Inquest Basics Series - Charlotte Davies

(Updated for 2026)

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Inquest basics: What is an Inquest?

In the first of a series of articles delving into the world of inquests, Charlotte Davies (2007) examines the role of a Coroner and what they need to determine during the inquest process.

There are certain situations in which somebody's death will be reported to a Coroner. This will be if someone died a violent or unnatural death, if they died in custody or otherwise in state detention, or if the cause of death is unknown; the circumstances in which a death must be notified to the Coroner are set out in the Notification of Deaths Regulations 2019. The majority of deaths are not reported to the Coroner and, since 9 September 2024, every death which is not investigated by a Coroner is instead scrutinised by an independent medical examiner before the cause of death is certified - a significant recent reform of the death certification system in England and Wales.

A Coroner is the person appointed to investigate reported deaths. Coroners are independent judicial office holders and are appointed by the relevant local authority. England and Wales is currently divided into 74 coroner areas (a number which continues to fall as areas are merged), each led by a Senior Coroner who may be supported by Area Coroners and Assistant Coroners. The system is led nationally by the Chief Coroner.

Inquests (the name given to the process) are public hearings - except when the interests of justice or national security require otherwise, the general public and press can attend - and can be held with or without a jury. Under Rule 8 of the Coroners (Inquests) Rules 2013 ("the Inquest Rules"),

Coroners are required to complete an inquest within 6 months of the date on which the Coroner is made aware of the death, or as soon as is reasonably practicable. The 6-month timeframe has caused difficulty in recent years - contributed to significantly by the Covid-19 pandemic and the backlogs which followed it - with inquests regularly being held much later than this.

Section 5 of the Coroners & Justice Act 2009 ("CJA 2009") states that inquiries by a Coroner are solely to ascertain:

1) Who the deceased was;

2) Where they came by their death;

3) When they came by their death; and

4) How they came by their death.

In an "Article 2" inquest (which will be the subject of a separate article in this series and is where the deceased was in the control of the state at the time of his or her death), an additional question must be answered: 5) and in what circumstances?

Coroners are not able to consider criminal or civil liability as part of their investigations. Where there is a suspicion that a criminal act led to the death, the Coroner will open an inquest and must adjourn until the outcome of any criminal proceedings (Schedule 1, Para. 1 CJA 2009).

Inquests are not trials and they are not adversarial; there are no "sides" to an inquest, merely "interested persons" whose role is to assist the Coroner with their inquiries. No party will be found guilty and no party will "win" or "lose".

Not every inquest now involves a hearing at all. Since 28 June 2022, in straightforward and non-contentious cases, Coroners have had the power to hold an inquest "in writing" (section 9C CJA 2009, inserted by the Judicial Review and Courts Act 2022). Before doing so, the Coroner must invite representations from the Interested Persons, and may only proceed in writing if no one makes representations, on reasonable grounds, that a hearing should take place; if there is no real prospect of disagreement as to the determinations or findings; and if no public interest would be served by a hearing.

Where there is a hearing, the Coroner will generally hear the evidence of the pathologist first. The pathologist's evidence will be in the form of a post-mortem report which will be used to determine "how" the deceased died. Thereafter, the evidence of witnesses is usually given in the same

chronological order as the actual occurrence of events, but it is for the Coroner to decide in what order witnesses will be called. Evidence will be given under oath or affirmation. Each Interested Person (or most likely, their legal representative) will be able to ask questions of any witness giving evidence. Questions which are intended to deal with issues of fault, blame or negligence are not allowed. Unlike court proceedings, the Coroner will take the lead with questioning, and the representative whose witness is giving evidence will ask questions of that witness last. Under Rule 23 of the Inquest Rules the Coroner can admit, into the documentary evidence, statements that are unlikely to be disputed. These witnesses do not need to attend the hearing and their statement will be read out to those present.

Remote attendance, which became widespread during the pandemic, has since been placed on a proper statutory footing. The Coroner (and any jury) must be physically present in the courtroom, but witnesses, Interested Persons and legal representatives may be permitted to attend by video-link, and members of the public and press may apply to observe proceedings remotely (section 85A of the Courts Act 2003 and the Remote Observation and Recording (Courts and Tribunals) Regulations 2022). There is, however, no right to attend remotely: the Chief Coroner's guidance makes clear that remote attendance should not normally be permitted purely because a participant would prefer it, and each application is decided on its own merits.

