Road death inquests in Northamptonshire
Guide for bereaved families

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Foreword

Whilst a road death may feel like the worst thing that could have happened, we believe that a family's suffering can be further aggravated by the lack of information about unfamiliar procedures, such as inquests. The Northamptonshire Police and Crime Commission works to prevent this and has funded RoadPeace, the national charity for road crash victims, to provide information and support to families bereaved by road crashes in Northamptonshire.

This guide explains the role of inquests and coroners after a road death in Northamptonshire. It is written from the perspective of the bereaved and highlights their rights and role whilst also flagging up common concerns. Produced by RoadPeace, it is based on their experience of supporting and representing bereaved families since 1992.

If you have any questions or would like to talk to someone who is further along this unchosen journey, please call the RoadPeace helpline (0845 4500 355). A list of other references and organisations to contact is provided at the end of this guide. You are not alone nor sadly will you be the last family to need information on coroners and inquests. Please send any suggestions to RoadPeace on how to make this guide more useful for the next bereaved family.

Adam Simmonds
Northamptonshire Police and Crime Commissioner

Key points

- An inquest is a fact finding inquiry to record who, where, when and how the deceased came to their death.
- It is not about blame. The coroner cannot determine criminal culpability or civil liability.
- Post mortems can be expected to be held in all road deaths.
- The deceased cannot be released to their family until the coroner gives permission, and this will be after the post mortem (there may be more than one).
- All road deaths have inquests opened, but they are then adjourned until the end of the police investigation.
- Inquests are held in cases where no one is being prosecuted for causing the death. This is the case with the majority of road deaths in Northamptonshire.

Key advice

- Inform the coroner's office which dates to avoid in the coming year.
- Try to attend another inquest first. Familiarise yourself with the structure and tone of an inquest before you attend the inquest into your loved one's death.
- If you want to read an opening statement about the deceased, ask the coroner for permission to do this.
- If you want specific questions asked at the inquest, send them to the coroner ahead of time. You don't have to but this will help ensure the issues are covered. All questions must relate to the death.
- If a specific conclusion (verdict) is wanted, write to the Coroner in advance.
- If a driver has pleaded guilty to causing the death and you want an inquest, notify the Coroner.
- Coroners can take action to reduce risk by making a Preventing Future Deaths report. If you want this, write to the Coroner before the inquest requesting one.

Introduction to this guide

Whilst most familes will have some understanding of a police investigation, few know what a coroner does or what an inquest involves. And most importantly, few know what it means for their deceased. It is only after a sudden and unnatural death as in a road crash, that families will need to know this. However, when you are reeling from such a shock, learning new information and procedures can be difficult. This guide is intended to supplement the national BrakeCare guide which all bereaved families receive, as well as the Guide to Coroner Services produced by the Ministry of Justice. Please do consider asking a relative or friend to help you by also reading these guides.

This guide has been organised into three main sections, based on our experience of answering questions about road deaths and inquests for over two decades.

Part 1 focuses on explaining the inquest system,including families' most likely immediate concerns.

Part 2 covers the full inquest on the day, including its structure and the role of the bereaved family.

Part 3 explains what happens after an inquest, including what you can do if you are unsatisfied with the inquest outcome.

Part 1 The Inquest System

1 What is an inquest

An inquest is a public hearing into an unnatural death. Inquests are opened (started) in all road deaths.

Why is it needed:
It is for the legal recording of :

- Who died
- How they died
- When they died
- Where they died

It does not determine blame. The coroner's court does not determine either criminal culpability or civil liability, though the evidence revealed at the inquest may help in a civil compensation claim.

Inquests are also intended to reduce the risk of reoccurence.

When does it happen?
Inquests are opened within a few days of the death but then adjourned for the police investigation. More on the opening of the inquest is covered in the next section.

The full inquest should happen within six-twelve months of the death.

If a driver is being prosecuted for causing the death, the inquest will not be resumed.

If new evidence at the inquest indicates a prosecution should be reconsidered, the Coroner can pass the case back to the CPS. This, however, is very rare and families should not rely on it.

If the driver pleads guilty and there is no trial, then the inquest may be resumed to allow a public hearing of the evidence and the opportunity to question witnesses. The family should contact the Coroner and request this, if they want an inquest.

How much notice will the family be given?
According to the Ministry of Justice, families must be told of the inquest date within one week of it being set. In Northamptonshire, the Coroner will give give familes several weeks notice. Please remember to inform the Coroner's office which dates are not suitable for your family.

