documentary evidence. The commissioner is responsible for approving the report, which will then go to the coroner.

In a case where the IPCC is managing a police investigation, the IPCC retains overall responsibility for the investigation.

You can read about the work of the IPCC on their website here: www.ipcc.gov.uk/a_guide_to_the_work_of_the_ipcc-3.pdf.

Will family members give statements to the IPCC?

The IPCC may want to interview key family members or friends so that they can build up a picture of the person who has died to help them understand what happened. Families can often find this difficult and intrusive unless it is done with great sensitivity. If you are not sure why you are being asked for information, it is important that you ask the investigator to explain. It is a good idea for families to arrange to see the investigators with their solicitor, or to prepare a statement with their solicitor to give to the IPCC investigator. An INQUEST caseworker may be able to attend this meeting.

You can ask the IPCC to investigate particular aspects of the death, if they are not already doing so – which they may or may not agree to. This is where an experienced solicitor can help you in deciding whether there are other things you want the IPCC to do.

How long does the IPCC investigation take?

There is no set timescale for how long the investigation should take to complete – but you should expect it to take at least six months. The IPCC guidance states that the family should be told at the start how long it is likely to take and be given regular updates on its progress.

The investigation report may be sent to the Crown Prosecution Service (CPS). This will depend on the evidence and the IPCC's judgement. The CPS will then decide whether any criminal charges should be brought against anyone involved. Prosecutions are extremely rare. If the CPS decides not to prosecute, you are entitled to be given the reasons in writing. If you are not happy with the decision, you should take legal advice.

After the CPS has made a decision – and in all cases where the CPS hasn't been involved – the investigation report will be sent to the coroner. The very fact that an inquest is held means that it has already been decided that no-one is criminally responsible for the death, based on the information available, or that for other reasons a prosecution cannot go ahead. This can be reviewed after an inquest and will be reviewed if there is a conclusion of unlawful killing.

Following the death of my brother, the 'police family' closed ranks – I felt bereaved, overwhelmed and isolated. The support given to me by INQUEST and my solicitor gave me the confidence to fight and stay focused.

Michelle Chadwick, sister of Mark Camm who died following police contact

Are any other inquiries carried out?

If there is going to be an inquest, the coroner will then decide if more inquiries need to be made in addition to those carried out by the police. The coroner will already have the relevant documents from the IPCC investigation. You and your solicitor may also identify other people or evidence that you will want the inquest to consider, for example particular experts or policies. The coroner will then set a date for an inquest. This can be months or even years after the death occurred.

What information will I be given during the IPCC investigation?

In an independent investigation, a family liaison manager (FLM) will be assigned to you by the IPCC. Their job is to ensure good communication between you and the investigator. You should be given regular information about how the investigation is getting on, at least every 28 days.

You may also want to get the FLM to arrange one or more formal meetings with the IPCC commissioner and investigator to check on progress and raise your concerns.

Will I be able to find out the results of the IPCC investigation?

You will be able to ask for access to the evidence gathered during the investigation. The IPCC has a policy about disclosing information before an inquest, called "Making Information Available". You can find it on their website here: www.ipcc.gov.uk/making_information_available-2.pdf.

Disclosure of the report should happen as early as possible, but at least 28 days before the inquest. The IPCC should decide what evidence they are willing to disclose to you, but as a courtesy they will normally seek the agreement of the coroner. The IPCC may not agree to you seeing all the documents until they have completed their report, or not at all. This is something a solicitor working for you can advise you on further.

The IPCC can decide not to disclose information prior to the final report being completed if they believe to do so would cause harm. For example, this might happen if disciplinary action or criminal charges could be affected if something is disclosed too soon. If you were also a witness to the death and are going to give evidence, the IPCC may not be willing to disclose other information to you in advance. In practice the IPCC may not make full disclosure at an early stage. You and your solicitor will need to contact them to ensure that you receive relevant access to documents and other material such as CCTV footage.

Once it has been decided to go ahead with the inquest and all other procedures have been completed, you can ask to see the documents gathered during the investigation.

Disclosure can assist lawyers in preparing for the inquest and in ensuring that all relevant evidence is called. This is particularly important in contentious cases where use of experts may assist the jury in reaching conclusions – e.g. those involving police shooting or use of restraint.

Can I use these documents for campaigning or talking to the media before the inquest?

No. You are given the documents on a confidential basis and they can only be used for preparing for the inquest. If you are in contact with INQUEST, you can give your solicitor permission to share the report with your caseworker and it will be treated with the same rules of confidentiality that apply to you and your solicitor. It is important not to disclose anything publicly which could be seen to influence the conclusion at the inquest. If you are thinking about making a press statement it is wise to talk to your solicitor and INQUEST first.

Will any decision be made about disciplinary action against the police officers involved?

Once the investigation has taken place the IPCC will state whether they believe there has been a breach of the Police Code of Conduct and whether to recommend any disciplinary action against any of the officers involved. If the police force concerned does not agree, the IPCC has the power to enforce their recommendations. A decision may be made before the inquest or it may happen afterwards.

Who will be represented at the inquest?

This will vary depending on the circumstances of the death and in some cases there will be a lot of different lawyers representing different parties. Apart from the family of the deceased, the Chief Constable of the police force involved (or in London, the Metropolitan Police Commissioner) is usually legally represented. Very often individual police officers are also represented separately by lawyers paid for by the Police Federation. If a forensic medical examiner (police doctor) has been involved they may also be represented, and also ambulance and hospital staff if the deceased was taken to a hospital before death. If the deceased had previous medical or mental health history then the NHS Trust may also be represented.

If the IPCC has carried out an investigation or is investigating the death, the IPCC will be an interested person in the inquest and has a right to be represented at the inquest, for the purposes of section 47 of the Coroners and Justice Act 2009.

Is there any other action we can take after the inquest?

See Section 4: ***After the inquest***. You may also want to raise any concerns about what happened after you have heard all the evidence at the inquest.

You could consider contacting:

- The Home Office minister responsible for the police.
- Your MP.
- The media.

You can discuss these options with your legal representative and with INQUEST.

Who else might help?

INQUEST. Other family campaigns and/or support groups.

Addresses and telephone numbers are in Section 8.

SECTION 5.2

Deaths in prison

This section gives you specific information about the investigation of deaths that occur in prison. You should read this section with the general sections in the guide.

What happens if my relative dies in prison?

You will be informed of the death by the Prison Service through a phone call or a visit to your home by a member of prison staff or a police officer. If it is not the prison who has informed you, they should give you details of a contact person at the prison for you to speak to. The prison should tell you where the body has been taken and that the death has been reported to the coroner, the police and the Prisons and Probation Ombudsman (PPO). They should also have given you a copy of this guide.

Who should I contact at the prison to find out more information?

The prison should appoint a senior member of staff, known as a family liaison officer (FLO), to be the family's main point of contact in the prison. They should be able to explain what will happen and provide information about where to get further assistance. The named person should give you a factual account of the events leading up to the death and how your relative was discovered. You can find more information at www.gov.uk/government/organisations/hm-prison-service.

Will I be able to visit the prison and see where my relative died?

The prison should invite you to visit if you want to. You should be able to see the cell or other place where the person died. The prison may also arrange a memorial service in the prison which you can attend if you want.

How do I get my relative's property back?

The coroner or the police will decide whether any property needs to be kept for evidence. The prison should release any cash or property not needed as evidence when the coroner authorises them to do so. Most items can be released at an early stage and the prison should contact you to let you know when you can recover the deceased's belongings. Unfortunately, personal items such as letters or other writings are usually needed as evidence. This sometimes means that the person a letter was written to may not be given it until quite some time after the death. The coroner may use their discretion to release a copy of any such letter earlier on to try to reduce any distress this may cause.

Will the Prison Service help with funeral costs?

Yes. There is a Prison Service Order 2710 that states that prisons should offer to pay "reasonable" funeral expenses. If you or your partner receive benefits you may also be entitled to financial help – talk to your local JobCentre Plus advisor or go to the direct.gov.uk website. The prison may also offer to help with making the funeral arrangements and offer to attend the funeral if the family wish.

Will there always be an inquest?

Yes. The only exception is if there is also a criminal prosecution then the coroner might decide that a separate inquest is not necessary. A criminal trial will not look at wider issues about how the prison cared for the deceased, just who was directly responsible for their death and so it might still be important for there to be an inquest. You should probably seek advice from a solicitor about this. A death in prison is automatically referred to the coroner and to the Prisons and Probation Ombudsman (PPO) and the inquest will be held with a jury.

Should I contact INQUEST?

Yes, INQUEST is the only independent organisation that works with families following a death in prison and can provide advice and support throughout the whole process and with help in finding a solicitor who can assist you. We can help after any death in prison, whether it is self-inflicted or due to other non-natural causes such as restraint or homicide, or from natural causes where issues of care the deceased received in prison are raised.

INQUEST's specialist advice service and its associated policy work means it can provide helpful background – for example information about other deaths in similar circumstances, relevant policies and practices on the care of people in prison, inquest conclusions, etc.

Will there be a post-mortem?

Yes, and it is usual practice that there is a post-mortem done almost immediately. This will be conducted by a Home Office registered pathologist. If you have any concerns about the physical cause of the death you may need to think about whether a further post-mortem should be carried out (see Section 2 on post-mortems). This is particularly important where the death followed the use of restraint, or concern about medical care or treatment.

Should I contact a solicitor?

Yes. You should contact a solicitor who has experience of the law in relation to prisons and inquests as soon as possible. You should contact INQUEST, who will either work with your solicitor to help if she or he has not dealt with a death in prison before, or put you in touch with a solicitor experienced in prison deaths.

Your solicitor should take a detailed statement from you about what you know about the circumstances of the death. If you have not been able to find a solicitor immediately, you should take a note of all the relevant information about the circumstances to help you in making a statement to your solicitor when you have one. Your solicitor should then request copies of the relevant documents such as the PPO's report, and any records from the Treasury Solicitors who are responsible for legal preparation for inquests on behalf of the Prison Service.

What does the Prisons and Probation Ombudsman do?

The Prisons and Probation Ombudsman (www.ppo.gov.uk) has responsibility for investigating all deaths in prison, approved premises (formerly probation hostels), secure training centres, court cells and immigration and detention centres. The PPO is funded by the government, but is independent of all these agencies.

What investigations will take place?

At least two investigations take place, by the police and by the PPO. After someone has died in prison the police and the coroner will be informed and initial inquiries made. The police investigate every death in prison, both on behalf of the coroner and to assess whether there are any suspicious circumstances. If the police decide that there should be a criminal investigation this will happen before the PPO investigation. In these circumstances the police will appoint a family liaison officer to keep in contact with you.

What happens at the end of the police investigation?

The report and file will be passed to the Crown Prosecution Service (CPS) who will decide if criminal charges are to be brought, which is very rare. If it is decided not to prosecute anyone in relation to the death there will then be an inquest. The coroner will already have a copy of the report.

If the police do prosecute someone will there still be a PPO investigation?

Even if the police decide to charge someone with a criminal offence, there should still be an investigation by the PPO. This is because the PPO will look at whether or not the prison could have managed the situation better and whether future deaths can be prevented.

The coroner will also have to decide whether to hold an inquest. If the coroner decides that an inquest is not necessary, you should seek advice from INQUEST or your solicitor.

How does the PPO investigate a death in prison?

The PPO investigation is intended to establish the circumstances and events surrounding the death, particularly how the person who died was looked after while they were in custody.

The Secretary of State sets terms of reference for the PPO and this forms the basis of their investigation plan. The investigator will have access to all the prisoner's records, including medical records and any other documents they think are relevant. They will interview prison, healthcare and other staff and any prisoners who may have useful information.

The PPO will always get a clinical review of the person's medical care while in prison. This review is usually carried out by the primary care trust that provides medical services for the particular prison.

If the PPO finds out information which they think could lead to criminal charges, they can contact the police at any time.

You can read about how the PPO investigate deaths in prison on their website: www.ppo.gov.uk/investigations/investigating-fatal-incidents/how-we-investigate/.