At the conclusion of the evidence, the Coroner will hear submissions on the law from the Interested Persons (no submissions on the facts are permitted) following which the Coroner will make their findings, addressing each of the four questions above, and come to a "conclusion" (no longer a "verdict"). In terms of conclusions, the most relevant short form conclusions are likely to be accident/misadventure; suicide; an open conclusion; natural causes; alcohol/drug related; neglect. The Coroner is alternatively able to provide a short narrative conclusion which must be brief, neutral and factual; it should not express any judgment or opinion (*R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson* [1995] QB 1). A more detailed article on conclusions will be published later in this series.

One further important feature of the process should be mentioned. Where anything revealed by the investigation gives rise to a concern that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future, the Coroner is under a duty to make a report to any person or organisation who may have power to take action - commonly known as a Prevention of Future Deaths (or "Regulation 28") report. The recipient must respond within 56 days, and both the report and the response are ordinarily published.

The findings and conclusions of a Coroner can be challenged by way of Judicial Review, as discussed in the final article in this series.

Inquest basics: Interested Persons

In the second of a series of articles delving into the world of inquests, Charlotte Davies (2007) examines the role played by those who may be able to assist the Coroner in their investigation into a death.

An Interested Person (or "IP" for short) is a person or corporate body that has the right to participate in inquest proceedings in order to assist the Coroner and adduce the best evidence regarding the four questions the Coroner must answer, referred to in the first article in this series: Who? When? Where? And, How? They are so called because they can be said to have an 'interest' in the outcome. They could be an Interested Person because of their relationship to the deceased, or due to their involvement in the circumstances of the death. The use of the term "person" might be somewhat misleading; an Interested Person can be a local authority (for example, in an inquest into the death of a young person in care); the local police force (for example, in inquests involving a death in police custody, or where the deceased had interaction with the police in the days leading up to their death); or a company (where a death occurred at work).

As clarified in my previous article (What is an Inquest?), the Interested Persons are not "parties" or "opponents", inquests are not adversarial and there are no winners or losers.

An 'Interested Person' is defined in section 47(2) of the Coroners & Justice Act 2009 and includes a long list of classes of people and organisations who may be deemed to be an Interested Person. Interested Persons can include:

- family members (more than one family member can be separately identified as an Interested Person);
- a personal representative of the deceased's estate (i.e. the Executor of their Will);
- a beneficiary under a policy of life insurance;
- a person who may have caused or contributed to the death of the deceased;
- a company;
- a local authority;

- a police force;

- an NHS Trust;

- any other person or organisation that the Senior Coroner thinks has a sufficient interest.

At an inquest into the death of a young person in care, who had involvement with child and adolescent mental health services, the Interested Persons could, for example, be a member of the family of the deceased; the Local Authority (due to the young person being subject to a Care Order); the police force for the area in which the death occurred (who were perhaps involved in the search after the young person was reported missing); and the NHS Trust of the area in which the death occurred (due to the involvement of CAMHS).

It is the duty of the Coroner to review the facts of each death and to identify those who should be Interested Persons. That being the case, if an individual or organisation believes they should be an Interested Person, they can contact the Coroner and set out their position.

The rights of Interested Persons (directly or via their legal representative, if instructed) include:

- to be notified of the date, time and place of the inquest hearing within seven days of the date being set;

- to be notified of the details of the post mortem examination and toxicology reports;

- to be notified of the date, time and place of and to attend any Pre-Inquest Review Hearing (these will be the subject of a later article) and make submissions;

- to receive relevant disclosure of documentation held by the Coroner;

- to see written evidence and to object to it being adduced (if appropriate) at a hearing;

- to ask questions of the witnesses at the inquest hearing;

- to make closing submissions on the law and available conclusions open to the Coroner, at the end of the evidence at the inquest hearing.

Finally, a significant change is on the horizon. The Public Office (Accountability) Bill - widely known as the "Hillsborough Law" - was introduced in September 2025 and, at the time of writing, has been carried over into the current Parliamentary session but has not yet received Royal Assent. If enacted in its present form, it will impose a statutory duty of candour and assistance on public authorities and public officials engaging with inquests and inquiries, significantly expand non-means-tested legal aid for bereaved families where a public authority is an interested person and is

represented, and require public authorities to ensure that their own expenditure on inquest representation is necessary and proportionate. Public bodies who regularly appear as Interested Persons would be well advised to prepare for that cultural shift now, rather than waiting for the Bill to become law.

