

Introductory Session: What to expect from an Inquest or a Fatal Accident Inquiry following a Death in State Custody

Introduction



- •This is the first of three sessions, we encourage you to sign up to all three:
 - What to expect from an inquest when a death arises in state custody
 - 2. Incident reviews and inquests
 - 3. Common themes arising from deaths in state custody
- Today's session will provide you with an introduction to inquests and fatal accident inquiries. The next two sessions will focus on the steps taken before an inquest is reached and common themes leading to deaths in state custody. The sessions will be interactive.
- We welcome your questions, thoughts and comments ahead of the next two sessions.

What is an inquest and what is a fatal accident inquiry?



- In England, Wales and Northern Ireland inquests take place, in front of a Coroner, when someone dies of unnatural, unknown or violent causes, or when an individual dies in custody or state detention.
- In Scotland, the equivalent process is a fatal accident inquiry (FAI), held in front of a Sheriff in a Sheriff Court as opposed to a Coroner's Court
- The job of the Coroner or Sheriff is, primarily, to answer four questions Who
 has died? When did they die? Where did they die? How did they come by their
 death?
- The Coroner or Sheriff will make any inquiries necessary to answer these questions.
- This is an inquisitorial process, it is not intended to apportion blame.
- If it concerns a death in custody, then the inquest/FAI will usually be heard in front of a jury.

Why is there an inquest or an FAI following a death in state custody?



- If an individual is in state custody then the state assumes full responsibility for protecting that individual's human rights the most fundamental is the right to life.
- Deaths in custody can occur in prison custody, police custody, mental health hospitals and immigration removal centres.
- When a death occurs in state custody, there must be an investigation into what has happened, what could be done to prevent such deaths and how better to protect the human rights of vulnerable people held in the custody of the state.

Deaths in state detention in England and Wales



"Deaths in state detention (including those released from custody within 7 days and residents of probation approved schemes) reported to coroners increased by 11% to 546 in 2024, driven by a rise in the number of deaths which occurred in prison custody".

Source: https://www.gov.uk/government/statistics/coroners-statistics-2024/coroners-statistics-2024/coroners-statistics-2024/coroners-statistics-2024-england-and-wales#deaths-reported-to-coroners (Accessed 2 July 2025)

Deaths in state detention in Scotland



64 deaths in state custody were recorded in Scotland in 2024. 40 deaths had been recorded in 2023.

Source: https://www.sps.gov.uk/about-us/transparency/death-custody (Accessed 2 July 2025)

Deaths in state detention in Northern Ireland



Prisoner Ombudsman investigations into Deaths in Custody assist the State to fulfil its duty, as required by Article 2 of the European Convention on Human Rights, by informing the Coroner's Inquest which is required by law ... As at 31 March 2024, the Death in Custody Team carried an outstanding live caseload of 37 cases broken down as follows:

- ► 24 Deaths in Custody;
- ► Eight Post Release Deaths;
- ► Five Serious Adverse Incidents;
- ► Three Death in Custody investigations were completed and await publication;
- ► Three Death in Custody investigations are at Inquest; and
- ► 23 Disclosure packages required for Coroner's inquest.

Source: Annual Report 2023 – 2024 https://niprisonerombudsman.gov.uk/publications/annual-reports (Accessed 2 July 2025)

What type of investigations can follow a death in state custody?



- A police investigation.
- A serious incident / root cause analysis investigation.
- An investigation by the Prisons and Probation Ombudsman, including a clinical review.
- As well as a Coroner's inquest or a Sheriff's FAI.

Why will I be asked to give evidence?



- Generally because you were on shift when the person died and/or you were directly involved in their care.
- Depending on your level of seniority, may be asked to attend to provide an overview of the care provided
- You will be asked to attend the inquest as either a witness or an interested person.

What is a witness?