What information will the PPO give me?

The PPO will appoint an investigator (sometimes a team of investigators) and a family liaison officer (FLO) to keep you informed of what is happening with the investigation. The FLO should contact you within 15 working days and usually after the funeral. They will be your link with the PPO during the investigation. You will be given the opportunity to meet the FLO and the investigator early on to tell them any concerns you have about what has happened. Your solicitor and/or INQUEST caseworker may be able to attend this meeting with you.

If you do not hear from the PPO within 15 days of the death, you should consider contacting them directly. When you contact them you should ask to speak to someone in the Fatal Incidents Team. The PPO contact details can be found in Section 8.

At the end of the investigation, the PPO will produce a draft report explaining their findings, including whether the prison's actions were appropriate and any recommendations to prevent deaths in the future. This draft report will be sent to the prison and family at the same time, unless advance disclosure to the prison is necessary. You are entitled to make comments and ask questions. If you have a solicitor they can help you to do this. You will be given eight weeks to respond to the draft report and then the PPO will send their report with any changes to you or your solicitor, as well as to the coroner and to the prison. If you need more time to consider the report you should contact your family liaison officer to let them know.

Who else will see the PPO report?

Before the inquest, anyone who the coroner has designated as an interested person (see Section 8: ***Definitions***) will be given a copy of the report. After the inquest a final version of the report is put on the PPO website

Can I use these documents for campaigning or talking to the media before the inquest?

No. You are given the documents on a confidential basis and they can only be used for preparing for the inquest. If you are in contact with INQUEST, you can give your solicitor permission to share the report with your caseworker and it will be treated with the same rules of confidentiality that apply to you and your solicitor. It is important not to disclose anything publicly which could be seen to influence the conclusion at the inquest. If you are thinking about making a press statement it is wise to talk to your solicitor and INQUEST first.

Who else will be represented at the inquest?

It is usually the case that the Prison Service is legally represented, and sometimes individual prison officers through their trade union, the Prison Officers Association. If a prison doctor or nurse has been involved they may also be represented separately through the local NHS Trust responsible for the delivery of prison health care.

After the inquest

See Section 4: ***After the inquest.***

In addition you may want to raise concerns with:

- HM Inspectorate of Prisons.
- The Parliamentary and Health Service Ombudsman.
- The Ministry of Justice's Equalities, Rights and Decency Group.
- The prisons minister at the Ministry of Justice.
- Your MP.
- The media.

You can discuss these options with your solicitor and INQUEST.

SECTION 5.3

Deaths involving poor medical treatment in hospital or in the community

This section gives you specific extra information about the investigation of deaths that occur in circumstances where the quality of medical care may be an issue – for example in hospital or following treatment by a GP. You should read this section with the general sections in the guide.

Will there always be an inquest?

If you think that your relative has died as a direct result of poor medical treatment – either a failure to provide treatment or the treatment was mismanaged – then you should report your concerns to the coroner. If the coroner suspects that the person died a violent or unnatural death or the cause of death is unknown, then they must investigate and establish the cause of death. The coroner should hold an inquest where there is reason to believe that negligent medical treatment may have caused the death. The inquest will normally be opened and then adjourned for further enquiries before the full inquest takes place. It can take several months or in some circumstances years for the inquest to take place.

Do I need specialist advice?

You may want to consider contacting Action against Medical Accidents (AvMA), a specialist organisation that runs a legal helpline which you can call for detailed advice when there is a question about medical treatment. They run a specialist referral panel of lawyers and can refer you to an expert solicitor in your location if appropriate. They also can advise you on other legal options and may be able to help in preparing for this sort of inquest through their inquest advice service. Solicitors will usually provide a free consultation to discuss a potential claim about medical negligence as well as whether inquest representation may be required.

AvMA's website is www.avma.org.uk and their helpline number is 0845 123 2352. AvMA have a specialist leaflet available on coroners and inquests, and you can download it here: www.avma.org.uk/help-advice/information-leaflets/.

What is medical or clinical negligence?

Words like negligence often have a different meaning in law than they do in everyday speech, and it is important to take advice on this. Clinical negligence is a legal term for a medical accident where a patient has not received care to a proper standard, and that substandard care has also caused the patient a physical injury.

It is important to understand that the law defines clinical negligence as the failure on the part of the doctor, or treating institution, to reach the accepted standard of medicine.

Will there be a post-mortem?

The coroner will arrange a post-mortem examination by a pathologist. If you are concerned about the accuracy of the post-mortem, you may want to consider instructing your own independent pathologist and a solicitor will be able to advise you about this (see Section 2 for more detailed information on post-mortems).

What needs to be done before a medical inquest?

As in all inquests, it is important to obtain as much information as possible before the hearing. It is vital that whoever is asking questions at the inquest is as well prepared as possible and has the specialist knowledge to understand and analyse the medical issues being examined.

What information can I have access to before the inquest?

As well as the disclosure you are entitled to as an interested person in all types of inquest, you are also entitled to copies of the deceased's medical notes and records under the Access to Health Records Act 1990. These are usually held by their GP and the treating institution. Once these records have been obtained a solicitor may instruct an independent medical expert to provide a report on any possible negligence. This can be of great assistance at the hearing itself. However, it is also open to your solicitor to request that the coroner instruct their own independent medical expert, which the coroner will pay for.

Should I find a solicitor?

If you think that the death of your relative may be due to poor medical treatment, and even if you are pursuing the complaints process, it is also advisable to contact a solicitor as early as possible. This will not halt the complaints process and will ensure that you get advice in good time for an inquest, if one is to be held. Many medical deaths are not subject to an inquest; or the inquest, if held, is very limited in the issues it investigates, in which case it might require some considerable work by the family and/or their legal advisor to convince the coroner of the need for holding a full inquest.

This is a specialist area of law and you need to find a solicitor who is a member of the Law Society's Clinical Negligence Accreditation Scheme and/or the AvMA referral panel and who has a legal aid franchise in the field (although legal aid is now only available for a limited number of claims involving clinical negligence), which are all indications of expertise in this area of law. It is particularly important to seek legal advice if you are worried that the coroner is not willing to take into account information that you think is important.

How can I help the solicitor?

It is important that you write down your own account of the facts surrounding the death. Whether you are represented legally or not, you can ask the coroner to call evidence which you believe is relevant to the cause of death. However, in the end it is the coroner's decision what evidence should be heard at the inquest.

What will happen at the inquest?

Have a good look at Section 4 which explains in more detail what happens. As already mentioned, it is important to understand that an inquest is not like hearings in other courts of law. The coroner is not allowed to decide any issues of civil or criminal liability on the part of a named individual. The inquest is purely a fact-finding exercise, which can be frustrating for families who may want to hear more detail than the coroner will allow.

What should I do if I think the death was due to clinical negligence?

If you believe that negligent medical treatment may have contributed to the death and you are unsatisfied with any explanation put forward by the medical staff concerned, you may wish to make a formal complaint against the hospital, health trust or others. Again it can often be of assistance to contact AvMA who will be able to advise on the complaints procedure, how to prepare a complaints letter and may also be able to advise on the medical issues.

If AvMA are unable to assist they will be able to direct you to other agencies such as the Independent Complaints and Advocacy Service (ICAS), whose contact details are in Section 8. ICAS can provide support for patients and their families who want to complain about NHS treatment by attending complaints meetings with patients and helping with correspondence with the doctor or hospital concerned. However, it is important to remember that the complaints process can sometimes take a considerable length of time and there is no obligation on a doctor or trust to respond to the complaint before an inquest, for example.

If I think there was clinical negligence involved in the death, will that be determined at the inquest?

No. The inquest is not the place to decide any kind of liability for the death. If you think there was medical or clinical negligence you need to obtain legal advice from lawyers with expertise in this area.

After the inquest

See Section 4: ***After the inquest***.

After the inquest you may not wish to be involved in any more legal procedures. If you think there are important lessons to be learned from the inquest that might help prevent other deaths, you could consider contacting AvMA or another relevant campaign and/or speaking to your MP.

An inquest is not like hearings in other courts of law. The coroner is not allowed to decide any issues of civil or criminal liability on the part of a named individual. The inquest is purely a fact-finding exercise, which can be frustrating for families who may want to hear more detail than the coroner will allow.

SECTION 5.4

Deaths in mental health settings

This section provides you with specific extra information about the investigation of deaths of patients in mental health settings, who are either detained under the Mental Health Act 1983, informal patients admitted to hospital, or community patients living independently or semi-independently in the community. You should read this section with the general sections in the guide.

Will there always be an inquest when someone dies whilst detained under the Mental Health Act?

Yes. Detention under the Mental Health Act is considered to amount to state detention for the purposes of the Coroners and Justice Act 2009.

The position is different if the patient was an informal patient or a community patient (see below).

Will the inquest be held with a jury?

The coroner must sit with a jury if the deceased died in state detention and he or she suspects that the death was violent or unnatural, or that the cause of death is unknown.

If the death was not violent or unnatural and the cause of death is known, the coroner has discretion as to whether to hold the inquest with a jury.

What if the deceased person was a community psychiatric patient?

If your relative was under the care of a Community Mental Health Team when he or she died, or was an informal patient in hospital, there may be an inquest. You should find out if there is to be an investigation by the coroner within a few days of the death. If there is no inquest and this is something that you are worried about, you should contact INQUEST or an experienced solicitor for advice.

Should I contact INQUEST or any other organisation?

Yes, you can contact INQUEST for specialist advice about the inquest process. It may also be helpful to contact the mental health organisations Mind or Rethink listed in Section 8 of this guide.

Will there be a post-mortem?

Usually and if so, it is normal practice that this is carried out immediately, although the final post-mortem report sometimes takes a while to be produced. The pathologist will normally produce an interim post-mortem report shortly after the death following his or her examination, but this will not usually contain the results of toxicology and histology testing if this has been done, and it is therefore incomplete. Toxicology testing is explained in further detail below. Histology is testing tissue samples to understand whether the person who died suffered from any diseases. These tests take more time, and there is sometimes a wait of several weeks before the final post-mortem report is disclosed to the family.

If you have any concerns about the way in which a person died, then you may wish to be represented at the post-mortem itself, or consider obtaining a second post-mortem (see Section 2 for more detailed information about post-mortems). This can often be important in cases involving restraint or the use of force.

What are toxicology tests?

A toxicology report is a report completed when a person's blood and urine has been tested for the presence of recreational and prescription drugs (including alcohol). These tests are normally carried out by a specialist toxicologist, but are then taken into account in the final post-mortem report when the pathologist gives a cause of death. Toxicology testing can be particularly important in deaths in mental health settings, especially if there are concerns about whether a person's medication played a part in their death.

It is often the case that toxicologists are not asked to test for specific prescription drugs. Therefore, if you are concerned and the cause of death is not immediately apparent, you may wish to ask the coroner to ensure that the toxicologist tests for the specific drugs that the deceased was being prescribed at the time of his or her death.

Blood and urine samples are needed to carry out toxicology tests. These samples can often be destroyed shortly after death, so if this is something you are worried about, you may need to ask the coroner as soon as possible to ensure that the samples are kept so that you can seek advice and possibly get a second opinion.

Should I contact a solicitor?

Yes. You should contact INQUEST, who will either work with your own solicitor or put you in touch with a solicitor in your area who has relevant expertise.

Your solicitor should take a detailed statement from you about what you know about the circumstances of the death. If you do not have a solicitor it is a good idea to write down what you remember as soon as possible so that this can be used as part of the inquest.

Your solicitor should request a copy of the medical records from the Mental Health Trust and make contact with the trust to find out whether an internal investigation will take place and to ensure that you can be involved if you want to be.

Will the hospital trust do its own investigation?

Yes. If a person dies whilst an inpatient under the care of a Mental Health Trust or is a detained patient on extended leave, that trust should carry out an internal investigation into the death in order to find out what happened and if lessons can be learned. These investigations are often called Serious Untoward Incident Investigations or Critical Incident Reviews, but they vary a lot from trust to trust.