Where is it held?
Road deaths that occurred in the south of the county are held at the Northamptonshire General Hospital. It may be possible to have the inquest held at another location, if families find the Hospital venue distressing. Ask the coroner's officer about this.

For deaths occurring in the north, inquests are held at the Kettering Magistrates Court.

Does it involve a jury?
Less than 2% of inquests involve juries. In general, jury inquests are only held in road deaths when a a police driver has been involved in the fatal crash.

Who is the coroner?

Mrs. Anne Pember is the coroner for Northamptonshire. As of 2015, she has been a coroner for 21 years. She was appointed by the Northamptonshire County Council but can only be removed by the Lord Chancellor. The Coroner is largely independent, though they are offered guidance by the Chief Coroner, to promote national consistency .

Mrs Pember has an Assistant Coroner, Mr. Shah. They are assisted by coroner's officers, who will be the primary point of contact for families.

What you can expect from the coroner's office

Below is the basic services that bereaved families can expect from the coroners office and their requested role.

The coroner's office will:

- explain the role of the coroner and answer your questions about coroner investigations;
- give you contact details for the office, i.e. a named individual and his or her phone number or email address
- help you understand the cause of death;
- inform you of your rights and responsibilities;
- take account where possible of your views and expectations, including family and community preferences, traditions and religious requirements relating to mourning, post-mortem examinations and funerals;
- provide a welcoming and safe environment and treat you with fairness, respect and sensitivity;
- act with compassion and without judgement about the deceased and the cause of death;
- treat children and young people involved in an investigation in an age-appropriate way in co-operation with the adult(s) responsible for their care;
- make reasonable adjustments, wherever possible, to accommodate your needs if you have a disability (including a learning disability);
- help you to find further support where needed;
- during a long investigation, unless otherwise agreed with you, contact you at least every three months to update you on the progress of the case, and explain reasons for any delays;
- explain, where relevant, why the coroner intends to take no further action in a particular case.

Source: Ministry of Justice (2014), Guide to Coroners Service, pp.1-2

Your role—what the coroner will expect from you

Your role in a coroner's investigation is very important and you have certain responsibilities. You should:

- co-operate fully with the coroner's office and promptly provide all information that is relevant to the investigation;
- inform the coroner's office of any concerns or worries you may have about the death;
- treat the coroner and his or her officers and other staff with respect;
- wherever possible nominate one individual as the 'next of kin' for communication with the coroner's office. This helps ensure prompt and accurate sharing of information;
- inform the coroner's office of any change of circumstances, such as address or contact number, so you can be contacted promptly;
- not share information that the coroner's office gives you if you are told that it is confidential;
- inform the coroner's office as soon as possible of any specific needs you have for the inquest, e.g. relating to a disability, or if English is not your first language, so that reasonable measures can be taken.

Source: Ministry of Justice (2014), Guide to Coroners Service, pp.2

Coroner contact details

Email: coroners@northantscoroner.com
Telephone: 01604 624732

HM Coroner for the County of Northamptonshire
110 Whitworth Road
Northampton, NN1 4HJ

2 Opening of the inquest

When will the inquest be opened
The inquest will be opened as soon as reasonably possible. The Northamptonshire Coroner sits (works) two days a week (Wednesday and Thursday) and so the inquest may be opened in the week following the death, at the latest. The post mortem, discussed in the next chapter, will most likely have occurred before the inquest is opened.

What happens at the opening?
It is a short hearing that may only last a few minutes. The coroner receives evidence of the identification of the deceased. This will include name, age and address of the deceased, and thus answers the question of who was killed. Once this information is reported at the opening, it is in the public domain. This means that the deceased's identify can be published on-line and in newspapers.

No evidence is ever called at the opening of an inquest in Northamptonshire. Families are not needed to speak or attend.

Coroners will give directions on when reports such as post mortem report is to be produced. These are usually required to be provided within six weeks.

At the opening, coroners set the date of the inquest. As this will depend upon the police investigation, the coroner sets an inquest data several (5-6) months away. However if the coroner has not received the collision investigation file from the police a month before the scheduled date, it will be postponed.

Do inform the coroner's office of any dates in the future which you want them to avoid.

The opening of the inquest should be recorded.

Rights of the family
Families are required to be notified of the opening. But as this is a short procedural hearing, they are not encouraged to attend.

