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Inquests: How wide should the scope be? The coroner's decision

04 July 2025 Kathryn Fearn

Determining the scope of **inquest** and what is and is not relevant can be a difficult balance to strike, particularly where families are unrepresented families and they have a number of concerns about the care their loved one received in the lead up to their death.

The case of R (Morrow) v HM Assistant Coroner for Merseyside (Sefton, Knowsley and St Helen's) [2025] EWHC 935 (Admin) serves as an important reminder that the coroner has a wide discretion to set the scope of an inquest, and is entitled to exclude matters, even issues relating to the care provided, if they see fit.

So what happened in this case?

The case involves the sad death of Ms Zoe Morrow who was found collapsed in her bedroom on 12 April 2021. The cause of her death was confirmed to be linked to multiple drugs found in her blood after death. Ms Morrow had been under the care of Mersey Care NHS Foundation Trust who undertook a root cause analysis which identified a number of shortcomings and missed opportunities in the care provided to her. However, the Trust concluded that none of these issues caused or contributed to Ms Morrow's death.

The coroner decided to limit the scope of the inquest to the circumstances immediately surrounding Ms Morrow's death i.e. what circumstances led to Ms Morrow being found dead on the floor in her bedroom. He did not investigate whether there had been any failings in Ms Morrow's care by the Trust, or whether such failings might have contributed to her death.

The coroner heard evidence from one trust witness, namely the Quality Matron for the Mental Health Urgent Care Services who answered questions in relation to the Trust's root cause analysis report. He returned a conclusion that Ms Morrow's death was drug related.

A judicial review claim was later brought by Ms Morrow's brother under section 13 of the Coroner's Act 1988 on the basis that the coroner did not allow the family to give evidence, or question witnesses, about Ms Morrow's treatment by the Trust in the months leading up to her death. Further, that the coroner did not properly consider if Ms Morrow's death was due to suicide.

What did the High Court say?

The key finding by the High Court was that the coroner was entitled to determine that the issues relating to Ms Morrow's treatment by the Trust in the months leading up to her death fell outside the scope of the inquest. The High Court went on to say that as a result, the coroner was entitled not to hear evidence on these points from trust witnesses, as it would not have helped the coroner determine the question of *"how"* Ms Morrow came by her death.

In relation to the coroner's conclusion, the High Court said that it recognised that the family were of the view that Ms Morrow intentionally took her life however, *"He [the Coroner] was justified in not going further (to a suicide conclusion) because taking all the evidence into account, he was not persuaded, on the balance of probability, that she intended to kill herself. This was a rational and lawful position to take".*

Conclusion

There is no new law here; it has always been the case that the coroner has a wide discretion to set the scope of the inquest and in this particular case, narrow the scope to the events that took place immediately prior to death. What this case does highlight however, is the often seen *"mismatch"* between the expectation of families and the reality of what an inquest is.

Health and social care professionals can equally struggle with what the remit of the coroner is and what is and is not relevant. Browne Jacobson's expert inquest and advisory team are here to support and guide professionals through the inquest process and can ensure they are prepared to assist the coroner.

If you have any questions about this case or our inquest and advisory team, please do not hesitate to get in touch.

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