Internal investigations for non-detained patients, both those in hospital and in the community, will vary depending on the circumstances of the death. If the person who died was detained under the Mental Health Act, a trust will tend to investigate in more depth and more thoroughly than following the death of a non-detained patient.

In order to be effective, an investigation into the death of a detained patient should be carried out reasonably speedily, with the involvement of the family and with an appropriate level of independence. The hospital trust should normally arrange to meet the family during the investigation in order to identify any concerns that the family has and to explain the investigation process.

How long does the investigation take?

Each trust should have a policy explaining how it investigates the death of patients under their care, how long the process should take and what steps are involved. You have the right to see a copy of this policy, which varies from trust to trust.

What information will I be given during the investigation?

You should receive updates regarding the progress of the investigation from time to time. Once the investigation is complete, you should receive a copy of the investigation report along with any recommendations which have been made. Sometimes trusts will not finalise a report until the coroner's investigation is complete, if an inquest is to be held.

If you are not informed by the hospital trust that they will be undertaking an investigation, you should contact them to find out what steps they are taking. If you are not happy with the trust's investigation or the report, you may wish to take further action and should contact INQUEST or a specialist solicitor.

Can I use documents from the trust investigation for campaigning or talking to the media before the inquest?

This is something that you should discuss with your solicitor or INQUEST before talking to the media. You or your solicitor may have signed an undertaking of confidentiality, which means that only you, your family and legal advisors can see the documents and they can only be used for preparing for the inquest.

What are the outcomes of the trust investigations?

Trust investigation reports will sometimes include recommendations which can cover a wide range of issues. The purpose of these investigations is to learn lessons for the future and improve unsafe practices within the relevant trust. As such, recommendations can include reviews of policy, training for staff, changes in practices and procedures and even disciplinary action against members of staff.

Usually the trust will review the report and the evidence heard on the conclusion of the inquest and consider if any further action should be taken.

Who will be represented at the inquest?

The family of a psychiatric patient have the right to be represented at the inquest, as with all inquests. In addition, the hospital trust itself is usually legally represented. Sometimes more than one trust will be involved in the provision of care, and so it is possible to have more than one trust represented at the inquest. Sometimes individual members of staff from the hospital trust will have separate legal representation as well.

Can I get funding for legal representation at the inquest?

It may be possible to obtain legal aid for preparation for and representation at the inquest. The funding system for inquests is unique and complex (see Section 3).

After the inquest

See Section 4: ***After the inquest***. After the inquest, there may be a number of matters which you may wish to consider:

- If you have concerns about the care and treatment that the deceased received and/or the trust's own internal investigation, you may wish to make a formal complaint to the trust regarding this. The trust will have a duty to investigate your complaint and respond to the matters that you raise. If you are unsatisfied with the outcome of that complaint, you may be able to refer it to the Parliamentary and Health Service Ombudsman.
- You may also wish to bring your concerns to the attention of the Care Quality Commission (CQC), which is the independent regulator of health and social care in England and Wales. In particular, the CQC protects the rights of people detained under the Mental Health Act and keeps a record of people who have died whilst detained.
- If you are concerned about the actions of a particular clinician, such as a doctor or a nurse, you may wish to consider making a referral to the body that regulates them such as the General Medical Council (for doctors) and the Nursing and Midwifery Council (for nurses).
- You may wish to seek advice on whether you have a civil claim arising out of the death of your relative.
- You may wish to contact your MP and/or the media.

You can discuss these options with your solicitor and INQUEST.

If INQUEST hadn't got involved, I don't know what would have happened. I am so grateful for your continuing involvement because that really does make such a difference and allows me to feel reassured. Thank you so much for continuing to help.

Jane Evans, mother of Sara Green who was in psychiatric care at the time of her death

SECTION 5.5

Deaths of patients who lack mental capacity

The Mental Health Act 1983 provides for the detention in hospital for the treatment of those suffering from a mental disorder. See Section 5: ***Deaths in mental health settings*** in this guide for extra information relating to such deaths, both in hospital and in the community.

This section provides you with specific extra information about the investigation of deaths of adults who are deprived of their liberty under the Mental Capacity Act 2005 (MCA 2005). You should read this section together with the general sections in the guide.

Deaths of adults deprived of their liberty

As an alternative to the Mental Health Act 1983, an adult with a mental disorder can be deprived of their liberty, usually in a care home or a hospital. Following a significant case in 2014,[3] a person who lacks mental capacity is considered to be deprived of their liberty if he or she is subject to continuous supervision and control and is not free to leave the place that he or she is living.

If a person is deprived of their liberty, this can be authorised either under the Deprivation of Liberty Safeguards (DoLS) regime or by an order of the court (either the Court of Protection or High Court).

What are Deprivation of Liberty Safeguards (DoLS)?

Under the Mental Capacity Act, if a person who lacks capacity is in a hospital or a care home to receive care and/or treatment and is deprived of their liberty then that deprivation of liberty should be authorised under the DoLS regime.

The DoLS scheme provides authorisation for the deprivation of someone's liberty in certain circumstances, without requiring an application to court. The scheme provides that a local authority (which in this context is referred to as the supervisory body) can authorise the deprivation of liberty if the necessary requirements are met. This is known as a Standard Authorisation. It is also possible for an Urgent Authorisation to be granted. This is granted by the care home or hospital itself and will usually last up to seven days only.

The DoLS scheme is only available in hospitals or care homes. For further information about the six requirements for authorisation of a deprivation of liberty under DoLS and more information generally, it may be helpful to contact relevant organisations such as Mind who produce factsheets regarding this. See www.mind.org.uk/information-support/legal-rights/mental-capacity-act-2005/deprivation-of-liberty/#three

[3] *P v Cheshire West and P and Q v Surrey County Council* [2014] UKSC 19.

Order made by the court

Where the DOLS regime cannot be used (for example, if a person is living in supported living accommodation or sheltered housing) an application can be made to court for an order authorising the deprivation of liberty. Such an order is usually made by the Court of Protection, but in very exceptional cases it can be made by the High Court.

Will there always be an inquest when someone dies whilst deprived of their liberty under the MCA 2005?

A coroner must investigate a person's death if they died while in custody or otherwise in state detention under the Coroners and Justice Act 2009. The Chief Coroner's Guidance[4] confirms that the death of someone deprived of their liberty under the DoLS regime should be the subject of a coroner's investigation and inquest because that person was in "state detention". It is likely that this will also be the case if a person was deprived of their liberty under a court order.

Will the inquest be held with a jury?

The coroner must sit with a jury if the deceased died in state detention and the coroner suspects that the death was violent or unnatural or the cause of death is unknown. If the death does not fall into any of these categories (in which case it is likely to be described as "natural causes"), the coroner has discretion as to whether to call a jury.

Who will notify the coroner of the death?

The state of the law is such that it is not clear who is responsible for notifying a coroner of the death of someone subject to a DoLS or for authorising a court order. If you are not sure whether the relevant coroner has been notified of the death of your friend or family member, you should try to speak to the doctor responsible for their care at the time of the death to check this, or you can contact INQUEST who will be able to point you in the right direction.

Should I contact INQUEST or any other organisation?

Yes, you can contact INQUEST for specialist advice about the inquest process.
It may also be helpful to contact the organisations listed in Section 8 of this guide.

Will there be a post-mortem?

Usually and if so, it is normal practice that this is carried out immediately, although the final post-mortem report sometimes takes a while to be produced. The pathologist will normally produce an interim post-mortem shortly after the death following his or her examination, but this will not usually contain the results of toxicology and histology testing if this has been done, and it is therefore incomplete. Toxicology testing is explained in further detail below. Histology is testing tissue samples to understand whether the person who died suffered from any diseases. These tests take more time, and there is sometimes a wait of several weeks before the final post-mortem report is disclosed to the family.

[4] Guidance number 16 'Deprivation of Liberty Safeguards (DoLS)', 5 December 2014.

If you have any concerns about the way in which a person died, then you may wish to be represented at the post-mortem itself, or consider obtaining a second post-mortem (see Section 2 for more detailed information about post-mortems). This can often be important in cases involving restraint or the use of force.

What are toxicology tests?

A toxicology report is a report completed when a person's blood and urine has been tested for the presence of recreational and prescription drugs (including alcohol). These tests are normally carried out by a specialist toxicologist, but are then taken into account in the final post-mortem report when the pathologist gives a cause of death. Toxicology testing can be particularly important in the deaths of patients who lack capacity, especially if there are concerns about whether a person's medication played a part in their death.

It is often the case that toxicologists are not asked to test for specific prescription drugs. Therefore, if you are concerned and the cause of death is not immediately apparent, you may wish to ask the coroner to ensure that the toxicologist tests for the specific drugs that the deceased was being prescribed at the time of his or her death.

Blood and urine samples are needed to carry out toxicology tests. These samples can often be destroyed shortly after death, so if this is something you are worried about, you may need to ask the coroner as soon as possible to ensure that the samples are kept so that you can seek advice and possibly get a second opinion.

Should I contact a solicitor?

Yes. You should contact INQUEST who will either work with your own solicitor or put you in touch with a solicitor in your area who has relevant expertise.

Your solicitor should take a detailed statement from you about what you know about the circumstances of the death. If you do not have a solicitor it is a good idea to write down what you remember as soon as possible so that this can be used as part of the inquest.

Your solicitor should request a copy of the medical records from the hospital or care home and make contact with the place where your loved one was living to find out whether an internal investigation will take place and to ensure that you can be involved if you want to be.

Will there be any other investigation?

If a person dies whilst subject to a DoLS and they are under the care of a NHS Trust, that trust should carry out an internal investigation into the death in order to find out what happened and if lessons can be learned. There is further information regarding such investigations in Section 5: ***Deaths in mental health settings***.

If the deceased is a resident in a care home or in other accommodation such as supported living or sheltered housing, there may be an internal investigation in line with each organisation's internal policies.

The depth of internal investigations will vary depending on the circumstances of the death. In order to be effective, an investigation should be carried out reasonably speedily, with the involvement of the family and with an appropriate level of independence.

Who will be represented at the inquest?

The family of a person who died whilst subject to a DoLS authorisation or authorising court order have the right to be represented at the inquest, as with all inquests. In addition, the organisation providing care to your loved one at the time of their death, such as the hospital or the care home, is usually legally represented. Sometimes more than one organisation will be involved in the provision of care, for example the local authority, a hospital trust or a private care agency, and so it is possible to have more than one such organisation represented at the inquest. Sometimes individual members of staff will have separate legal representation as well.

Can I get funding for legal representation at inquests?

It may be possible to obtain legal aid for preparation for and representation at the inquest. The funding system for inquests is unique and complex (see Section 3).

If there was no DoLS authorisation in place and no court order, how do I know whether this section of the guide might apply?

If your friend or relative was someone who you believe did not have capacity to decide where they should live or on the care that they were being given, and you consider that they were deprived of their liberty but that had not been authorised under the Mental Capacity Act 2005, whether or not there will be an investigation by the coroner will depend on the circumstances of the death. If there is no investigation by the coroner and this is something that you are worried about, you should contact INQUEST or an experienced solicitor for advice.

After the inquest

See Section 4: ***After the inquest***.

After the inquest, there may be a number of matters which you may wish to consider:

- If you have concerns about the care and treatment that the deceased received, you may wish to make a formal complaint to the NHS Trust or organisation responsible for their care. If you are unsatisfied by the response to your complaint, you may wish to pursue the matter with the relevant ombudsman.
- You may also wish to bring your concerns to the attention of the Care Quality Commission (CQC), which is the independent regulator of health and social care in England and Wales. The CQC inspect care providers and accept information from the public which can be useful to their work.
- You may wish to seek advice on whether you have a civil claim arising out of the death of your relative.
- You may wish to contact your MP and/or the media.

You can discuss these options with your solicitor and INQUEST.

SECTION 5.6

Work-related deaths

This section gives you specific information about the investigation of deaths that occur at work or that are related to the workplace. You should read this section with the general sections in the guide.

What is a work-related death?