Who else may attend?
The opening of the inquest is held in public and others, including the press, may attend. It is a public hearing and represents the start of the coroner court proceedings.

After the opening
The coroner's officer will be in touch after the opening of the inquest. Let them know how you would like your loved one's belongings returned.

3 Post mortems and release of the deceased

The Coroner is not able to release the body of your loved one until the post mortem(s) are completed. Coroners are supposed to release the deceased within 28 days but this can be delayed due to a second post-mortem.

The Coroner will allow you to see your loved one before release is authorised. Contact the coroner's office to arrange viewings.

What is a post mortem?
A post mortem is a medical examination to determine the cause of death. Post mortems are held for all road deaths in Northampton.

There are different types of post-mortems. If a criminal prosecution is not expected, a standard post mortem may be conducted by a hospital pathologist. But if a driver is being prosecuted for causing the death, a forensic post mortem will be required. This is conducted by a Home Office approved pathologist. It is more thorough (and also more expensive).

Rights of the family
The Coroner is required to tell you when the post mortem is to be held and where. Although you do not have the right to attend, you do have the right to be represented by a medical practitioner. This could be your GP.

Warning—second post-mortems
If a driver has been arrested on suspicion of causing the death, they have the right to request a second post mortem in order to confirm the death was caused by the crash, and not natural causes. In Northamptonshire, they will have two weeks to decide if they want a second post mortem.

If no-one has been charged within a month but the investigation remains open and a criminal prosecution possible, the coroner will arrange a second post-mortem examination. This will be done by a second pathologist who is independent of the one who carried out the first post mortem.

This can delay the release of the deceased's body for several weeks, which can cause much distress. Families do not have the right to prevent this.

The post-mortem examination report
A report will be send to the coroner with the results of the post mortem including tests conducted for drugs and alcohol. All road deaths over the age of 16 are tested for alcohol or drugs. The results of the toxicology report will be presented at the inquest and will thus be in the public domain.

What the post mortem report does not clarify is if the death was instantaneous. This is a key question for many families and is often asked of the pathologist at inquests.

You can request a copy of the post mortem report. There should be no charge for this.

Are organs ever retained after a coroner's post-mortem examination?
Very rarely, small pieces of tissue or an organ may need to be taken from the body for further examination.

When can a death be registered?

A death certificate cannot be issued until after a criminal case or inquest is finished. But an interim death certificate, officially known as a coroner's certificate of fact of death, can be issued for road deaths. This will be acceptable to banks.

4 Preparing for the inquest

One of the most common remarks RoadPeace hears from families is how unprepared they feel at the inquest.

You can prepare by attending another inquest first. Avoid having your loved one's inquest be the first time you experience an inquest. Tell the coroners' office that you would like to observe another road death inquest and ask to be provided with possible dates and times. Inquests are open to the public but you may want to ask permission of the other bereaved family first.

What you need to know

Disclosure before the inquest

Since 2013, coroners have a pro disclosure policy and are expected to release evidence before the inquest, unless a criminal prosecution is still being considered. Mrs Pember will will write to the family (and any other properly interested persons) to ask if they want to see the evidence, including the post mortem report, witness statements, and collision investigator report. There is no charge for these documents.

What are pre-inquest reviews?

Pre-inquest reviews are held if the coroner needs to discuss the scope of the inquest. They are rarely held with road death inquests in Northamptonshire.

Rights of the family

If a pre inquest review is scheduled, the family will be notified and can attend. The (other) driver involved and their legal representatives, and any other "properly interested person" will also be invited to attend.

Legal Representation--do I need a solicitor?

If you are concerned about the circumstances of the death, please consider getting a solicitor to represent you. Families will not only lack the professional experience and training of solicitors, but they can also be expected to be emotionally affected by the evidence given about their loved one's death.

If a civil claim is being pursued, families should first ask their personal injury solicitor about representation at the inquest. It is useful for solicitors to attend the inquest and hear the evidence in cases they are handling. It should be possible to claim the cost of legal representation in a civil compensation claim.

Is legal aid (free legal assistance) available?
Legal aid is very rarely available.

Families can contact the Bar Pro Bono unit (http://www.barprobono.org.uk/), who may be able to help.

Ways you can contribute to the process

Preparing a statement on the deceased
The inquest will open with a statement on the deceased. This should be kept short and simple. Many families want to speak at the inquest and ensure that the deceased is portrayed accurately and sensitively. This can be a written statement that the coroner reads out, if the family does not want to speak.