Inquest basics: Article 2 Inquests

In the third of a series of articles delving into the world of inquests, Charlotte Davies (2007) examines what an Article 2 inquest is, and what difference it makes to the inquest process.

There are, in fact, two different types of inquest:

- A traditional, or "Jamieson inquest", is not intended to establish blame but to provide clarity as to how the deceased's life ended.

- An "Article 2", or "Middleton inquest", is held where there is the potential that the State (or 'its agents') has failed in its negative obligation to refrain from taking life, or in its positive obligation to take appropriate measures to safeguard life, or where there has been a violent, unnatural or unexplained death in custody.

What is an Article 2 Inquest?

As a result of the European Convention on Human Rights ("ECHR") being given further effect in domestic law by the Human Rights Act 1998, coroners' courts must act compatibly with the rights set out in the ECHR and, more specifically, with Article 2(1), under which the State has an obligation to take appropriate steps to safeguard the lives of individuals within its jurisdiction. As a consequence of this duty, an Article 2 inquest involves not just looking at the "who, when, where, and how" questions but also whether there was a failure on the part of the State under its Article 2 obligations that led to the death.

All inquests must comply with Section 5(1) of the Coroners and Justice Act 2009 which sets out that the purpose of a coroner's investigation into a person's death is to ascertain: (a) who the deceased was; (b) how, when and where the deceased came by his or her death; and (c) certain formal particulars which need to be registered concerning the death. Ascertaining 'how' the deceased came by his or her death had been understood narrowly as meaning "by what means". However, in the case of *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 it was held that in

order to comply with the state's obligations under Article 2, the purpose of the investigation extends to ascertaining "…and in what circumstances" the deceased came by their death.

When is an Inquest an Article 2 Inquest?

A violent, unnatural or unexplained death in custody - and therefore under the care or guardianship of the State - will lead to an Article 2 inquest. The most obvious circumstances are where the deceased was a prisoner, or was detained under the Mental Health Act 1983. (Where a person in state detention dies a plainly natural death, however, the enhanced investigative duty is not automatically engaged: *R (Tyrrell) v HM Senior Coroner for County Durham and Darlington* [2016] EWHC 1892 (Admin).)

For Article 2 to be engaged, in terms of a positive obligation on the State to protect an individual, it is necessary to show that the State knew, or ought to have known at the time, of a real and immediate risk to the life of the individual and failed to take whatever action it could - being both within its powers and considered reasonable - to prevent that risk.

In this context the term 'risk' means a significant or substantial risk, rather than a remote or fanciful one. The risk must be "present and continuing" as opposed to "imminent" and it must be a risk to life rather than of harm, even serious harm. The term 'real' in this context focuses on what was known or ought to have been known at the time (*Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2).

The leading modern authority is now the Supreme Court's decision in *R (Maguire) v HM Senior Coroner for Blackpool & Fylde* [2023] UKSC 20. The Court drew a clear distinction between the State's systems duty - to have appropriate legal and administrative frameworks in place to protect life - and the operational duty described above, and confirmed that the enhanced (*Middleton*) form of inquest is required only where there is an arguable breach of one of those substantive duties. In *Maguire* itself, which concerned the death of a vulnerable care home resident who had been deprived of her liberty under the Mental Capacity Act 2005, the Court held that Article 2 was not engaged: such failings as there may have been were individual lapses in the provision of care, rather than systemic failures. Similarly, in *R (Morahan) v West London Assistant Coroner* [2022] EWCA Civ 1410 the Court of Appeal held that there was no automatic investigative duty where a voluntary psychiatric in-patient died of a drug overdose in the community.

Whether an inquest should be an Article 2 inquest or not can lead to a great deal of argument. The decision is usually taken at a Pre-Inquest Review Hearing and if it looks as if it might be appropriate to hold an Article 2 inquest, then the Coroner can invite submissions on the point. Bear in mind however that even if a decision is taken not to hold an Article 2 inquest at that stage, this can change at a later point, even during the final inquest hearing or at the very end.