A work-related death is defined by the Health and Safety Executive (HSE) as "a fatality resulting from an incident arising out of or in connection with work." It covers:

- The death of a worker during the course of his or her employment.
- The death of a member of the public arising from work activities.
- The death of a member of the public in an incident like a train crash.
- Some work-related road deaths which require an investigation into a company's working practices, such as a lorry driver working excessive hours.

The common feature of all these deaths, whether they involve a worker or a member of the public, is that they raise questions about whether the working practices of a company or organisation were adequate or not.

Will there be an inquest?

You would normally expect an inquest to take place following a work-related death. An inquest is required when a death is "unnatural", which is likely to be the case in most work-related deaths. All inquests concerning a work-related death are held with a jury.

Who investigates work related deaths?

All work-related deaths will be reported to one of a number of regulatory bodies, depending on where the incident took place and the circumstances surrounding the death:

- The Health and Safety Executive (HSE) and local authorities which are responsible for the investigation and prosecution of health and safety offences.
- The Maritime and Coastguard Agency (MCA), which is responsible for the investigation and prosecution of offences when the death takes place in British waters or on a UK-registered ship.
- The fire authorities, which are responsible for the investigation and prosecution of fire safety offences when the death is a result of a fire.
- The police, who will investigate whether or not the death was the result of manslaughter by a company or an individual.
- The Crown Prosecution Service (CPS), which is responsible for deciding whether any individual or company should be prosecuted for the offence of manslaughter.

The purpose of these investigations are:

- To make sure that there are no continuing risks and to make the situation safe.
- To undertake a criminal investigation.

Should I obtain legal advice?

If you have any concerns about the investigation or the inquest, or if you want to consider making a claim for compensation, you should take further advice, including legal advice. You may find that a solicitor is only interested in issues relating to compensation, whilst you are concerned about issues of accountability.

Compensation (also called damages) is one important way of establishing accountability if an employer has been negligent. Unfortunately, since the employers' insurance will probably pay for the compensation, many families do not feel this is an adequate way to hold them to account. That is why it is important to ensure that there is a good investigation by the police and the regulatory agencies, and that proper consideration is given to whether the company and/or an individual should be prosecuted.

Can a trade union help?

If the bereaved person was a member of a trade union, the union may provide you with free legal representation at the inquest and help you in any claim for compensation. The trade union may be able to take further action, particularly in relation to any safety issues for the company involved.

Can anyone be prosecuted if mistakes have been made?

Work-related deaths often lead to questions about the practices and safety standards of an employer and there may be grounds for criminal charges.

There are two sorts of offences that could have been committed in relation to a work related death:

- An offence under regulatory law like the Health and Safety at Work Act etc 1974, requiring evidence of systemic failures in working practices.
- An offence of manslaughter, which requires evidence of gross negligence.

The criminal investigation

Work Related Deaths: A Protocol for Liaison was established in April 1998 encouraging the importance of the investigatory bodies working together to investigate thoroughly, and to prosecute appropriately, those responsible for work-related deaths in England and Wales. The protocol can be obtained from the HSE and is available on the HSE website at www.hse.gov.uk/pubns/wrdp1.pdf.

In every case a police officer of supervisory rank (sergeant or above) should come to the scene of the death and undertake an initial assessment of whether a full-scale manslaughter investigation should take place.

If the officer decides against it, the case is referred to the HSE or one of the regulatory bodies noted above. The investigating body can refer the case back to the police at any time during the course of the investigation if there is "evidence that indicates that manslaughter may have been committed".

The investigation: what should you expect?

This can take several months to complete. During this time the police and the HSE will conduct interviews with key witnesses, instruct experts, analyse evidence collected on site, look into the working practices and/or activities which caused the fatality, keep the coroner updated with the progress of the investigation and investigate the conduct of senior managers and company directors with particular responsibility for the day-to-day running of the organisation.

The HSE should appoint a named person or a family liaison officer (FLO) to keep you informed of developments during the investigation. If you have any concerns with the investigation, raise these with your FLO or the named contact you have from the HSE.

You can read more about how the HSE investigate work-related deaths here: www.hse.gov.uk/pubns/wrdp2.pdf.

What will happen at the inquest?

If a manslaughter investigation is taking place, a full inquest will be delayed until after a criminal trial. It is then up to the coroner to decide after the trial whether there will also be an inquest. It is extremely unusual for there to be an inquest after a criminal trial.

If there is no manslaughter investigation, and only the HSE is investigating, the inquest will take place before the HSE decides whether or not to prosecute. This is likely to be about 12-18 months after the death.

It is important that you ensure the coroner knows what witnesses you want to be called to the inquest. You or your legal representative should write to the coroner listing the witnesses you want to attend. It is not uncommon for coroners to decide not to call company directors or managers. This often means that crucial evidence indicating failures on the part of the company may not be heard at the inquest. This can then mean that a jury is prevented from giving an unlawful killing conclusion even when this might seem appropriate.

Can I see the documents created during the investigation?

Unlike inquests into deaths in prison and in police custody, the regulatory authorities like the HSE refuse to hand over any documents before the inquest.[5] If copies are given to the coroner, any interested person can seek disclosure of the documents. The coroner will disclose them if he or she considers them relevant to the inquest, unless the author of the report refuses permission for disclosure. Even if the HSE report isn't disclosed to you, it is likely that the investigating officer will be called to give evidence as part of the inquest to set out their findings.

What conclusions can the inquest reach?

Although the coroner may leave to the jury any of the conclusions for a work-related death, the most relevant conclusions, if the evidence supports it, are:

- Unlawful killing – where a worker died as a result of conduct on the part of some individual considered to be "grossly negligent".
- Accidental death – this covers a large range of situations, from a mishap to a death caused by conduct which would be considered to be negligent, but is not so negligent that a conclusion of unlawful killing is appropriate. It may be followed by a written narrative identifying any systemic failures in working practices which may have come to light during the inquest.
- Open conclusion – when the evidence given does not disclose enough about how someone died, for instance if there was no eyewitness, so there is not enough evidence to return another conclusion.

Can the HSE prosecute after the inquest?

Yes. The HSE will decide after the inquest whether to prosecute for health and safety offences. It only prosecutes companies in about 20% of workplace deaths. 70% of these prosecutions take place in the magistrate's court rather than the crown court, where there would be the possibility of an unlimited fine. The failure to prosecute in the crown court has meant that the average fine for a conviction following a workplace death is just over £18,000.

The HSE very rarely prosecutes senior managers or directors. Between 1996 and 1998, the HSE did not prosecute a single manager or director relating to any one of over 500 workplace deaths. It is therefore important to make sure that you or your legal representative looks carefully at the decisions made by the HSE.

In particular:

- Make sure that they have considered properly whether to prosecute a company director or manager.
- Make sure that, if they prosecute, they make attempts to get the magistrate to refer the case to the crown court.

In the event that the HSE decide not to prosecute, make sure you scrutinise the decision – ask for detailed reasons why they are not going to prosecute the company and/or senior manager(s) or directors. You may prefer to meet the HSE to raise your concerns about the decision as well as writing to them.

[5] Rule 15 of the Coroner's (Inquest) Rules 2013.

What information will I get from the HSE?

The HSE has a policy of providing information to bereaved families once the case has been formally closed. At the beginning of every case, a HSE inspector should make contact with you both by letter and personally. It is also the HSE's policy to explain their involvement, give details of the investigation, its conclusions, including the circumstances of the death, and to explain what action is to be taken and the reasons for such actions.

Make sure that you make use of this right to be kept informed by the HSE of what they are doing. Don't feel shy of making your views known to them or providing them with any information that you feel might help their investigation. It is our experience that often families have information that is not known by the HSE.

After the inquest

See Section 4: ***After the inquest***.

You may also want to raise any concerns about what happened after you have heard all the evidence at the inquest.

You could consider contacting:
- Your MP.
- The media.
- Other relevant campaigns and organisations.

Addresses and telephone numbers are in Section 8.

At the beginning of every case, a Health and Safety Executive inspector should make contact with you both by letter and personally.

NOTES

SECTION 6: Coping with a death and an inquest

Dealing with the sudden death of someone close to you as well as an inquest is a particularly difficult experience. Feelings of grief are often made worse by having to deal with the legal issues surrounding the death and the inquest.

The death of someone close affects people at every level: thoughts, feelings, physical health, thoughts and feelings about others and their responses. Grieving is the expression of feelings about the death and loss. Grief is often interrupted by the inquest and held back until it is over; or the inquest itself can cause extra pain and anguish to deal with.

This section of the guide describes what it may feel like after a sudden death, the way the inquest may affect you and how you can get help.

Grieving

How people grieve depends a lot on four things:

- The sort of person they are.
- Their relationship with the person who died.
- The circumstances of the death.
- The support they receive after the death.

The kind of person you are

Bereavement involves all aspects of yourself: your personality, your beliefs, your thoughts and feelings about yourself and others – the sum of your experience of life. Previous experiences of other losses, however big or small, will also affect how you grieve.

Your relationship with the person who died

This depends partly on who that person was: maybe your child, friend or partner. For example, you are likely to feel protective towards a son or daughter, even when they have grown up, while you might expect a parent or older friend to be a support to you.

Your feelings will also depend on the kind of relationship you had with the person. It is very common to have mixed feelings about the people you are close to. Relationships change as the years pass by and you go through different experiences, both good and bad. If your relationship was basically loving and secure, you will probably feel that the death is a loss without measure. However, the positive nature of your relationship with the person who has died is likely to be one of the strengths that will help you to keep going.

Many people have more complicated relationships with their family members – there may have been unspoken anger or hurt between you, there may be feelings of regret or guilt about the relationship and what you or they could have done – and you are then likely to have very mixed emotions after the death. There may also be different experiences of grief among different family members that can lead to divisions and disputes.

The circumstances of the death

For many people reading this guide the circumstances of the death will be one of the most important factors in their grief. It is obvious that you are affected by how, when and where the person died. For example, you are likely to feel very different about an elderly parent dying gently but unexpectedly while dozing in a favourite chair than the way you might feel if they collapsed when out on their own, or were killed by a car while crossing the road. You are also likely to feel very different about the death of an elderly parent than about the death of a son or daughter who you thought would live longer than you. This can be one of the most painful experiences for many of the families we work with.

If the death was as a result of what you believe was carelessness, negligence, violence or an accident caused by themselves or someone else, this will also affect you very strongly. This sort of death also tends to make people question the value of life and the way we think the world ought to be. It will also be very difficult if the person died in custody or in hospital while you thought they were in the care of other people. If someone's loved one dies in custody they can also feel shame and embarrassment about where they died and overwhelmed if the media say things about the person that are not true or does not present the whole picture of who they were.

Your relative or friend will have been many things in life other than someone who died in prison or in police custody. This can also be true for people whose relative has died in other controversial circumstances and is something that can cause great anxiety and fear before the inquest. At the inquest, many things might be said about your family or the person who died which sometimes paint a one-sided picture of who they were and you may feel very upset by this.

INQUEST were a lifeline for us, we wouldn't be where we are now if it wasn't for your help, when something like this happens you don't know which way to turn for help.

Sandra Whitehead, mother of Gemma Whitehead who was in psychiatric care at the time of her death

Support

Everyone needs support after the death of someone close. Support can come from family, friends, religious or community groups and people with experience of bereavement. Some people find it helpful to read books and leaflets on coping with death which may be available from your local library, health centre or the organisations listed below:

- Cruse Bereavement Care
- The Compassionate Friends
- Survivors of Bereavement by Suicide

Details of these organisations and how to contact them can be found in Section 8 at the back of this guide.

If you experience severe and ongoing symptoms you should go to your GP who may be able to refer you to a counsellor or offer you other help.

There are some very helpful websites which give information and support on bereavement, including www.healthtalk.org.

What is grief?

There are some common aspects of grief which people experience, including thoughts and feelings, psychological and physical reactions, and some of the social and practical consequences of dealing with the death of someone close.

