THE CHARTERED INSTITUTION OF HIGHWAYS & TRANSPORTATION

Giving Evidence to the Coroner

presented to

The Society of Road Safety Auditors

at its

National Conference 2016

by

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Introduction and background

Good morning
My name is Guy Rigby
I am a chartered civil engineer and barrister

I graduated from Imperial College London back in 1977
and have spent most of my career in transport, working with clients, consultants and contractors
… and doing road safety audits!

I am bound by my code of conduct to tell you that I am what used to be called a non-practising barrister,
now called an unregistered barrister
This means that I cannot undertake what are called reserved legal activities,
but I am permitted to advise and to educate
which includes giving this talk
on the understanding that I am not bound by the same rules as a registered barrister

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I am going to talk about

Giving Evidence to the Coroner

but first a bit of background and context

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We are road safety engineers and auditors

Our job is to make our roads safer …

But accidents still happen

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Why?

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Our recommendations have not been implemented?

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Our recommendations have not been implemented?

Or not implemented in full?

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Our recommendations have not been implemented?

Or not implemented in full?

Maybe no RSA?

Some of these accidents result in **serious injury**

Need to establish

Who is involved

What happened

When it happened

Where it happened

How it happened

It is also usually necessary to establish **who** is **liable**

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May be witnesses at the scene

They can say

Who was involved

What happened

When it happened

Where it happened

they are usually known as **witnesses of fact**

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We were not there

We may be called by the court as **experts**

for one or both sides (Kate's presentation)

of any personal injury litigation

We are giving our expert **opinion** on

How the accident happened, and

Why it happened

We are assisting the **court** to establish **who** is liable

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Sadly, some accidents result in the **death** of a road user
Either at the scene or later on

Sometimes **much** later on

There may then be an **inquest** before a **coroner**

Often opened straight away then **adjourned** for **expert** evidence

History
Differences
Dos and don’ts

So a word about coroners and inquests:

Violent or unexplained death since 1194

England and Wales

Cause not liability, but

As before,

In a courtroom (various!)

The Coroner's questions ...

the **who**, the **how**, the **when** and the **where**

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More about coroners and inquests:

The Coroners Act 1988 and the Coroners' Rules 1984

The Shipman Inquiry

Fundamental review of death certification and investigation

Coroners and Justice Act 2009 - part 1

2010 election, consultation

2013 implementation

Coroner's (Inquests) Rules 2013

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More about coroners and inquests:

Evidence on oath (r20)

Written evidence (r23)

Chief Coroner - HHJ Peter Thornton QC

s36 annual report to Lord Chancellor

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More about coroners and inquests:

Investigations and preliminary inquiries

Also prevent future deaths

Duty to report

Coroners and Justice Act 2009 sch 5 para 7

where the investigation reveals a concern that circumstances creating a risk of other deaths will occur

A18 ....

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Guy's pub quiz:

2 starter questions:

It doesn't happen often, but

How many of you have given evidence in the Coroner's Court?

and

what's the first thing to know?

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Yes!

It's independent, like any other court, but

It's different!

SO ...

How is the Coroner's Court different from other courts?

How many differences can you think of?

Some important differences:

Still local authority financed (history, s24 C&JA)

No bag search

Rules of evidence and etiquette

It's there to find out what happened, not who was to blame

No litigation

Inquisitorial not adversarial …

Another pub quiz question:

What does this mean?

Some important differences:

There are **no sides**, and …

The Coroner's Court only deals in **death** … so

Bereaved families are there and

Special care is needed …

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For us, this is important when it comes to giving evidence:

What we are **NOT:**

We are **NOT** there to promote or oppose a project
We are **NOT** about the what, where or when
that's for those who saw it happen
They are called witnesses of **fact**
They are **NOT** experts, but
They have seen someone die

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For us, this is important when it comes to giving evidence:

What we **ARE:**

We **ARE** there to help find the truth
We **ARE** about the how and the why
We **didn't see it happen**, but we have **expert knowledge**
We are **non-medical experts** giving our **professional opinion**
We **help** the Coroner to make findings of **fact**
We are there to **assist the court**

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so, with this in mind:

What is involved?

