Briefing on coronial reform

Consideration of Statutory Instrument
Draft Coroners and Justice Act 2009
(Consequential Provisions) Order 2013

July 2013
Introduction and background

1. This Supplementary Briefing has been prepared for the short debate on the Draft Coroners and Justice Act 2009 (Consequential Provisions) Order 2013. It will be considered by Sixth Delegated Legislation Committee on Wednesday 26 June.¹

2. INQUEST has welcomed the Government’s decision to implement many the provisions of the Coroners and Justice Act 2009 as it will help ensure bereaved people are at the heart of an overhauled system. This statutory instrument is a first step in bringing some of the new legislative framework into effect. The Order preserves the current provision under s.13 of the Coroners Act where, subject to the consent of the Attorney General, an inquest verdict can be quashed and a fresh inquest ordered into a death. We urge parliamentarians to approve this measure.

3. However, whilst welcoming this Order, INQUEST believes it highlights an ongoing problem: the lack of any effective appeal mechanism for bereaved families to challenge poor decision making by coroners. We are also concerned that current government proposals on judicial review and legal aid, if implemented, will make the situation worse for bereaved families. We urge parliamentarians to raise these concerns during the short debate on approving this instrument.

The repeal of s.40 of the Coroners and Justice Act 2009

4. INQUEST’s work with bereaved families over thirty years indicates there is a need for a straightforward, streamlined system of appeals against coroners’ decisions. We welcomed the original plans for an appeal system laid out in the Coroners and Justice Act 2009. We were disappointed that s.40 of the 2009 Act was repealed² in the final parliamentary debates on the Public Bodies Bill and the Chief Coroner’s office.

5. Section 40 of the 2009 Act provided for the establishment of an appeals mechanism by the Chief Coroner. As the statute requires the Chief Coroner to be a judicial post-holder, it would have enabled an experienced, specialist judge to deal expeditiously with appeals made against coroners’ decisions. The appeals system was intended to deal with issues often raised by coroners’ rulings such as whether: to investigate a death or not; to request a post-mortem or not; and whether there should be a jury at an inquest. This would have offered families a route to resolve poor decision-making by coroners before or during the course of the inquest so that any legal questions on these points could be dealt with efficiently (avoiding the need for judicial reviews and reducing the cost of postponed or adjourned inquest hearings while the issue is dealt with by the High Court). Far from creating a litigious culture and an endless right

¹ In Committee Room 12 at 2.30pm
² See s.33 of the Public Bodies Act 2011. In a September 2011 joint proposal setting out a pragmatic way forward for coroner reform, INQUEST and The Royal British Legion set out our suggestion that s.40 should remain on the statute book until, at a time to be agreed in the future, the provision would be brought into force by the Secretary of State once a full pilot and review of the appeals process could be undertaken by the Chief Coroner. This would enable a properly costed, informed decision to be taken about rolling out a new avenue of appeal across coroners courts in England and Wales. Terms of the pilot and review would be decided between the Chief Coroner and the Ministry of Justice and, under our proposal, an appeals process would not have come into effect for several years.
of appeal after inquests (as the government had argued), INQUEST believes that the carefully-crafted framework in the Act had the potential to, ultimately, reduce the need for so many bereaved people to engage in litigation. In fact we think the new appeal process would have reduced the number of judicial reviews of Coroner decisions. We expected the Chief Coroner’s decisions on appeals to set helpful precedents for other coroners, drive up standards and inform best practice guidance – improving the overall conduct of inquests and bereaved families’ experiences.

Appealing coroners’ decisions – the current situation

6. Currently, the only avenues of appeal for bereaved families wishing to challenge the lawfulness of coroners’ decision-making and/or their conduct of an inquest is by persuading the Attorney General to exercise his or her power of fiat under s.13 of the Coroners Act 1988 (the power which this Statutory Instrument will preserve) or through complicated and expensive judicial reviews. It is not a choice as to which procedure to use as the Attorney General can only exercise his fiat if there is new evidence to be considered.

Section 13, Coroners and Justice Act 1988

7. Section 13 of the Coroners Act 1988 sets a high threshold to be met for an inquest verdict (inquisition) to be quashed and for ordering a new inquest into a death. It involves a complex and lengthy process which requires the Attorney-General’s consent. As a result, this remedy has only been granted to bereaved families in rare cases – the most recent example being the quashing of the original inquests into the 96 deaths at Hillsborough Stadium in 1989.

8. An example of the difficulties bereaved families face when attempting to pursue s.13 challenges can be illustrated by the recent experience of Jim and Gill Clark. Their son Samuel died in September 2008 from a heroin overdose. The original investigation by Dorset police and subsequent inquest concluded that he had brought and injected himself with heroin. However, concerns emerged about the role of third parties in his death and, in 2011, Dorset police asked the Devon and Cornwall constabulary to re-investigate and instructed Dr Nat Cary to review the pathology findings. Dr Cary’s opinion was that it was not reasonable to conclude Samuel Clark had injected himself and the police review found there was ‘significant new evidence’ for a coroner to consider.

9. In 2012 the Clark family applied for a fresh inquest under s.13 of the 1988 Act. In June 2013 this was refused on the basis that the government’s law officer was not satisfied that the new evidence met the high threshold that it was “necessary and desirable in the interests of justice” to re-open the inquest. Jim and Gill Clark have said their experience underlines that “only a properly constituted system of appeal will make it possible for families to have confidence in the coroner system which is not the case with this archaic Section 13 procedure. Proper appeals systems exist in other judicial areas, and ought to do so in the case of inquests”.