Conclusions in Article 2 Inquests

Narrative conclusions in Article 2 inquest cases tend to be longer and more detailed. A short-form conclusion may be sufficient, however, frequently a narrative conclusion will be required in order to satisfy the procedural requirement of Article 2, including, for example, a conclusion on the events leading up to the death, or on relevant procedures connected with the death. A conclusion in an Article 2 inquest may be a 'judgmental conclusion of a factual nature [on the core factual issues], directly relating to the circumstances of death', without infringing either section 5(3) of the 2009 Act (limiting opinion) or section 10(2) (avoiding questions of criminal liability on the part of a named person or civil liability). This is the crucial difference between an Article 2 inquest and a "traditional" inquest in which "judgmental" language is not allowed.

Inquest basics: Juries

In the fourth of a series of articles delving into the world of inquests, Charlotte Davies (2007) examines when and why a jury may be empanelled for an inquest.

It used to be the case that every inquest had a jury. The default position today however is that inquests will be held without a jury and the vast majority of inquests are heard by a coroner sitting alone.

Section 7 of the Coroners and Justice Act 2009 provides as follows:

7 Whether jury required

(1) An inquest into a death must be held without a jury unless subsection (2) or (3) applies.

(2) An inquest into a death must be held with a jury if the senior coroner has reason to suspect—

(a) that the deceased died while in custody or otherwise in state detention, and that either—

(i) the death was a violent or unnatural one, or

(ii) the cause of death is unknown,

(b) that the death resulted from an act or omission of—

(i) a police officer, or

(ii) a member of a service police force, in the purported execution of the officer's or member's duty as such, or

(c) that the death was caused by a notifiable accident, poisoning or disease.

(3) An inquest into a death may be held with a jury if the senior coroner thinks that there is sufficient reason for doing so.

Where the facts surrounding the death point to circumstances identified in s.7(2), a jury must be empanelled. The phrase "has reason to suspect" imposes a low threshold, does not require prima facie proof, and any information giving "reason to suspect" will suffice. Greater argument surrounds s.7(3): where the coroner thinks that there is "sufficient reason" for a jury. However, even situations that arguably fall under s.7(2) may not be so straightforward. For example, there has been significant case law surrounding what amounts to "custody" or "state detention".

One temporary qualification to s.7(2)(c) should be noted. From 28 June 2022, Covid-19 was disapplied as a notifiable disease for these purposes (s.7(5) CJA 2009, inserted by the Judicial Review and Courts Act 2022 and extended by regulations in 2024), so that a death suspected to have been caused by Covid-19 did not of itself require a jury. That disapplication was time-limited to 27 June 2026 and, unless further extended, has now lapsed.

The CJA 2009 defines a person as being in state detention if they are compulsorily detained by a public authority within the meaning of s.6 of the HRA 1998. The explanatory notes to the Act give examples "such as while the deceased was detained in prison, in police custody or in an immigration detention centre, or held under mental health legislation, irrespective of whether the detention was lawful or unlawful".

In *R (Boyce) v HM Senior Coroner for Teesside and Hartlepool (and (1) Middlesbrough Borough Council (2) Tees Valley Care Ltd)* [2022] EWHC 107 (Admin) it was decided that a child placed in a care home by the Local Authority was not in state detention. In *R (Ferreira) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31 the Court of Appeal decided that a person receiving life-saving treatment in intensive care was not in state detention. Following the Policing & Crime Act 2017, with a death occurring on or after 3 April 2017, any person subject to a deprivation of liberty

formally authorised under the MCA 2005 is no longer 'in state detention' for the purposes of the CJA 2009.

In *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, it was held that the position of a voluntary patient will in some circumstances equate with that of a patient detained under the Mental Health Act 1983 for the purposes of engaging Article 2 ECHR, which may affect the jury requirement in cases of 'state detention'.

In deciding whether or not to exercise the discretion under s.7(3), the coroner will consider a number of factors. It is important to note that the mere fact that Article 2 is engaged, is not in and of itself sufficient.

In *R (Fullick) v HM Senior Coroner for Inner North London* [2015] EWHC 3522 (Admin) the court said appropriate matters for consideration were:

- the wishes of the family;

- submissions made on behalf of any other interested person;

- whether the facts of the case bear any resemblance to the types of situations covered by the mandatory provisions;

- the circumstances of the death; and

- any uncertainties in the medical evidence.

In *R (Paul) v Deputy Coroner of the Queen's Household and the Assistant Deputy Coroner for Surrey* [2007] EWHC 408 (Admin) it was stated that factors which might influence the exercise of the discretion include the views of the family and whether the facts of the case bear any resemblance to the situations in which a jury is required. Taking into account the policy considerations behind those situations, an important consideration is where there is a possibility that state agents have some responsibility for a death. It was further confirmed that a relevant consideration may be the ability of a coroner sitting alone to provide a reasoned decision.