There are well-known reactions to a death which most people will experience:

- Shock
- Searching and denial
- Sadness and despair
- Anger
- Guilt
- Anxiety, fear and panic attacks
- Loss of confidence and feeling powerless
- Poor physical health
- Loss of hope for the future
- Isolation
- Depression

In your grief you may feel some or all of these in this order, or in a muddle. You will probably find you go through these feelings and experiences – as well as others which are not described – again and again. You may experience the strongest emotion you have ever known, and feel you will never get through it all and think that the pain will never end. You may experience things about yourself and others which you have never experienced before or did not expect.

What usually happens is that as time goes by the feelings are less acutely painful and there will be longer periods during which you can get on with life fairly well – but the experience will always be with you. How long it takes to get on with life depends on who you are and your individual circumstances. If you are at all worried about how you are getting on or are worried about someone else, do talk to one of the people or organisations listed in Section 8 of this guide.

The effect of an inquest

An inquest will be an additional stress for people on top of the loss of someone they love. Waiting for an inquest can put the grieving process on hold and the many official procedures are likely to upset you in many ways, creating extra difficulties to cope with.

Ensuring that the inquest answers as many of your questions as possible can help in the grieving process. We hope that this guide will give you some information that will help.

Many bereaved people that we have worked with have described feeling some of the following:

- It can be difficult to accept the death if, for example, you do not view the body; if there is a delay before you are told the cause of death because of the length of time it takes to get post-mortem reports and other medical tests completed as well as holding the inquest; if there is a delay in releasing the body for the funeral because of a post-mortem.
- Evidence presented at the inquest or reports in the media (see Section 7) reawaken feelings that you thought you had overcome.
- You feel that everyone else – the coroner, the police, the doctors, the prison officers or anyone else involved in the death – knows more about what happened than you.
- You feel the body has been taken over by the post-mortem process and that you are the last person to be considered in all these official procedures.
- Grieving can be delayed, held up at certain stages or blocked altogether if your emotional energy is focused on someone or something other than your loss. This often happens if you feel upset or angry about some aspect of a post-mortem or inquest. For example, there may be long delays in medical or legal procedures, or you are not told about the procedures and what part you can play in them:

- The cause of death given as a result of a post-mortem is not the same as your view of the cause of death.
- The inquest leaves you with more questions than answers about how someone died.
- The inquest does not establish what caused the death.
- The inquest conclusion does not reflect what you thought had happened after you had heard all the evidence.
- The inquest is held weeks, months or years after the death.
- The inquest returns a conclusion of unlawful killing and yet no one is brought to trial.
- Someone is charged with an offence relating to the death, but it is months or even years before they come to trial.
- The person charged is found to be responsible, but in your view is given an inadequate sentence.
- The charges are dropped or are lesser than you think they should be.
- You see the person(s) you believe to be responsible at the inquest.
- You are upset by statements made about the person who has died because they do not reflect the true picture of who they were.
- You are distressed by the way the death or inquest is reported in the media.
- You are distressed by the way the media deal with you, your family or your friends.

For some people getting involved in campaigns or trying to stop things like this happening to others can be a help. Other people prefer to keep their grief private. Getting in contact with others who have been through a similar experience can be an immense support and helping others through a similar experience can help you in turn. There may well come a time when you feel that you want to move on with your life.

INQUEST have provided huge support since we lost our son James in 2010, not least through an opportunity to meet other bereaved families.

Tony Herbert, father of James Herbert who died in police custody

SECTION 7: Can campaigning help?

Sometimes people find it helpful to get involved in a campaign about the circumstances of their relative's death. Some people find it helps them to help others going through the same experience. Others want to campaign for changes to prevent similar deaths happening in the future. Some of the most powerful voices for change are those of the people most directly affected by a death.

It is important that you feel comfortable with whatever you decide to do, and that you don't feel under pressure to do anything you don't want to. Not everyone wants to be involved in a campaign or to be in the public eye. It might instead be a comfort to know that INQUEST or other organisations will raise the issues arising out of the death or your experiences of the inquest system more generally on your behalf.

Campaigning can mean meeting with your MP and/or local councillor, talking to the media or taking more direct action. INQUEST does not run individual campaigns for families, but can give support and advice to families who do. Casework informs our policy, research and campaigning work and the organisation tries to ensure that the collective experiences of families are central to its work for changes to the inquest and investigation process and for greater state and corporate accountability. INQUEST supports families to present their cases directly to parliamentarians and policy makers.

INQUEST's website has a page for family campaigns as well as other information about some of the more general campaigns that INQUEST is involved in. You may be able to find information on the website that will help you in what you are doing or link you to these other campaigns. There are also details of some of these campaigns in Section 8 at the back of this guide.

What should I do if I want to campaign about my relative's death?

There are many ways to campaign. It is always sensible to talk to your lawyer, particularly if you want to take any action before the inquest. You must be careful not to make allegations about the circumstances of the death or about anyone involved with the death that others involved might disagree with before the inquest. You should be careful about giving out personal information about your relative during a campaign. Any of these things could have a negative effect on what happens at the inquest or in any other legal proceedings.

Some family campaigns have set up their own websites or use other facilities on the internet. You could look at how they have done this (some family campaigns are listed in Section 8) and consider setting up your own. It is also a good way of making contact with people who might be willing to support you or who have had similar experiences.

Can I speak to the press before, during or after the inquest?

Yes, but be careful about what you say and when you say it. For many families it can help to speak to the media about the death, but you must be aware that they will not always be sensitive or sympathetic, and they may not understand your concerns or even agree that they are important. Despite all this, speaking to the media can still sometimes be a very important way for families to raise their concerns.

Can my MP help?

Sometimes MPs can be very helpful, and they may help you raise the profile of what has happened in the local press. They can sometimes raise concerns in parliament or with other politicians or ministers and they may be able to help you to meet other people with influence or power. So it can help to contact your MP.

Of course, not every MP will be able or willing to help you. If you would like to know more about your MP, it is worth reading about them on www.theyworkforyou.com. This is a website which can help you identify who your MP is, what their interests are, how they vote in parliament and what committees they sit on. If different members of your family live in different constituencies you might want to think about which MP is likely to be more sympathetic to your concerns.

Dealing with the media

When there is a sudden or controversial death there is often media interest of some sort. Their interest will depend on the nature of the death and what else is going on in the news at the time.

In many cases there will be interest from the local press immediately after a death. Local papers will often report a controversial death, such as a death in custody or workplace death, even if it is only a brief paragraph, but there is no guarantee that they will keep reporting on what happens over time. The national media is much less likely to report a sudden death, unless there is something particularly controversial or unusual about what has happened. You should be prepared for the possibility that there may be no interest from the media, even though you may feel it should really be of interest to them.

Sometimes families can feel hounded by journalists and it is a good idea to get advice before speaking to them. If you have a solicitor, or are being supported by INQUEST, they may be able to help protect you from journalists if you do not want to talk to them at certain times.

Because an inquest is a public hearing, it is not possible to prevent journalists from attending and reporting on what happens. This can often be distressing because private details about the person who has died may be revealed during the inquest. Things may be said by witnesses attempting to damage the character of the deceased and these can be reported, even though they may be unfair. This is why it can be a good idea to put out a press release before the inquest. That way you can include details about the deceased which you want the public to know and have more chance of getting journalists to see the things that you know are important. If you think that the media might be interested in the inquest, it can also be a good idea to have a prepared statement to read out at the end of an inquest.

INQUEST advises families to say only very general things before the inquest about the circumstances of the death and any concerns or questions you have. You may be convinced that something has happened which later turns out not to be true, or you may say things in anger or hurt that you will later regret.

Sometimes the media can be very helpful and will investigate and raise concerns about the circumstances of a death. It is often a good thing to work with organisations like INQUEST who have experience of working with a lot of journalists to try to get sympathetic press interest for coverage of the inquest.

A word of caution though: for every family who loses someone in contentious circumstances it is the worst event that has probably ever happened to them, but the media do not view things in the same way. Whilst sometimes they are interested in the death, often they will not cover it unless there is a new problem or a particularly dreadful circumstance. They will also often cover the news of the inquest, but not explore in a more considered way the issues that arise.

You may meet sympathetic journalists who are genuinely interested but cannot convince their editors to take up the story. There is no guarantee that because a journalist interviews you that their newspaper will print it, or that the television or radio will broadcast it. Sometimes a journalist may offer you a fee to run a story about your situation – be very careful and think hard about whether this is a good idea. If you are being offered money, there is a real possibility that the magazine, newspaper etc is much more interested in entertaining than in serious reporting and you may feel unhappy with the final version. They may also want you to sign a contract, for example preventing you from talking to other journalists, which may not be a good thing.

Campaigning can be a powerful way to achieve something positive after a sudden death. But you also need to be prepared that it can be time consuming and take over more of your life than you had expected. It is important to think about the impact it will have on you and your family, and to feel able to stop when you think you have done as much as you can cope with.

The journey that I and my family have been on has been a very long and strenuous one. At times we did feel as though we were fighting a losing battle but whenever we began to feel consumed, we remembered the fight that mum faced for 26 years, drew strength from it, and persevered.

Lee Lawrence, son of Cherry Groce who died following police contact

SECTION 8: Further help and information

SECTION 8.1

Definitions

These are some of the legal and technical terms used in this guide.

Attorney General
The chief legal officer of the United Kingdom. This is a government cabinet position.

Balance of probabilities
The standard of proof in civil court cases and for inquest conclusions other than unlawful killing or suicide. In these cases, one outcome need only be more probable than all the others.

Barrister
The legal practitioner who can represent you at the inquest or in any legal proceedings.

Beyond reasonable doubt
The highest standard of proof required in legal hearings and needed for returning inquest conclusions of unlawful killing or suicide.

Civil proceedings/claim
A legal claim for damages/compensation.

Clinical negligence
A legal term for a medical accident where a patient has not received care to a proper standard, and that substandard care has also caused the patient a physical injury. Sometimes also called medical negligence.

Compensation
A payment of money in recognition of certain kinds of suffering or injury, also called damages.

Coroner The legal official who is in charge of the inquest procedure and who orders a post-mortem.

Coroner's officer
The person who works for the coroner and is responsible for making arrangements for the inquest.

Court of Protection
A court created under the Mental Capacity Act 2005. It has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves.

Criminal proceedings
A prosecution which is pursued for a crime which arises for example from the circumstances of a death.

Crown Prosecution Service (CPS)
Responsible for deciding whether or not there is enough police evidence to undertake a criminal prosecution for a general criminal offence (e.g. manslaughter) both before and in some cases after the inquest, and whether or not a prosecution is in the public interest.

Damages
See compensation.

Director of Public Prosecutions (DPP)
A government-appointed legal officer who is the head of, and responsible for, the CPS.

Divisional court
A term used to describe proceedings in the High Court (such as a judicial review) when they are heard by two or more judges.

Deprivation of Liberty Safeguards (DoLS)
Deprivation of liberty can be authorised under the DoLS scheme provided for by the Mental Capacity Act 2005 for someone who lacks capacity to consent to residence and /or treatment.

European Convention on Human Rights (ECHR)
An international treaty to protect human rights and fundamental freedoms in Europe. All Council of Europe member states including the UK have signed the ECHR.

Family liaison officer (FLO) or family liaison manager (FLM)
A person from a prison, the PPO, IPCC, the police or HSE who works with the family during an investigation into a contentious death.

Forensic medical examiner (FME)
Formerly known as police surgeons, FMEs or police doctors examine and assess the medical needs of people detained in police custody.

Legal Help
The part of the Public Funding scheme that allows a solicitor to give advice for the preparation of an inquest for no cost if the client is on income support.

Legal Services Commission
The organisation responsible for providing Public Funds for legal work.

High Court
The highest civil court where cases may be heard for the first time. It also hears appeals and conducts judicial reviews, and supervises magistrates and crown courts.

Human Rights Act 1998
An act of parliament that incorporated the European Convention on Human Rights into UK law.

Health and Safety Executive (HSE)
A government authority set up under the Health and Safety at Work Act 1974 to enforce that and other occupational health and safety legislation.