Judicial review

10. The second, more common remedy, available to families seeking to challenge coroner’s decisions which may be unlawful is judicial review. The effective operation of the rules and the process of judicial review are clearly important in the context of an inquest system which is acknowledged as having wide variations in the quality of coroners’ decision making. Tom Luce, the government-appointed independent reviewer concluded in 2003 that the system was “not
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fit for purpose”. INQUEST’s research reports and briefings have previously demonstrated how bereaved families face significant delays and a ‘postcode lottery’ of service. Partly in response to such evidence, Parliament passed the Coroner and Justice Act 2009 to improve the system.

11. It was against this backdrop that, during the November 2011 parliamentary debates on the Public Bodies Bill, government ministers assured parliamentarians that bereaved families could challenge poor decision-making in coroners’ courts through judicial review. For example, the Government Briefing on the Bill circulated to MPs and Peers stated “a new appeals system [for coroners] will not be taken forward because of the significant costs that this would entail. However, we are retaining the existing appeal mechanisms, whereby the outcome of an inquest can be challenged by Judicial Review.”

Government proposals to restrict the availability of judicial review for bereaved families challenging coroners’ decisions

12. INQUEST is concerned that a year after those parliamentary debates the Ministry of Justice has already put forward two sets of proposals which, if implemented, would severely restrict bereaved families’ ability to bring judicial review proceedings against flawed coroners’ rulings.

13. The first set of proposals were made in the consultation paper Judicial Review: proposals for reform (CP25/2012). INQUEST’s January 2013 response expressed concern that the consultation paper betrayed a complete lack of understanding of the importance of judicial review for bereaved families. The questions that are raised by judicial reviews of coroners’ decisions frequently involve fundamental rights such as ECHR Article 2 (the right to life).

14. For example, at the original inquest into the death of 14 year old Adam Rickwood in Hassockfield Secure Training Centre the coroner refused to rule on both the legality of the use of force on Adam by staff shortly before he died and whether the restraint used on him was causative of his death. His mother, Carol Pounder, had to bring a judicial review to challenge these decisions and ask for a new inquest into Adam’s death. In allowing the claim, the administrative court quashed the original verdict and ordered the coroner to conduct a fresh inquest. Carol Pounder also had to judicially review the coroner a second time when he subsequently refused to recuse himself from hearing the second inquest. The administrative court also granted an application that article of the coroner to appoint a colleague to hear the second inquest. This was more than a “pyrrhic victory”. The second inquest was held in January 2011 and resulted in a narrative verdict from the jury which condemned the conduct of bodies such as the Youth Justice Board and the private contractor Serco who ran the facility where Adam Rickwood died. Adam was the youngest person to die in custody and the evidence heard at the inquest into his death revealed that thousands of other children had also been systematically subjected to unlawful restraint in privatised secure training centres and that regulatory and inspection bodies had failed to stop these practices. Since that

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3 Para 1, the independent review of Coroner Services commissioned by the Home Office and chaired by Tom Luce, Death Certification and Investigation in England, Wales and Northern Ireland, 2003.

4 See INQUEST’s evidence based reports such as How the Inquest System Fails Bereaved People (2002) and Unlocking the Truth – Families’ Experience of the Investigation of Deaths in Custody (2007): both included in-depth surveys which sought bereaved families’ views and experiences of the inquest process

5 Government Briefing on the Public Bodies Bill, DEP2011-1213 available from www.parliament.uk


evidence was heard there has been significant public and parliamentary debate about the use of force on children in custody – resulting in the government introducing a new policy and practice framework in July 2012.

15. Given the detrimental impact the consultation proposals would have on bereaved families we urged the Ministry of Justice to reconsider their proposals: particularly in relation to shortened time limits and the proposed abolition of the right to an oral permission hearing in judicial reviews involving coroners’ decisions. We note that the government’s April 2013 response to consultation does not pursue these proposals.

16. However, in the recent Transforming Legal Aid consultation, the Ministry of Justice proposed a new set of restrictions on funding for judicial reviews and test cases which, if implemented, would have the cumulative effect of limiting bereaved families’ access to judicial review as a remedy by making it harder to qualify for any public funding to challenge coroners’ decisions, and; reducing the number of legal representatives able to take the financial risk of doing this type of work. Once again, the Ministry of Justice has failed to understand the importance of effective access to justice for bereaved families facing an inquest into a contentious death. INQUEST’s concern is that, if pursued, the current proposals will allow unlawful or poor decisions by coroners to go unchallenged, which risks perpetuating these practices. This is clearly worrying both for families but also for society as a whole.9

Conclusions and questions

17. INQUEST believes that the current situation raises two pressing questions which we ask Parliamentarians to raise with government ministers or spokespeople during the short debate:

   a. Can the government give an assurance that they will look again at their proposals on restricting access to judicial review which will make it even harder for bereaved families to challenge poor decision-making by coroners?

   b. Will the government give consideration to a proper solution to the lack of accountability for poor decision-making by coroners? In particular will they agree to resource the Chief Coroner to conduct a number of small pilots to assess the true costs and feasibility of establishing an appeals mechanism and, in light of that evidence, will they agree to revisit the need for a streamlined system of appeals in relation to the coroners’ courts?

18. For further information or briefing please contact:

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About INQUEST

INQUEST is the only charity in England and Wales that provides expertise on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. INQUEST provides a general telephone advice, support and information service to any bereaved person facing an inquest and the Inquest Handbook is available to any bereaved person free of charge. INQUEST also runs a free, in-depth specialist casework service on deaths in custody/state detention or involving state agents and works on other cases that also engage article 2 (the right to life) of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability.

INQUEST's policy and parliamentary work is informed by its casework and we work to ensure that the collective experiences of bereaved people underpin that work. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; ensures accountability and disseminates the lessons learned from the investigation process in order to prevent further deaths occurring.

More information from www.inquest.org.uk.