In *R (Collins) v HM Coroner for Inner South London* [2004] EWHC 2421 (Admin) it was stated that the coroner's discretion must be exercised judicially and that it was a proper exercise of the discretion to take into account that the coroner sitting alone could give a reasoned decision, whereas a jury could not. The relevant events had occurred long before and it was particularly important that any conclusion should be fully reasoned. It was also held to be relevant in weighing

against calling a jury that at the end of the inquest the coroner would have to consider a mass of heavy and difficult documentation, which is the sort of exercise best carried out by a professional judge.

As can be seen, whether or not to empanel a jury is often not a straightforward question for the coroner. Submissions are often invited at the Pre-Inquest Review Hearing.

Inquest basics: Causation

Charlotte Davies - who has a specialist practice area in inquests - examines the case law on causation in the coroners' court in the context of the conclusion of the inquiry into the death of Steve Dymond.

The well-publicised findings and conclusion delivered in 2024 by the coroner at the close of the inquest into the death of Steve Dymond, who took his own life seven days after appearing on the Jeremy Kyle Show in May 2019, raised questions about what evidence is required to satisfy a coroner of a causative link between an event and subsequent death.

The case law on causation in the coroners' court is well-traversed.

In *R (Tainton) v HM Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin) it was said that for causation of death to be established, the threshold is *"whether on the balance of probabilities, the event or conduct more than minimally, negligibly or trivially contributed to the death"* [para.41]. The relevant event *"must make an actual and material contribution to the death of the deceased"* [para.62]. The crucial point being that it must be proven that the relevant event *itself* was causatively linked to the death.

In *R (Wandsworth) v HM Senior Coroner for Inner West London* [2021] EWHC 801 (Admin) the deceased had lived in a property where asbestos was present. However, this was not sufficient to establish that the fatal mesothelioma they went on to develop was caused by the fibres from that asbestos. The fact that a person was possibly exposed to asbestos at an address, combined with asbestos often being the cause of mesothelioma, was not sufficient for a finding that the asbestos from the property caused the death.

The Court of Appeal case of *Dove v Assistant Coroner for Teesside* [2023] EWCA Civ 289 further confirmed the above approach and made it clear that any consideration of the causation on a "but-for" basis would be wrong.

Most recently, in *R (O'Brien) v HM Assistant Coroner for Sefton, Knowsley and St Helens* [2026] EWCA Civ 499, the Court of Appeal gave guidance on causation in the context of a death in which domestic abuse, and earlier contact between the deceased and the police, featured. The Court cautioned against dismissing counterfactual possibilities - the "what ifs" of causation - too readily at an early stage of the inquiry. The threshold remains as set out in *Tainton*, but the evidence capable of satisfying it must be properly explored before it is rejected.

In Mr Dymond's case, His Majesty's Area Coroner Jason Pegg, in what was a *Jamieson* (non-Article 2) inquest, found that there was *"insufficient evidence"* to find that his appearance on the Jeremy Kyle Show was either contributory or the direct cause of Mr Dymond's death, adding that there was *"no causal link"* between the two. Mr Dymond had failed a lie detector test which had been used to determine whether he had been unfaithful to his partner. Mr Pegg said *"The deceased's decision to take his own life was made in the context of his mental distress that was probably exacerbated by his belief that a significant relationship had now irretrievably broken down following his participation on a television programme where it had been suggested that the deceased had lied to his partner"*. There had been no mention of his treatment on the show in any of the notes Mr Dymond had left for his family. Mr Pegg said, that *"whilst possible"* that his appearance on the show added to his distress, *"it is not probable"*.

The case of Mr Dymond serves as a reminder about the causation test in coronial proceedings and how coroners apply the evidence in the context of that test in making their findings. As with all inquests, and indeed any proceedings, the findings will turn on the evidence heard and the facts of the case. Whilst it may appear surprising to those who watched the events (literally) play out on television, and read the subsequent tabloid headlines, the coroner would have carefully considered whether the evidence before him met the tests set out above.

It is worth noting that in an Article 2 (*Middleton*) inquest (held where there is the potential that the state (or 'its agents') has failed in its negative obligation to refrain from taking life, or in its positive obligation to take appropriate measures to safeguard life), the coroner has a power to record (or leave to the jury) - for the purpose of a narrative conclusion - circumstances that are *possible* but not probable causes of death.

