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Inquests – A Change In Approach?

MENTAL HEALTH LAW

Many healthcare professionals will have been involved in inquests and will be familiar with the common short conclusion (known colloquially as a “verdict”). This has often been a pithy verdict such as “accidental death”, or “suicide”.

However, recent case law¹ means that in many cases the verdict will often now be much more extensive.

The Middleton case arose because of Article 2 of the Human Rights Act. Article 2 provides for a right to life. European Jurisprudence makes it plain that this Article includes a substantive obligation on member states to establish a framework of laws, precautions, procedures and means of enforcement which will to the extent practical protect life. This includes the need to investigate deaths.

In England and Wales an inquest is the usual basis by which the state undertakes this investigation, unless there is either a public inquiry or a criminal prosecution.

In order to meet the requirements of Article 2, the House of Lords held in Middleton that the verdict at an inquest ought to include an expression, even if brief, of a conclusion on the disputed factual issues canvassed at the inquest. This meant that in some cases the current inquest regime was incompatible with the Human Rights Act, particularly where a traditional “short form” verdict was provided.

The House of Lords went on to hold that the current inquest regime only needed one change. The ambit of an inquest is limited to ascertaining who, when and how the deceased died. The House of Lords held that the only change was to interpret “how” as meaning not meaning simply “by what means” but instead by the expanded “by what means and in what circumstances”.

This means that in many cases a short form verdict will be inappropriate and a “narrative” verdict setting out the disputed issues will be necessary. The House of Lords gave the following example for such a verdict:

“the deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so”

Whilst the House of Lords made it plain that inquest verdicts may still not attribute criminal or civil liability, nevertheless, the more extensive nature of the verdict is clearly likely to mean that inquests will take longer, delve more deeply into the factual background and produce longer verdicts, notwithstanding that the inquest is not a court in which blame may be attributed.

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¹ R (Middleton –v- Coroner for the Western District of Somerset) 2004 (UKHL10)

The House of Lords also considered the verdict of “neglect” (previously known as “lack of care”) and confirmed that the pre-existing definition of this² was appropriate, namely that to return a finding of neglect required (in the medical context) that there was evidence that it was a failure to provide basic medical care which caused the deceased’s death.

Comment

These developments clearly underline the need for legal representation at inquests which are likely to become more adversarial and extensive in their review of the circumstances surrounding a death. RadcliffesLeBrasseur have developed a special inquest service and a leaflet for medical practitioners attending inquests. If you would like further details of this service or a copy of the leaflet please e-mail julia.worton@rlb-law.com.

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Bournewood – European Court of Human Rights Decision

Our previous Briefing reported the decision of the European Court of Human Rights in the Bournewood case. If you would like advice on the practical implications of this please contact andrew.parsons@rlb-law.com.

For more information on Mental Health Law contact Andrew Parsons at RadcliffesLeBrasseur on 020 7227 7282, or email: andrew.parsons@rlb-law.com.

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² R v North Humberside & Scunthorpe Coroner Ex parte Jamieson [1994] 3 All ER 972