- As a witness you will provide evidence to the Coroner or Sheriff usually in the form
 of a written statement, with the potential for you to attend in person and give oral
 evidence.
- Your evidence must be true, complete and accurate to the best of your knowledge.
 Your evidence must under no circumstances be misleading. You must not withhold information.
- Your witness statement will be circulated, by the Coroner or Sheriff, to all parties. If your regulator is involved then they will be provided with a copy.
- For more information on being a witness we refer you to the RCN's website (https://www.rcn.org.uk/Get-Help/RCN-advice/witness-for-nmc-gmc-disciplinaryor-coroners (accessed 2 July 2025)).
- The RCN's website also includes helpful information on preparing a witness statement (https://www.rcn.org.uk/Get-Help/RCN-advice/statements (accessed 2 July 2025)).

A witness statement template

Date:



Statement		
Name:		
Job title:		
Professional address:		
Subject of statement: [for example, patient/client X at what incident/location]		
I am employed by [insert your employer]. I qualified as [profession] in [month/year of qualification]. My previous experience includes [insert previous roles and clinical experience to date]. I have worked in my current job for [months/years] and my duties include (insert detail).		
This statement is based on [personal recollection/review of records – or a combination].		
I have been involved in the care of Patient X since [date]. My last involvement in their care was on [date]. On the date of the patient's death I was on duty [inserts times].		
I am responding to your request for a written statement. [Insert the content of your statement here, following our guidance – the pointers below may also assist you in structuring your statement]		
During the time I was involved in the patient's care I (insert a factual and concise account of your involvement in the patient's care including how well you knew them This should include:		
References to any clinical records		
Any notes you might have relating to a serious incident investigation		
Other relevant documents (national guidance, polices, post mortem report)		
An explanation of your clinical reasoning		
 Address any errors, mistakes or omissions in your care – but seek guidance on how this can be worded to avoid criticism or further investigation into the same. 		
 Any other relevant, factual information – it can be useful to try and pre-empt any questions that may be asked by the Coroner and include them in your statement). 		
[Add the following statement of truth at the end and sign and date your statement]		
This statement is true to the best of my knowledge and belief, based on the information available to me at this time.		
Name:		
Job title:		
Signature:		

What is an "interested person"?



- An "interested person" (IP) is an individual (or organisation) who the Coroner or Sheriff believes may have caused or contributed to a patient's death, due to some act or omission.
- As an IP you have enhanced rights, this includes the right to representation and the right to receive a copy of all disclosure.
- In some circumstances, if you are an IP then there is a possibility that you
 may be criticised for the care that you have provided.
- You will be given support by your employer or, if they are unable to support you, the RCN's in-house legal team may be able to provide you with support.

What is your role?



- As a professional witness, the Coroner or Sheriff will look to you for assistance and may need your professional advice / opinion on a clinical issue.
- Not to be confused with an expert witness which brings with it additional duties and responsibilities.

How does an inquest or FAI usually proceed?



Inquest	FAI
Death reported to Coroner who decides whether an inquest is required. If proceeding, the inquest will be formally opened. A death in state custody requires an inquest to be held	Following a death, the Procurator Fiscal will consider whether a FAI is required. A death in state custody requires a FAI to be held.
Post-mortem examination usually occurs. The findings may show that an inquest is not required.	A post-mortem may be completed.
The Coroner will review and make any enquiries necessary. The Coroner will notify any witnesses and grant IP status as appropriate.	The Sheriff will make any appropriate enquiries necessary.
A pre-inquest review hearing (PIRH) may be held, this is an administrative hearing generally to discuss the scope of the inquest and the attendees.	A preliminary hearing may be held to discuss the parities to the inquiry and what issues should be considered.
The inquest is heard, generally in public. The Coroner will present their findings in a record of inquest.	A FAI is held, generally in public. The Sheriff will issue a determination which contains their findings based on the evidence. This may not be published for a few months.
The death will be registered.	The death will be registered.
Depending on the evidence heard, the Coroner may make referrals such as to a witness's regulatory body and if there are ongoing concerns the Coroner may, for example, submit a PFD report.	Depending on the evidence heard, the Sheriff may also make referrals or submit reports if there are ongoing concerns. The Sheriff will also submit a Fiscal's Report.