Inquest basics: Conclusions

In the fifth of a series of articles delving into the world of inquests, Charlotte Davies (2007) examines the conclusions that can be reached at the end of an inquest.

The Coroner's Court is a fact-finding inquiry rather than an adversarial trial, and so it reaches a "conclusion", as opposed to a "verdict". The use of the term "verdict" was removed from the inquest process in July 2013 when various parts of the Coroners & Justice Act 2009 came into force, albeit you may still see the phrase used (wrongly) in press reports.

The purpose of this final stage of the process is to answer the "how" of the "who, where, when and how" questions the coroner must answer.

Legal representatives acting for the Interested Persons can make submissions about which conclusion(s) the coroner should consider, with representatives only being allowed to make submissions on the law, and not on the facts. Coroners are reminded by the Chief Coroner's guidance (now largely consolidated into the Chief Coroner's Bench Book) that they should at all times use moderate, neutral and well-tempered language, befitting the holder of a judicial office.

The coroner is required to arrive at a conclusion by way of a three-stage process.

1. To make **findings of fact** based upon the evidence.

The coroner will make key findings on the evidence that they have heard. The standard of proof on which they will do this is the civil standard.

2. To record **by what means** the deceased came by their death.

This will usually be a description of the mechanism of death such as 'by drowning while swimming in the open sea' or 'hanging from a beam using a rope as a ligature'. Coroners, in their judicial discretion, will use their own form of words which should be brief, neutral and clear. They must not include opinion other than on matters which are the subject of statutory determination (s.5(3), 2009 Act) and they must not appear to determine any question of criminal or civil liability on the part of a named person (s.10(2)).

3. The **conclusion** will either be what is known as a 'short-form' conclusion or a narrative conclusion.

Short Form

Some examples of short form conclusions are:

Natural causes - This is considered to be the normal progression of a natural disease or illness, where a naturally occurring disease runs its full course without any significant amount of medical care or human intervention;

Suicide - This is defined as a deliberate act by the deceased where the intended consequence of that act was, at all times, death. The requirement that a conclusion of suicide had to be reached on the criminal standard of proof was removed by the Supreme Court in the case of *R (Maughan) v HM Senior Coroner for Oxfordshire* [2020] UKSC 46; the civil standard - the balance of probabilities - now applies to all conclusions, including suicide and unlawful killing;

Accident/misadventure - an unnatural event which was neither unlawful nor intended by the deceased to result in death;

Industrial disease - when the death resulted from a disease caused by work;

Alcohol/drug-related - this can cover an accidental death resulting from abuse of alcohol or drugs, or from death being the result of being addicted to alcohol/drugs;

Open - this is used when none of the other conclusions are appropriate and/or the evidence does not fully explain the circumstances of the death. For example, where there is insufficient evidence as to intent to record a conclusion of suicide.

A Narrative Conclusion

This is an 'alternative' to a short-form conclusion whereby the coroner may record a 'brief narrative conclusion' which goes into more detail regarding the factual findings.

Narrative conclusions may be used in both Article 2 and non-Article 2 cases. In a non-Article 2 case, a narrative conclusion should be a brief, neutral, factual statement; it should not express any judgment or opinion. For example, in a clinical death, a narrative conclusion might state that the deceased died from recognised complications of a surgical procedure.

If the inquest is an Article 2 inquest, the wording used in a narrative conclusion can be judgmental. In a non-Article 2 case, by contrast, judgmental words such as 'missed opportunities' or 'failure' should be avoided. This is why there is often significant argument over whether an inquest should be Article 2 or not. Interested Persons may be seeking to avoid the prospect of there being a narrative conclusion which includes judgment or critical wording.

The higher courts have repeatedly emphasised the need for brevity in a narrative conclusion. A sentence or two, or a single short paragraph, will be sufficient.

Inquest basics: Challenging a Coroner's Decision

In the sixth, and final, article of a series delving into the world of inquests, Charlotte Davies (2007) examines when a decision or conclusion following an inquest can be challenged, and how.

It is sometimes possible to challenge a decision taken by a Coroner, or indeed the conclusion of an inquest, however there is no automatic right to appeal.