Disclosure of medical records
At the inquest a GP report will be presented in addition to the post-mortem. Families should contact the coroner's office if they have concerns about the medical information that may be disclosed at an inquest and reported by the press. But you have no right to stop the release of information.

Witnesses called
The coroner chooses which witnesses need to attend the inquest in person, which can have statements read and which are not mentioned. You may have questions about the witnesses and why certain individuals have not been invited. It is possible to see all the witness statements in advance. You can ask the coroner to request witnesses attend in person.

Who can attend an inquest?
Inquests are open to the public. All can attend, including the press. A few days before the inquest, the media will be alerted to the date and time of the inquest.

Many families also want to see lessons learned from their loved one's death and, if they attend, the press can help. If this is the case, then you are encouraged to prepare a statement and have photos that can be emailed to the press.

Preventing Future Death (PFD) Reports
Coroners have a public health duty to prevent future deaths. Coroners can make a Preventing Future Deaths Report which asks for certain aspects of the death to be considered. Most PFD reports related to highway design, but they can also address vehicle design or be driver related.

Families should inform the coroner if they would like a PFD report to be made.

Part 2: The Inquest – On the Day

5 Order of the Day

At the Court

Where do we wait?
There is no separate waiting area for the family outside the Court so expect to be in close proximity to any other drivers (and their families) or witnesses to the crash.

How many people can come with me?
The Coroner Courts in Northamptonshire are large and can hold up to 50 people so you can bring family and friends to support you.

What support is available during the inquest?
In Northamptonshire, Police Family Liaison Officers (FLOs) attend inquests and so should be able to answer any questions you have.

How long will it last?
Road death inquests involving multiple vehicle collisions can last less than an hour whilst a single vehicle fatal collision (where the driver is the only fatality) may only last 20-25 minutes.

Sequence

1. The inquest starts with a reading of the opening statement about the victim, written by the family. This will usually be read by the Coroner, but as mentioned previously, the family can ask to do this

2. Evidence is then heard. The post mortem may be read, or summarised. A report from the GP of the deceased will also be presented.

   > Families should not worry about having to hear details or see photos that they don't want to. Coroners will allow families to leave the room if any potentially distressing information is to be given.

3. Witnesses to the crash are next. They will either give evidence or their statements will be read out, as determined by the Coroner. Witnesses who have been summoned must attend or face prosecution, with a fine or prison sentence possible (though highly unlikely).

   Witnesses are questioned by the coroner first. Coroners can warn drivers that they do not have to answer any question that might incriminate them. Families should be prepared for this.

   You (or your legal representative) will be offered the chance to ask questions after the coroner. Questions must not imply blame.

   Others can also ask questions if they have been identified as a "Properly Interested Person". This will include the driver and their legal team.

4. The collision investigator is usually the last to give evidence.

5 At the end of the hearing, the Coroner will leave the court to review of the evidence and prepare the report on their conclusions.

Coroner's conclusions
What used to be called the verdict is now known as the conclusion. This is intended to avoid any association with a criminal court trial. The conclusion of the inquest will relate to the cause and circumstances of the death, based on an evaluation of the evidence. It does not imply guilt.

It can take three different forms: a *short form conclusion*, a narrative conclusion or a combination of the two.

There are nine short form conclusions possible. The key one for road deaths is Road Traffic Conclusion. This conclusion was introduced in 2013. The other short form options include:

- Accident or misadventure
- Alcohol/drug related
- Industrial disease
- Lawful/unlawful killing
- Natural causes
- Open (used when there is insufficient evidence for any other outcome)
- Stillbirth
- Suicide

A narrative verdict is a summary description of the circumstances involved. A narrative verdict can be given on its own, or in combination with one of the short form conclusions.

The Coroner should also say if they are planning to produce a Preventing Future Death Report.

Inquest recordings and transcripts
Families can purchase copies of the inquest hearing recordings for £5 per diskette.

Transcripts are much more expensive with families charged per page.

Part 3 After the inquest

6 Preventing Future Death Reports

If the Coroner decides to make a Preventing Future Deaths Report (PFD), this will be sent after the inquest. In an attempt to encourage more PFD reports, the Chief Coroner has issued guidance and provided templates for coroners to use.

A PFD report is a request that a problem be considered. They are not supposed to recommend what action should be taken. PFD reports are addressed to the relevant authority. This can be a national or local agency.