Is it scary?

What will happen?

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To start with:

Instructed by the Coroner

Your area of expertise

Refuse if not your area, and explain

Preparation!

Submit your report in advance and on time

Written evidence - how and why

Admitted under rule 23 - evidence usually oral

Will draw on the who, the what, the when and the where

Relevance, importance, weight

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More pub quiz questions:

What sort of evidence is your written report?

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More pub quiz questions:

What sort of evidence is your written report?

Yes, it is expert evidence

Did you notice what was after my name at the beginning?

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Yes, my designatory letters

Why are they there?

More pub quiz questions:

What sort of evidence is your written report?

Yes, it is expert evidence

Did you notice what was after my name at the beginning?

Yes, my designatory letters

Why are they there?

Because I am an expert

The court will rely on yours as evidence that you are an expert in your field

After you submit your report:

Coroner may ask you to attend the inquest hearing

If asked, you **MUST** attend

You will be contacted to arrange a date

Oral evidence

Again it is **expert** evidence

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Protocol when you attend court:

Accessibility

Other languages

Family members as witnesses

Other non-medical witnesses

Medical witnesses

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Protocol when you attend court:

Arrive early for the hearing

Check in with the court usher

Let them know if affirming or not Bible

Mobile off!

Waiting room for everyone

Normally do not wait outside to be called

There may be a jury, video links, screens

Remember, the deceased's family will be there

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Protocol when you are in court:

Wide variety of courtrooms

Etiquette relaxed, but

No recording or photography

All rise when the Coroner enters the courtroom

Coroner will explain why there is an inquest hearing

and what will happen - listen carefully!

If a jury, it will be sworn in

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When you are in court:

Each witness is called to give evidence

Each witness is sworn in

Family first

Then experts - that's you

Present main findings of your report

Address the Coroner

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When you are in court:

Coroner has read your report in advance

and will have questions

Then members of the family will have questions

And their representatives

And other interested parties

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Dos and don’ts in the box:

DO

Speak up
Answer questions clearly
Don’t speak too quickly
Recorded but
Watch the coroner’s pen
Be precise and factual
When describing technical concepts
Address the Coroner, but
Use layman’s terms (family)

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Dos and don’ts in the box:

DO

Remember you were not at the scene
Remember you are an expert
But only in your area
Stick to the point
Stick to your area of expertise
Be honest - if you don’t know the answer, say so
Remember NOT helping establish liability
(Recent A18 case)

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Dos and don'ts in the box:

DON'T

Use complicated technical terms or jargon

Go into unnecessarily distressing details

Allow others to draw you out of your area of expertise

Attempt an answer if you are not absolutely sure

Waffle!

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Dos and don'ts in the box:

DON'T

Get emotional

Rely on memory - have your report with you

Address the family - address the coroner

Play the blame game - cause not liability

Worry if there is a disturbance - stop speaking, coroner will sort - contempt

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To conclude
Points to remember about inquests:

Fact finding inquiry into a violent or unexplained death
Who, what, when, where, how?
Coroner hears evidence to establish the truth
Like a public inquiry
Not a trial so no formal parties
Verdict establishes cause of death, cannot determine individual liability
2013 Coroner's (Inquests) Rules
Coroners Act 1988 and Coroners Rules 1984 replaced
New verdicts - conclusions - 9 including alcohol/drug related, road traffic collision
Civil standard of proof unless unlawful killing or suicide
Duty to report - Coroners and Justice Act 2009 sch 5 para 7 - where the investigation reveals a concern that circumstances creating a risk of other deaths will occur

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Questions?

Coroner's Courts - Christopher Dorries QC
Second edition - Oxford University Press