Inquest
The formal legal inquiry into sudden, unexplained, violent or unnatural deaths.

Interested person
Those people defined in the Coroners and Justice Act 2009 as having a right to ask questions at the inquest. Family members such as parents, children, spouses, civil partners or partners of the person who has died automatically come within the definition and can ask questions at the inquest. Other relatives and those with close relationships may also be regarded as interested persons. This can be a complicated area and you should seek advice on your individual situation.

Judicial review
A type of court proceeding in which a High Court judge or judges review the lawfulness of the way a decision was made or action was taken by a public body or official such as a coroner.

Lord Chancellor
The cabinet minister in the government responsible for the effective running of the legal system in England and Wales.

Medical negligence
See clinical negligence.

Mortuary
The place where the body is taken after its removal from the place of death.

Pathologist
The medically-qualified practitioner who carries out a post-mortem examination.

Police Federation
The national organisation in England and Wales representing the interests of police officers from the ranks of constable to chief inspector.

Post-mortem
A medical examination to determine the cause of death, also called an autopsy.

Public Funding
Public means-tested financial assistance for representation during legal proceedings. It is not available for representation at most inquests. The Lord Chancellor can grant it in exceptional cases.

Solicitor
A legal practitioner who advises on legal matters concerning a death, carries out the preparation work for the inquest and either represents you at an inquest or instructs any barrister who is representing you in court. The solicitor receives her or his instructions from you.

Statement
A written account from anyone who has information and/or an opinion that may be relevant to the death.

Sub judice rule
The rule which prohibits the publication of statements which may prejudice court proceedings.

Supreme Court of the United Kingdom
The court of last resort and highest court of appeal in the United Kingdom. The supreme court in all matters under English law, taking over the judicial functions of the House of Lords since 1 October 2009.

Treasury Solicitors
The government's in-house lawyers, who will act for the Prison Service in instructing barristers at inquests.

Thank you so much for explaining article 2. I didn't understand it before. I'm so pleased INQUEST is involved. We need to look at how we are treating people. I can't thank you enough.

Julia Dawson, sister of Anthony Dawson who was under DoLS at the time of his death

SECTION 8.2

Further reading

Relevant Acts of Parliament and related legislation

- Coroners and Justice Act 2009
- Coroners (Inquests) Rules 2013
- Coroners (Investigations) Regulations 2013
- Coroners Act 1988
- Health and Safety at Work Act 1974
- Mental Health Act 1983
- Mental Capacity Act 2005
- The Human Rights Act 1998

Books

Inquests – a practitioners guide (3rd edition) – Leslie Thomas, Adam Straw and Danny Friedman. 2014, published by the Legal Action Group

Jervis on Coroners (13th edition) – Paul Matthews. 2014, published by Sweet and Maxwell

Coroner's Courts – a guide to law and practice (3rd edition) Christopher Dorries. 2013, published by the Oxford University Press

Levine on Coroners' Courts – Sir Montague Levine and James Pyke. 1999, published by Sweet and Maxwell

INQUEST books and reports

Unlocking the Truth – Families' experiences of the investigation of deaths in custody – Deborah Coles and Helen Shaw. 2007, published by INQUEST

Dying on the Inside: Examining women's deaths in prison – Marissa Sandler and Deborah Coles. 2008, published by INQUEST

How the inquest system fails bereaved people – Deborah Coles and Helen Shaw. 2002, published by INQUEST

Reports

Deaths in Mental Health Detention: An investigation framework fit for purpose? – Deborah Coles, Anna Edmundson *et al*. 2015, published by INQUEST.

Stolen Lives and Missed Opportunities: The deaths of young adults and children in prison – Ayesha Carmouche and Deborah Coles. 2015, published by INQUEST.

Preventing the Deaths of Women in Prison: The need for an alternative approach. 2014, published by INQUEST.

Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison? 2012, published by the Prison Reform Trust and INQUEST.

Learning from Death in Custody Inquests: A new framework for action and accountability – Deborah Coles and Helen Shaw. 2012, published by INQUEST.

Independent Advisory Panel on Deaths in Custody Report on a Family Listening Day. 2010, published by the Independent Advisory Panel on Deaths in Custody.

In the Care of the State?: Child deaths in penal custody in England and Wales – Deborah Coles and Barry Goldson. 2006, published by INQUEST.

Death Certification and Investigation in England, Wales and Northern Ireland: The report of a fundamental review. 2003, published by The Stationery Office.

Death and Disorder: Three case studies of public order and policing in London – Tony Ward. 1986, published by INQUEST.

SECTION 8.3

Useful contacts

INQUEST

89-93 Fonthill Road, London N4 3JH
Phone: 020 7263 1111
Fax: 020 7561 0799
Email: inquest@inquest.org.uk
Web: www.inquest.org.uk

INQUEST delivers an in-depth casework service on deaths in state detention or involving state agents. It also works on other cases that engage article 2, the right to life, of the European Convention on Human Rights and/or that raise wider issues of state and corporate accountability. INQUEST also gives advice and a free information guide to any bereaved family about inquest procedure.

INQUEST is the only charity in England and Wales that works specifically on contentious deaths and their investigation, including the inquest process, to provide information and advice to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public.

The pages that follow (pp 104-115) are lists of other organisations that might be helpful. It does not mean that INQUEST endorses the organisations if they are listed here.

Voluntary organisations

Action for Prisoners' Families (APF)

Can Mezzanine, 49-51 East Road, London N1 6AH
Helpline: 0808 808 2003
Email: info@offendersfamilieshelpline.org
Web: www.prisonersfamilies.org.uk
A national membership organisation for those interested in the wellbeing of prisoners' families. Action for Prisoners' Families wants every prisoner's family to get the support they would like and need.

Action against Medical Accidents (AvMA)

Freedman House, Christopher Wren Yard, 117 High Street, Croydon CR0 1QG
Helpline: 0845 123 2352
Email: info@avma.org.uk
Web: www.avma.org.uk
An independent charity and the only organisation working exclusively for the victims of medical accidents, where avoidable injury has been caused as a result of medical treatment or failure to diagnose. AvMA has a specialist inquest advice service to provide help with inquests for bereaved families who believe their loved one has died as a result of a medical mistake. The service provides access to specialist advice to help redress the imbalance between NHS Trusts and families trying to find out what went wrong.

Black Mental Health UK (BMH UK)

Phone: 07947 189 682
Email: editor@blackmentalhealth.org.uk
Web: www.blackmentalhealth.org.uk
BMH UK campaigns to raise awareness and address the stigma associated with mental illness. Their work includes campaigning to reduce inequalities in the treatment and care of people from African Caribbean communities who use mental health services, to inform these communities on how to influence the strategic development, policy design and implementation of services, and to reduce the over-representation of Black people at the coercive end of psychiatric care.

BRAKE

PO Box 548, Huddersfield HD1 2XZ
Helpline: 0808 8000 401
Fax: 01484 559 983
Email: helpline@brake.org.uk
Web: www.brake.org.uk
A registered charity that offers support for people whose lives have been devastated by the death of a loved one or a serious injury in the family following a road crash or other similar sudden disaster.

The Carbon Monoxide and Gas Safety Society (CO-Gas Safety)

Priory Cottage South, Priory Road, Seagrove Bay, Seaview, Isle of Wight PO34 5BU
Emergency: 0800 111 999
Email: office@co-gassafety.co.uk
Web: www.co-gassafety.co.uk
An independent charity which works to try to reduce accidents from carbon monoxide (CO) poisoning and other gas dangers. They lobby for changes to help achieve this, help with inquests involving deaths from carbon monoxide poisoning and help and advise people whenever possible.

Cardiac Risk in the Young (CRY)

Unit 1140B, The Axis Centre, Cleeve Road, Leatherhead KT22 7ND
Phone: 01737 363 222
Email: cry@c-r-y.org.uk
Web: www.c-r-y.org.uk
A charity that offers help, support and counselling to families where there has been

a sudden cardiac death of an apparently fit and healthy young person.

Child Bereavement UK

Clare Charity Centre, Wycombe Road, Saunderton, Buckinghamshire HP14 4BF
Helpline: 0800 028 8840
Telephone: 01494 568 900
Email: support@childbereavementuk.org
Web: www.childbereavementuk.org
A national UK charity that supports families and educates professionals both when a child dies and when a child is bereaved.

Childhood Bereavement Network (CBN)

8 Wakley Street, London EC1V 7QE
Tel: 020 7843 6309
Fax: 020 7843 6053
Email: cbn@ncb.org.uk
Web: www.childhoodbereavementnetwork.org.uk
A national multi-professional federation of organisations and individuals working with bereaved children and young people. It involves and is actively supported by all the major bereavement care providers in the UK. It seeks to ensure that all children and young people in the UK, together with their families and other caregivers, including professional carers, can easily access a choice of high-quality local and national information, guidance and support to enable them to manage the impact of death on their lives.

Citizens Advice

3rd Floor North, 200 Aldersgate, London EC1A 4HD
See website for local branches
Phone: 03444 111 444 (England) or 03444 772 020 (Wales) for local offices that can provide free information and advice
Fax: 020 7833 4371
Web: www.citizensadvice.org.uk
Information on all aspects of bereavement, including registering the death, arranging the funeral and bereavement benefits available. Offers free, confidential, impartial and independent advice. Citizens Advice help solve problems which are central to people's lives, fill out forms, write letters, negotiate with creditors, represent clients at court or tribunal and provide specialist advice.

Committee on the Administration of Justice (CAJ)

1st Floor, Community House, Citylink Business Park, 6A Albert Street, Belfast BT12 4HQ
Phone: 028 9031 6000
Fax: 028 9031 4583
Email: info@caj.org.uk
Web: www.caj.org.uk
An independent human rights organisation working since 1981 to ensure the protection and promotion of human rights of all those in Northern Ireland by reference to internationally agreed human rights standards.

The Compassionate Friends

14 New King Street, Deptford, London SE8 3HS
Helpline: 0345 123 2304
Email: helpline@tcf.org.uk
Web: www.tcf.org.uk
A charitable organisation of bereaved parents, siblings and grandparents dedicated to the support and care of others who have suffered the death of a child/children. They offer support both directly to bereaved families and indirectly by fostering understanding and good practice amongst professionals concerned with child death and by increasing public awareness.

Construction Safety Campaign (CSC)

PO Box 23844, London SE15 3WR
Phone: 0774 779 5954
Email: construction.safetycampaign@talk21.com

An organisation dedicated to health and safety issues in the workplace, including deaths on construction sites.

Coroners' Courts Support Service

Westminster Coroner's Court, 65 Horseferry Road, London SW1P 2ED
Phone: 020 7802 4763
Email: info@ccsupport.org.uk
Web: www.coronerscourtssupportservice.org.uk
An independent organisation supported by the Ministry of Justice and others. Volunteers give emotional and practical support to families and other witnesses at the time of the inquest hearing itself at various courts throughout London (where they work in partnership with the Metropolitan Police) and the south-east of England.

CRUSE Bereavement Care

PO Box 800, Richmond, Surrey TW9 1RG
Helpline: 0844 477 9400
Email: helpline@cruse.org.uk
Web: www.crusebereavementcare.org.uk
CRUSE promotes the well-being of bereaved people and enables anyone bereaved by death to understand their grief and cope with their loss. Services are free to bereaved people. The charity provides support and offers information, advice, education and training services.

Disaster Action

No.4, 71 Upper Berkeley Street, London W1H 7DB
Phone: 01483 799 066
Email: pameladix@disasteraction.org.uk
Web: www.disasteraction.org.uk
A charity founded by survivors and bereaved people from UK and overseas disasters offering guidance and support to others who find themselves similarly affected by major tragedy, and to raise awareness of the needs of survivors and the bereaved.