A response is required within 56 days explaining what action, if any, is to be taken, and a timetable. If no action is to be taken, then it should clarify why not.

A copy of the PFD report and the response will be be sent to the family.

In the five years between October 2008 and October 2013, the Northamptonshire Coroner was reported as having issued two road death related Rule 43 reports. Both related to highway design and included:

- Writing to Northamptonshire County Council to ask that they consider regularly checking gullies and drains in Towcester Road, Milton Malsor to prevent them becoming blocked (Summary of Rule 43 reports, Number 3, 1 October 2009 and 31 March 2010)
- Writing to the Highways Agency to consider erecting a pedestrians crossing warning sign on the A45 dual carriageway at Wootton, Northamptonshire. (Summary of Rule 43 reports, Number 4, 1 April and 30 September 2010).

Since 2014, PFD reports are being published on line on the Chief Coroners website pages of the judiciary website.

7 Complaints and appeals

Complaints about a coroner's personal conduct
If you are unhappy with a coroner's behaviour, you are supposed to raise this with the coroner first.

You can then complain to the Judicial Conduct Investigations Office at

The Judicial Conduct Investigations Office
81-82 Queens Building
Royal Courts of Justice
Strand
London WC2A 2LL
Tel 020 7073 4719
Email inbox@jcio.gsi.gov.uk

Complaints about the standard of service received
Families should send complaints about the standard of service to the coroner involved and a copy to the Chief Coroner and the Northamptonshire County Council. RoadPeace would like to receive copies of any complaints. We want to keep the Chief Coroner informed but families should be aware that he does not investigate complaints about individual coroners.

Complaints about a pathologist who conducts the post-mortem examination
Complaints about the pathologist should be first raised with the coroner.

Appeals
Families do not have the right to appeal an inquest conclusion.

Seek advice from a solicitor on how to challenge a coroner's decision. This usually involves a judicial review which can be very expensive. It is also possible to request the Attorney General squash the determination. But legal aid for judicial reviews is difficult to obtain.

8 Feedback

Since your loved one was killed in a crash, more people have died on Northamptonshire's roads. If you have any suggestions on how to improve this guide, RoadPeace would like to know. We would appreciate learning if this guide was useful to your family.

9 Further support and information

Where can I get further general information about coroner investigation?

We have a list of additional sources of information on coroners and inquests on our website. This includes references from both government and other campaigning and support organisations. This list can be posted if needed.

Where can I get bereavement support?**RoadPeace**

In addition to a local (Northampton) group for bereaved families, RoadPeace runs a national helpline, a befrienders service and a Resilience Building Support Programme.

www.roadpeace.org

Brake

National Road Safety charity providing support for road crash victims and carers, advice for road users and information exchange for professionals.

www.brake.org.uk

Child Bereavement Trust

Supporting Families and educating professionals when a child dies and when a child is bereaved.

www.childbereavement.org.uk

The Compassionate Friends (UK)

Supporting bereaved parents and their families by those similarly bereaved.

www.tcf.org.uk

Cruse Bereavement Care

Cruse Bereavement Care exists to promote the well being of bereaved people and to enable anyone bereaved by death to understand their grief and cope with their loss.

www.crusebereavementcare.org.uk

Road Victims Trust

The Road Victims Trust is a registered charity (1142336) offering a range of free support services to residents of Bedfordshire, Cambridgeshire and Hertfordshire who have been affected by fatal road collisions.

www.rvtrust.org.uk

S.C.A.R.D

Support and Care after Road Death and Injury

SCARD offers support to all people affected by road death and injury

www.scard.org.uk

Way Foundation

Resources and support for men and women who have been widowed aged 50 or under.

www.wayfoundation.org.uk

Winston's Wish
The leading child bereavement charity and the largest provider of services to bereaved families in the UK
www.winstonswish.org.uk

Other sources of information include:
Ministry of Justice (Feb, 2014), Guide to Coroner Services [online], 1-56, available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283939/guide-to-coroner-service.pdf [accessed 28th May 2014]
Coroners' Courts Support Service http://www.coronerscourtssupportservice.org.uk/
Inquest http://www.inquest.org.uk/
MOJ guide to coroner services
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/363879/guide-to-coroner-service.pdf
MOJ, Coroner investigations-- A short guide
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283937/coroner-investigations-a-short-guide.pdf
Northamptonshire General
http://www.northamptongeneral.nhs.uk/Downloads/NorthamptonGeneralBer.pdf