A challenge may be made in two ways:

Applying to the High Court for a judicial review

An application to the High Court for permission to judicially review a decision taken by a Coroner needs to be made as soon as possible following the making of that decision, and within three months at the very latest. The principles upon which the application will be assessed are the same as for any application for judicial review and are concerned with the fairness of the procedure and whether the Coroner properly exercised his or her powers.

An application under s.13 of the Coroners Act 1988

The timeline for an application pursuant to s.13 of the Coroners Act is not as strict as for judicial review. Such an application can only be brought with the consent, or *'fiat'*, of the Attorney General. If the fiat is refused, that is effectively the end of the matter: the Divisional Court has recently confirmed that a refusal by the Attorney General to grant a fiat is non-justiciable and cannot itself be judicially reviewed, save perhaps in cases of dishonesty or bad faith (*R (Campbell) v HM Attorney General* [2025] EWHC 1653 (Admin), following the earlier decision in *R (Lyttle) v (1) Attorney General (2) HM Senior Coroner for Preston* [2018]). Once the consent of the Attorney General has been given, the High Court may order an investigation into the death to be held by the same or another coroner, or quash the determination or finding of the original inquest, if one has taken place.

To quash the original inquest and order a fresh investigation, s.13 of the Act provides that the High Court must be satisfied that it is necessary or desirable in the interests of justice that an investigation, or another investigation, be held, whether because of fraud, rejection of evidence,

irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise.

The most notable example of a quashing is of the original Hillsborough inquest findings. In 2012 the Hillsborough Independent Panel published a report which highlighted new evidence relating to the Hillsborough disaster. The Attorney General then applied under s.13 and the court subsequently quashed the original findings and ordered that fresh inquests should take place.

The following further examples of challenges to Coroners' decisions are also of interest:

In *R (Sturgess) v HM Senior Coroner for Wiltshire and Swindon* [2020] EWHC 2007 (Admin), Dawn Sturgess had died in 2018 after spraying herself with Novichok from a bottle disguised as perfume following the poisoning of the Skripals. The claim challenged the Coroner's preliminary ruling to consider only the actions of two Russian nationals and how the Novichok arrived in Salisbury, but not to investigate whether other members of the Russian state were involved, or the source of the Novichok. The court confirmed that Coroners' obligations do not extend to investigating agents of another state believed to be implicated in the death. In terms of Russia's responsibility more generally, the court held that an inquest was the appropriate forum to investigate the source of the Novichok and the directions given to the two Russians. Given the Inquest Rules allow for a conclusion of "lawful killing", the court was "puzzled" by the Coroner's reluctance to consider the actions of the men on the basis that it could lead to a civil liability determination against Russia. The matter was remitted to the Coroner for further consideration.

The subsequent history of the Sturgess case is itself instructive. The inquest - by that stage being conducted by Baroness Hallett - was suspended and converted into a statutory public inquiry under the Inquiries Act 2005, so that closed material bearing on Russian state responsibility could be considered. The Dawn Sturgess Inquiry, chaired by Lord Hughes of Ombersley, published its report on 4 December 2025, concluding that Ms Sturgess's death was a direct consequence of the attempted assassination of Sergei Skripal and that responsibility for the attack lay with the Russian state. Following publication, the Chief Coroner confirmed that the suspended inquest would not be resumed. Conversion to a public inquiry remains the established route where an Article 2-compliant investigation cannot be achieved at an inquest because sensitive material cannot be heard in public.

In *R (Iroko) v HM Senior Coroner for Inner London South* [2020] EWHC 1753 (Admin), the Chief Coroner stated that the court's role in considering the decision of the Coroner was narrow. Mrs

Iroko had died in hospital following cardiac arrest but issues had arisen over the Trust's Do Not Resuscitate policy. As a preliminary ruling, it was held that there was no evidence that any failure or dysfunction in her treatment was systemic or due to a failure to put in place a regulatory framework, and as such Article 2 did not apply despite the acceptance that there may have been failings in her care. The court noted deficiencies by hospital staff but was unpersuaded that they cumulatively gave rise to 'systemic dysfunction' such as to require an Article 2 inquest and the judicial review was therefore dismissed.

There perhaps appears more of a willingness on the part of the courts to entertain challenges to decisions arising out of deaths that provoke an international interest, rather than those taking place in a medical setting. Whilst it is understandable that greater scrutiny might be expected by the public over the incidents that took place at Hillsborough and in Salisbury, where does that leave families who have lost loved ones to the "deficiencies" of our health service?

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