Epilepsy Bereaved (EB)

PO Box 112, Wantage, Oxfordshire OX12 8XT
Helpline: 01235 772 850
Email: contact@epilepsybereaved.org.uk
Web: www.sudep.org
A charity working to prevent unnecessary deaths from SUDEP (Sudden Unexpected Death in Epilepsy) and other epilepsy deaths. EB is the only charity dedicated to the support and enablement of those bereaved in this way.
It provides a helpline for initial support and information, provides support, lobbies clinicians, heath managers and policy makers with the aim of raising awareness and ultimately reducing the risk of epilepsy-related death, and carries out and supports research into the causes of SUDEP and other epilepsy deaths.

Families Against Corporate Killing (FACK)

c/o Hazards Campaign, Windrush Millennium Centre, 70 Alexandra Road, Manchester M16 7WD
Phone: 0161 636 7557
Email: mail@gmhazards.org.uk
Web: www.fack.org.uk
A national campaigning network formed by the relatives of people killed at work that campaigns to stop workers and others dying in preventable incidents. They direct bereaved families to sources of legal help and emotional support.

Family Lives

CAN Mezzanine, 49-51 East Road, London N1 6AH
Helpline: 0808 800 2222
Phone: 020 7553 3080
Web: www.familylives.org.uk
Action for Prisoners' Families is a part of Family Lives. Action for Prisoners' and Offenders' Families is a membership organisation that works for the benefit of prisoners' and offenders' families by

representing the views of families and those who work with them, and by promoting effective work with families.

The Footprints Project

Henley Court, 32 Christchurch Road, Bournemouth, Dorset BH1 3PD
Phone: 07789 937 637
Email: info@footprintsproject.co.uk
Web: www.footprintsproject.co.uk
A charity that mentors men and women who are leaving prison or serving a community sentence in the Dorset, Somerset and Hampshire area and aims to reduce the risk of re-offending by helping clients to re-integrate into their local community. They offer a through the gate service, meeting clients prior to and on release from prison.

4WardEver Campaign UK

Phone: 0843 289 4994
Email: info@4wardever.org
Web: www.4wardeveruk.org
Provides a one-stop resource for profiles, news and event details, useful information, appeals and more in relation to deaths and abuse whilst in custody, other injustices in the UK and internationally. Set up in 2006 in memory of Mikey Powell, who died in police custody in September 2003.

The Hazards Campaign

c/o Greater Manchester Hazards Centre, Windrush Millennium Centre, 70 Alexandra Road, Manchester M16 7WD
Web: www.hazardscampaign.org.uk
A network of resource centres and campaigners on health and safety at work. Their website has a directory of organisations providing support to people and groups working on health and safety issues, including worker and community resource centres, occupational health projects, victim support groups, specialist campaigns, etc.

Health Talk Org

Web: http://healthtalk.org/peoples-experiences/dying-bereavement
Healthtalk.org is a charity website that provides information about health issues from the patient perspective. Researchers at the University of Oxford have travelled all over the UK interviewing people about their experiences of dying and bereavement. Visitors to the site can watch video excerpts from interviews with people discussing their experiences of bereavement due to suicide, bereavement due to traumatic death, terminal illness and caring for someone at the end of life.

Hope Again

Helpline: 0808 808 1677
Email: hopeagain@cruse.org.uk
Web: www.hopeagain.org.uk
Hope Again is a website designed for young people by young people. It is part of Cruse Bereavement Care's Youth Involvement Project and is available to support young people after the death of someone close.

Howard League for Penal Reform

1 Ardleigh Road, Islington, London N1 4HS
Phone: 020 7249 7373
Fax: 020 7249 7788
Email: info@howardleague.org
Web: www.howardleague.org
A national charity that works for humane and rational reform of the penal system, researches and comments on criminal justice policy and practice, holds conferences and debates and publishes books and reports. The Howard League also runs projects in schools and prisons.

Independent Complaints and Advocacy Service (ICAS)

c/o The Carers Federation (for people on the

East Midlands and the north of England)
Carers Federation Head Office, Christopher Cargill House, 21-23 Pelham Road, Nottingham NG5 1AP
Phone: 0115 962 9310
Fax: 0115 962 9338
Email: info@carersfederation.co.uk
Web: www.carersfederation.co.uk

c/o POhWER Advocacy Services (for people in London, the West Midlands and the east of England)
Various addresses and phone numbers (see website)
Email: pohwer@pohwer.net
Web: www.pohwer.net

c/o The South of England Advocacy Projects (SEAP) (for people in the south-east and west of England)
Various addresses (see website)
Phone: 0330 440 9000 (head office of SEAP)
Fax: 01424 204 687
Web: www.seap.org.uk
A free, independent and confidential service which provides advocacy support to people who wish to make a complaint about the service (or lack of it) that they have received from the NHS. ICAS advocates support you through the NHS complaints process.

Institute of Race Relations (IRR)
2-6 Leeke Street, London WC1X 9HS
Phone: 020 7837 0041 / 020 7833 2010
Fax: 020 7278 0623
Email: info@irr.org.uk
Web: www.irr.org.uk
The IRR is at the cutting edge of the research and analysis that inform the struggle for racial justice in Britain, Europe and internationally. It seeks to reflect the experiences of those who suffer racial oppression and draws its perspectives from the most vulnerable in society.

Irish Council for Prisoners Overseas (ICPO)
50-52 Camden Square, London NW1 9XB
Phone: 020 7482 5528
Fax: 020 7482 4815
Email: prisoners@irishchaplaincy.org.uk
Web: www.icpo.ie
Established in 1985 as a specialised response to the needs of the Irish prisoner abroad, the ICPO aims to fulfil its mission by providing a comprehensive service to Irish prisoners and their families.

JUSTICE
59 Carter Lane, London EC4V 5AQ
Phone: 020 7329 5100
Fax: 020 7329 5055
Email: admin@justice.org.uk
Web: www.justice.org.uk
An all-party law reform and human rights organisation working to improve the legal system and quality of justice, in particular by promoting human rights, improving the legal system and access to justice, improving criminal justice and raising standards of EU justice and home affairs.

Liberty
Liberty House, 26-30 Strutton Ground, London SW1P 2HR
Advice line: 0845 123 2307 or 020 3145 0461
Web: www.liberty-human-rights.org.uk
An independent human rights organisation which fights to secure equal rights for everyone by campaigning and lobbying parliament, taking human rights cases to UK courts and the European Court of Human Rights, conducting research and providing advice and training to lawyers and the public. Liberty gives advice on human rights issues to private individuals and to voluntary organisations.

Mind
15-19 Broadway, Stratford, London E15 4BQ

Info/advice line: 0300 123 3393
Legal advice line: 0300 466 6463
Email: info@mind.org.uk
Web: www.mind.org.uk
The leading mental health charity in England and Wales that helps people take control of their mental health by providing high-quality information and advice, and campaigning to promote and protect good mental health for everyone.
Mind's specialist Legal Advice Service provides legal information and general advice on mental health-related law, covering mental health, mental capacity, community care, human rights and discrimination/equality related to mental health issues.

The Monitoring Group (TMG)

London Civil Rights and Arts Centre, Upper Floors, 37 Museum Street, London WC1A 1LQ
Phone: 020 7430 2869
Email: office@tmg-uk.org
Web: www.tmg-uk.org
Established in London in the early 1980s by community campaigners and lawyers who wished to challenge the growth of racism in the locality, TMG is a leading UK anti-racist charity that promotes civil rights and have led many family campaigns.

National Association for the Care and Resettlement of Offenders (Nacro)

First Floor, 46 Loman Street, London SE1 0EH
Phone: 0300 123 1999
Fax: 020 7902 5448
Email: helpline@nacro.org.uk
Web: www.nacro.org.uk
Nacro reduces crime by changing lives, working with the most disadvantaged people, offenders and those at risk of offending to help them find positive alternatives to crime and to achieve their full potential in society. Nacro provides a range of services across England and Wales, from resettlement to youth projects, education and employment.

Newham Monitoring Project (NMP)

The Harold Rd Centre, 170 Harold Road, London E13 0SE
Helpline: 0800 169 3111 (24 hour Emergency)
Phone: 020 8470 8333
Email: info@nmp.org.uk
Web: www.nmp.org.uk
An independent community-based anti-racist organisation which works with members of the black community suffering racial discrimination/violence, police misconduct and civil rights issues. NMP runs a casework service providing advice, support, advocacy and access to specialist legal assistance for individuals and families and a free 24-hour emergency helpline for members of the black community in east London facing racial attacks or policing issues.

Pact

29 Peckham Road, London SE5 8UA
Helpline: 0808 808 3444
Phone: 020 7735 9535
Email: info@prisonadvice.org.uk
Web: www.prisonadvice.org.uk
Pact supports prisoners and their families in making a fresh start and to minimise the harm that can be caused by imprisonment on offenders, families and communities. They work to ensure that families of prisoners have access to appropriate advice and care, facilitate opportunities for positive contact between prisoners and their families, respond to needs of prisoners at risk of suicide and self-harm, and support development of restorative justice and community involvement in helping people affected by imprisonment.

PAPYRUS Prevention of Young Suicide

Unit 1, Lineva House, 28-32 Milner Street, Warrington, Cheshire WA5 1AD
Helpline: 0800 068 4141
Phone: 01925 572 444
Email: admin@papyrus-uk.org
Web: www.papyrus-uk.org
PAPYRUS run a national helpline, HOPELineUK, including text and email services, staffed by a team of mental health professionals who provide practical help and advice to vulnerable young people and to those concerned about any young person who may be at risk of suicide. They offer a range of training sessions aimed at raising awareness of the prevalence of young suicide and campaign for the protection of young people at risk of suicide.

Prison Reform Trust

15 Northburgh Street, London EC1V OJR
Phone: 020 7251 5070
Fax: 020 7251 5076
Email: prt@prisonreformtrust.org.uk
Web: www.prisonreformtrust.org.uk
A charity that works to create a just, humane and effective penal system by inquiring into the workings of the system; informing prisoners, staff and the wider public; and by influencing parliament, the government and officials towards reform.

Prisoners Abroad

89-93 Fonthill Road, London N4 3JH
Helpline: 0808 172 0098
Email: info@prisonersabroad.org.uk
Web: www.prisonersabroad.org.uk
The only UK charity caring for the welfare of all British citizens held in foreign prisons and helping their families with information and guidance. Works closely with British consular officials who frequently refer prisoners and their families to Prisoners Abroad services.

Prisoners' Advice Service (PAS)

PO Box 46199, London EC1M 4XA
Phone: 020 7253 3323 or 0845 430 8923
Fax: 020 7253 8067
Email: advice@prisonersadvice.org.uk
Web: www.prisonersadvice.org.uk
A national service offering free, confidential advice and information by legal professionals to prisoners, particularly concerning prisoners' rights and the application of prison rules. PAS takes up prisoners' complaints about their treatment within the prison system, taking legal action where appropriate.

Rethink

89 Albert Embankment, London SE1 7TP
Advice and information line: 0300 500 0927
Web: www.rethink.org
Rethink is dedicated to improving the lives of everyone affected by severe mental illness, whether they have a condition themselves, care for others who do, or are professionals or volunteers working in the mental health field.

Revolving Doors Agency

4th Floor, 291-299 Borough High Street, London SE1 1JG
Phone: 020 7407 0747
Web: www.revolving-doors.org.uk
The Revolving Doors Agency works across England to change systems and improve services for people with multiple problems, including poor mental health, who are in repeat contact with the criminal justice system. Its purpose is to stimulate reform of the health, welfare and criminal justice systems and create practical solutions in partnership with the police, NHS, Prison Service and councils across the country and the involvement of people with direct experience of the issues through a national service user forum and wide network of policymakers, local leaders and service providers.

RoadPeace

Shakespeare Business Centre, 245A Coldharbour Lane, London SW9 8RR
Helpline: 0845 450 0355
Email: helpline@roadpeace.org
Web: www.roadpeace.org
A national charity for road crash victims which represents the interests of and supports people injured in road crashes as well as the bereaved friends and relatives of road crash victims. Members include those who have been bereaved or injured in road crashes and also those who are concerned about road danger.