How will the Inquest/FAI run on the day?



- 1. Coroner opens and swears in jury
- 2. Pen portrait of the deceased family may read out a statement and pictures of the deceased may be shown
- 3. Scene setting evidence Governor/Head of Healthcare
- 4. Pathologist/toxicologist evidence
- 5. Chronological ending with those who responded to Code Blue if appropriate
- 6. Legal submissions on available conclusions
- 7. Coroner's summing up and jury retires
- 8. Jury returns with conclusion
- 9. Prevention of Future Deaths evidence

How does an inquest or FAI conclude?



- Having heard all of the evidence in the case, the Coroner or Sheriff will make findings of fact on the balance of probabilities.
- The Coroner at an inquest will complete a 'Record of Inquest' which will answer the four questions. At the end of a Fatal Accident Inquiry the Sheriff will publish a document called a 'Determination'
- If the Coroner is of the view that lessons must be learnt from the case then they may issue a "Preventing Future Deaths" (PFD) report. When considering the PFD report, the Coroner may be interested to hear from you whether there have been any changes in your workplace since the death.
- Within the Determination the Sheriff will consider precautions that could have avoided the death and defects in the system, the Sheriff may then make recommendations.

How will I find out about an inquest or FAI?



- You will usually find out that you have been asked to give evidence through your employer.
- Your employer will also tell you if you are a witness or an "interested person", although this status could change as the matter progresses.
- You may be contacted directly by the Coroner's Officer
- On some occasions, the Coroner's Office is staffed by police officers do not be alarmed if you receive an e-mail from them.

What should I do when I am aware of an inquest or FAI?



- You should contact RCN Direct (0345 772 6100) as soon as you find out so that we can consider what support you might need.
- You will often be supported or represented by your employer and, if this is the case, then you are not likely to need further support from the RCN.
- However, it is still a good idea to have a conversation with our advisers at the start of the inquest process so that they can offer you advice and check that you have the support that you need.

Tips on giving evidence at an inquest or FAI



- The questions that you are asked at the inquest or FAI will be based on your witness statement.
 Therefore, familiarise yourself with your witness statement prior to the inquest or FAI, we would suggest practising reading the statement out loud. You should take a copy of your witness statement with you.
- Take your time when answering questions, do not rush. Listen to the question and if you need the question repeated or reworded then ask for this.
- When answering questions, you should avoid giving opinion or speculating. Your answer must be truthful and complete, do not withhold information. If you do not know the answer then you must say so.
- Make best use of what you have in front of you water will be provided. If you need a moment to think, take a sip of water
- Direct your answers to the jury rather than the barrister asking you the questions

Logistics



- You should address the Coroner or Sheriff as 'Sir' or 'Madam'.
- Ensure that you know where the inquest or FAI is being held and how to get there if it is being held in person. You should arrive early.
- You should dress smartly.
- If you are attending as an IP we suggest that you attend as much of the inquest or FAI
 as possible.
- If you are unwell on the day and are unable to attend, you will be required to provide medical evidence from a healthcare professional explaining why you cannot give evidence (if not in person, then remotely).
- Refusal to engage or attend has significant consequences witness summons and contempt of court + NMC referral

Further information



- Coroners' Courts in England and Wales https://www.judiciary.uk/courts-and-tribunals/coroners-courts/
- Coroners' Support Service https://coronerscourtssupportservice.org.uk/wp content/uploads/2018/11/CCSS EL_Inquest_Factsheet_Final29317221_3.pdf
- The Coroners Service for Northern Ireland https://www.justice-ni.gov.uk/articles/coroners-service-northern-ireland#:~:text=An%20inquest%20is%20an%20inquiry,needs%20to%20register%20the%20death
- Scotland Fatal Accident Inquiries -<u>https://www.scotcourts.gov.uk/fatal-accident-inquiries/</u>
- Crown Office & Procurator Fiscal Service -https://www.copfs.gov.uk/services/bereavement-support/guide-to-fatal-accident-inquiries/