The Royal British Legion Inquest Advice Service

Haig House, 199 Borough High Street, London SE1 1AA
Helpline: 020 3207 2144 or 020 3207 2137
Email: iia@britishlegion.org.uk
Web: www.britishlegion.org.uk/iia
A charity that provides support and free legal advice throughout the UK to the bereaved families of all services personnel (and reservists on active service) through the legal and other procedures arising out of the Service Inquiry and the inquest. Confidential advice and support are provided by their solicitors at all stages of the investigation into operational and non-operational deaths.

The Samaritans

PO Box 9090, Stirling FK8 2SA
Helpline: 116 123
Email: jo@samaritans.org
Web: www.samaritans.org
The Samaritans provides confidential 24 hours a day non-judgemental emotional support in the UK and Ireland for people who are experiencing feelings of distress or despair. They offer their service by telephone, email, letter and face-to-face in most of their branches.

If you live outside of the UK and Ireland, visit www.befrienders.org to find your nearest helpline.

SANE

St Mark's Studios, 14 Chillingworth Road, London N7 8QJ
Helpline: 0300 304 7000
Email: info@sane.org.uk
Web: www.sane.org.uk
A registered charity which campaigns to combat stigma and ignorance and improve the quality of life for people affected by mental illness.

Support After Murder and Manslaughter (SAMM)

L&DRC, Tally Ho! Police Training Centre, Pershore Road, Edgbaston, Birmingham B5 7RN
Helpline: 0845 872 3440
Email: support@samm.org.uk
Web: www.samm.org.uk
SAMM offers help to families and friends who have been bereaved as a result of murder or manslaughter through mutual support of others who have suffered a similar tragedy.

Survivors of Bereavement by Suicide (SOBS)

The Flamsteed Centre, Albert Street, Ilkeston, Derbyshire DE7 5GU
Helpline: 0300 111 5065
Email: sobs.support@hotmail.com
Web: www.uk-sobs.org.uk
A voluntary organisation set up to meet the needs and break the isolation of those bereaved by the suicide of a close relative or friend. It offers emotional and practical support and aims to provide a safe, confidential environment in which bereaved people can share their experiences and feelings, so giving and gaining support from each other.

Widowed by Suicide

Web: www.widowedbysuicide.org.uk
A support website for people and partners directly affected by suicide. It aims to reduce the isolation felt by those who have lost their life partner through suicide, providing emotional support and informal advice, by sharing individual experiences in a safe and secure environment.

Winston's Wish

3rd Floor, Cheltenham House, Clarence Street, Cheltenham GL50 3JR
Helpline: 0845 203 0405
Fax: 01242 546 187
Email: info@winstonswish.org.uk
Web: www.winstonswish.org.uk
A charity for children and young people bereaved by the death of a parent or sibling by providing professional assistance before, during and after bereavement and offers practical support and guidance throughout the grieving process. Winston's Wish has a range of services that include a national helpline for anyone caring for or concerned about a bereaved child.

Wish

15 Old Ford Road, London E2 9PJ
Phone: 020 8980 3618
Fax: 020 8980 1596
Email: info@womenatwish.org.uk
Web: www.womenatwish.org.uk
A national charity which provides long-term, gender-sensitive support and services to women with mental health needs in their journey through the criminal justice and mental health systems and into the community, and helps women to have their voices heard at a policy level.

Women in Prison (WIP)

Unit 10, The Ivories, 6 Northampton Street, London N1 2HY
Helpline: 0800 953 0125 (only for women offenders and ex-offenders)
Phone: 020 7359 6674
Email: info@womeninprison.org.uk
Web: www.womeninprison.org.uk
WIP supports and campaigns for women offenders and ex-offenders. WIP is the only women-centred, women-run organisation that provides specialist services to women offenders both in prison and in the community throughout England.

The Zahid Mubarek Trust

Hampstead Town Hall, 213 Haverstock Hill, London NW3 4QP
Phone: 020 7443 5551
Email: admin@thezmt.org
Web: www.thezmt.org
Set up in memory of Zahid Mubarek, who was murdered by his cellmate whilst in the care of HMYOI Feltham in 2002, the trust runs a helpline for prisoners and families of prisoners in Feltham, available to any prisoner experiencing unfair treatment, racism, religious intolerance or discrimination. The trust campaigns for a more humane penal system and is especially concerned with those most vulnerable and in need of support. It can also support families who have concerns about a prisoner's welfare.

Government and professional organisations

Your MP

House of Commons, London SW1A 0AA
Phone: 020 7219 3000
Email: hcinfo@parliament.uk
Web: www.parliament.uk
Your MP is there to represent you as a constituent and may be able to assist you. To find out who your MP is, visit www.parliament.uk or www.theyworkforyou.com or call the Houses of Parliament (Commons and Lords) switchboard on 020 7219 3000.

Care Quality Commission (CQC)

Finsbury Tower, 103-105 Bunhill Row, London EC1Y 8TG
Helpline: 03000 616 161
Fax: 0300 0616 171
Email: enquiries@cqc.org.uk
Web: www.cqc.org.uk
The CQC regulates health and adult social care services in England, whether provided by the NHS, local authorities, private companies or voluntary organisations, and protects the rights of people detained under the Mental Health Act.

Coroners Division, Ministry of Justice (MoJ)

4th Floor, 102 Petty France, London SW1H 9AJ
Phone: 020 3334 6409
Email: coroners@justice.gsi.gov.uk
Web: www.justice.gov.uk
The Ministry of Justice is responsible for the law and policy governing coroners and deals with the operation of the current coroner system. They develop policy and practice for coroners, facilitating their training and lead the programme of coroner reform which resulted in the Coroners and Justice Act 2009. The MoJ also deals with enquiries from the general public about coroners and inquests.

Coroners' Society of England and Wales

HM Coroner's Court, The Cotton Exchange, Old Hall Street, Liverpool L3 9UF
Phone: 0151 233 4708
Web: www.coronersociety.org.uk
The Coroners' Society promotes the usefulness of the office of the coroner to the public, ascertains the difficulties of coroners' duties, recommends appropriate law reform and protects the rights and interests of coroners. You can find the contact details for your local coroner's court on their website.

Courts and Tribunals Judiciary

Judicial Office, 11th Floor, Thomas More Building, Royal Courts of Justice, Strand, London WC2A 2LL
Web: www.judiciary.gov.uk
A useful website for information about the judiciary including listings and judgements. Prevention of Future Death reports and responses arising out of inquests are also published on this website.

Department of Health *Help is at Hand* guide

Web: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_115629
Help is at Hand guide: www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
The Department of Health *Help is at Hand* guide is aimed at the wide range of people who are affected by suicide or other sudden traumatic death. It contains information

about what may happen after the death, including the coroner's inquest, and about the feelings and emotions that bereaved people may experience. Suggestions for how to cope are given, as well as details about sources of support and pointers to useful reading material.
The booklet also provides information for healthcare workers and other professionals who come into contact with bereaved people to assist them in providing help and to suggest how they themselves may find support if they need it.

Gov.uk

Web: www.gov.uk
The official UK government website where you can find out information on what to do when someone dies, coroners and inquests, benefits payable after a death and also on jury service at inquests.

HM Inspectorate of Prisons

First Floor, Ashley House, 2 Monck Street, London SW1P 2BQ
Phone: 020 7035 2136
Fax: 020 7035 2141
Email: hmiprisons.enquiries@hmiprisons.gsi.gov.uk
Web: www.justice.gov.uk/inspectorates/hmi-prisons
HMI Prisons is an independent inspectorate. HM Chief Inspector of Prisons is appointed from outside the Prison Service and reports to ministers on the treatment of prisoners and conditions in prisons, young offender institutions and immigration detention facilities in England and Wales.

Human Tissue Authority (HTA)

151 Buckingham Palace Road, London SW1W 9SZ
Phone: 020 7269 1900
Email: enquiries@hta.gov.uk
Web: www.hta.gov.uk
The watchdog that licenses and inspects organisations that store and use human tissue for purposes such as research, patient treatment, post-mortem examination, teaching and public exhibitions.

Independent Advisory Panel on Deaths in Custody (IAP)

Room G19, Abell House, John Islip Street, London SW1P 4LH
Email: iapdeathsincustody@noms.gsi.gov.uk
Web: iapdeathsincustody.independent.gov.uk
The IAP helps shape government policy through the provision of independent advice and expertise to the Ministerial Council on Deaths in Custody. The remit of the council covers deaths in prisons, in or following police custody, in immigration detention, deaths of residents of approved premises and deaths of those detained under the Mental Health Act (MHA).

Independent Police Complaints Commission (IPCC)

90 High Holborn, London WC1V 6BH
Phone: 0300 020 0096
Fax: 020 7404 0430
Email: enquiries@ipcc.gsi.gov.uk
Web: www.ipcc.gov.uk
The IPCC has overall responsibility for the system for complaints against the police and the investigation of deaths in police custody.

Independent Press Standards Organisation (IPSO)

Gate House, 1 Farringdon Street, London EC4M 7LG
Phone: 0300 123 2220
Fax: 020 7236 3139
Email: inquiries@ipso.co.uk
Web: www.ipso.co.uk
An independent regulator for the newspaper and magazine industry in the UK. The IPSO

upholds standards of journalism by monitoring and maintaining the standards set out in the Editors Code of Practice, and provides support and redress for individuals seeking to complain about breaches of the code.

Judicial Conducts Investigations Office (JCIO)

81-82 Queens Building, Royal Courts of Justice, Strand, London WC2A 2LL
Phone: 020 7073 4719
Fax: 020 7073 4725
Email: inbox@jcio.gsi.gov.uk
Web: judicialconduct.judiciary.gov.uk
The JCIO handles complaints and provides advice and assistance to the Lord Chancellor and Lord Chief Justice in the performance of their joint responsibility for the system for considering and determining complaints about the personal conduct of all judicial office holders in England and Wales and some judicial office holders who sit in tribunals in Scotland and Northern Ireland. Formerly the Office for Judicial Complaints (OJC).

National Offender Management Service Equalities, Rights and Decency Group

Phone: 03000 497 220
The Equalities, Rights and Decency Group is a multidisciplinary group under the National Offender Management Service, dedicated to reducing suicide, self-harm and violence in prisons.

Patient Advice and Liaison Service (PALS)

Various local branches
PALS services: www.nhs.uk/Service-Search/Patient-advice-and-liaison-services-(PALS)/LocationSearch/363
NHS summary of PALS: www.nhs.uk/chq/Pages/1082.aspx?CategoryID=68
PALS was introduced to ensure that the NHS listens to patients, their relatives, carers and friends, and answers their questions and resolves their concerns as quickly as possible.

Prisons and Probation Ombudsman (PPO)

Ashley House, 2 Monck Street, London W1P 2BQ
Phone: 020 7633 4100 / 0845 010 7938
Fax: 020 7633 4141
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
The PPO is appointed by the Home Secretary and investigates complaints from prisoners and those subject to probation supervision, or those upon whom reports have been written. The PPO also investigates all deaths that occur among prisoners, immigration detainees and the residents of probation hostels (Approved Premises). The Ombudsman is independent of both the Prison Service and the National Probation Service.

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Index

Please see also Section 8.3 (pages 104-115) for a directory of useful contacts and organisations. Entries in the index marked * can also be found in the directory.

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This handbook holds important information for anyone who has found themselves dealing with a sudden death in difficult circumstances where an inquest will be held. It gives detailed information on what happens next and guides you through the inquest process.

It covers:
- What happens after a sudden death
- Post-mortem examinations and the rights of bereaved people
- Coping with a death and the process before and during an inquest
- When you may need legal advice and how to find and fund it
- Other sources of help, information and further reading
- A directory of voluntary, government and professional organisations

Specialist sections on contentious deaths in:
- Police custody or following police contact
- Prison
- Mental health settings
- Hospital or the community
- and work-related deaths

Third Edition

INQUEST
TRUTH, JUSTICE AND ACCOUNTABILITY

Providing FREE, completely independent, confidential advice and support for over 30 years.

INQUEST Charitable Trust Registered Charity No. 1046650
Registered Company No.03054853
89-93 Fonthill Road, London N4 3JH