INQUEST’s Response to Ministry of Justice consultation

Post-implementation Review of the Coroner Reforms in the Coroners and Justice Act 2009

December 2015
About INQUEST

INQUEST is the only independent organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths, their investigation and the inquest process to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. We have a proven track record in delivering an award-winning, free, in-depth complex casework service on deaths in state detention or involving state agents. We also work on other cases that involve multi agency failings and/or raise wider issues of state and corporate accountability. We monitor public interest inquests and inquiries into contentious deaths to ensure the issues arising inform our strategic policy and legal work.

Our specialist casework service gives INQUEST a unique perspective on how the whole system operates through the monitoring of the investigative and inquest process. We work with over 2,000 bereaved people each year, on around 700 open cases, including approximately 300 new cases. This enables us to identify systemic and policy issues arising from avoidable deaths and the way they are investigated.

INQUEST co-ordinates the INQUEST Lawyers Group (ILG) which is a national network of over two hundred lawyers who provide preparation and legal representation for bereaved families. The ILG also promotes and develops knowledge and expertise in the law and practice of inquests by providing training and acting as a forum for the exchange of ideas and experience. ILG members have been involved in thousands of inquests into deaths in custody/detention over the last thirty years.

Our response

Our response is written in the context of INQUEST’s longstanding work on the coroner’s inquest system, and the extent to which families’ needs are understood and accommodated throughout the process. We have made a number of submissions in regards to the coronial system. Some of these include:

- Implementing the Coroners and Justice Act 2009 - July 2013
- INQUEST & Royal British legion briefing for Lords on Commons amendments to Public Bodies Bill - November 2011
- INQUEST’s response to the green paper on Legal Aid - February 2011
Overall there have been significant improvements to the inquest system and how coroners interact with families following implementation in 2013 of key aspects of the Coroners and Justice Act 2009. These are positive advances which we support and hope can be sustained. One positive example includes the appointment of the Chief Coroner, who has provided national guidance, leadership, and developed training for coroners and coroner’s officers in an attempt to drive up standards.

However, there are still issues which have not been fully resolved and require greater attention. We recognise that this is still early on in the process of transition and that change will be a process but highlight some of the key outstanding concerns. These include:

- Delays in the release of bodies
- Poor communication with families
- Disclosure of information
- Inconsistent coronial practices resulting in a postcode lottery service

INQUEST has also identified key concerns, which have not been addressed in this consultation, but are fundamental to ensuring the coronial system is fair, effective and one that prompts institutional learning. These include:

- The absence of an appeals system
- The failure to enforce learning through the use of Prevention of Future Death (PFD) reports
• The proposal to amend the Coroners and Justice Act 2009 to make it more difficult for inquests to be held in Deprivation of Liberty cases
• The six months prescribed period for inquests to be held following a death
• Lack of access to public funding for family legal representation

Failure to address these concerns has a deleterious impact on how humane and responsive the coronial system is to families’ needs. For example, instances of poor communication are still widespread and tend to undermine the trust families have in the inquest system. Likewise, while PFD reports have been extremely important in highlighting institutional failings, the repetition of deaths (either in the same establishment or which raise similar issues) has increased families’ sense of frustration with the inability to compel “learning”.

Another concern is the patchy level of support and service across coroner’s courts. This has been a recurring feature, which we have highlighted in previous reports. As argued in our consultation response, Getting it right for victims and witnesses, the inconsistencies are largely due to the lack of “robust, enforceable set of standards” for coroners to follow, thus impacting on the treatment and support families receive and their ability to participate in the inquest process. This was highlighted by the 2003 Luce report, Death Certification and Investigation in England, Wales and Northern Ireland and was supported by a further recommendation to appoint and fund coroners centrally. Currently coroners are paid and appointed by local authorities, and this has resulted in the variation across coroner’s courts.

1. Guide to Coroner’s Service

In INQUEST’s experience, families do not refer to or have knowledge of the Guide to the Coroners Services which may indicate both a communication problem and a training need. INQUEST sends a copy of its handbook to families following their initial contact, and signposts them to the online version, and they are often very grateful to receive this. Many relatives tell us that they have not received information about the inquest process prior to receiving the handbook.

The handbook is a comprehensive guide to the inquest system in England and Wales and has been developed in collaboration with specialist lawyers, advice

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agencies and bereaved people who have been through the difficult circumstances of a death involving a coroner’s inquest. While we only provide a casework service on deaths in the circumstances outlined above the handbook provides an overview of the inquest procedure for any bereaved person or their advisor involved in the coronial system, alongside specialist information about inquests following deaths in particular circumstances.

Feedback from families indicates the enormous value of the handbook, whereby relatives have referred to it as an “informative and helpful” resource with a good combination of legal and experience-led advice. As contributors to the coroner’s officers training we have also seen the positive impact of increased dialogue resulting in more appropriate referrals to our service and better working relationships between our team and coroner’s officers.

We also understand that coroner’s offices are under-resourced, particularly as further cuts to local authorities are expected, and we encourage coroners to utilise our knowledge, and of other advice and support agencies. Coroner’s offices should disseminate hard copies and the online version of our handbook and incorporate this as part of a wider effort to signpost families to specialist organisations.

2. The release of bodies and post mortem examinations

One of our longstanding concerns is the well documented failures to properly inform families about the post mortem examination process and their rights in relation to this. Despite the reforms there are still areas of poor and inconsistent practice in relation to this.

There are still unacceptable delays in post mortem examinations and families are not adequately informed about the reason for this. The lack of communication has often added to the stress many families feel following their relative’s death, and there has been evidence of poor complaint procedures in which individuals cannot address issues of delays to the appropriate authority. While delays in the release of a body are sometimes necessary, it is important to communicate the reasons why, particularly as the delay may conflict with other religious customs which call for the immediate burial of a body.

AA contacted INQUEST two months after his uncle’s death in a secure psychiatric hospital, on 24 February 2014, as he was exasperated with the lack of information from the coroner. He had been informed that a post mortem had been conducted and that the coroner was awaiting toxicology results before his uncle’s body could
be released. He was not given any other information despite numerous efforts to contact the coroner’s officer.

AA was under a lot of pressure from his family and the community to have his uncle’s body released so he could be buried in accordance with Islamic customs.

In May 2014 AA was informed that his uncle’s body would be released and that they could start making preparations for the funeral. AA had made arrangements only to be told that the coroner had decided further tests were needed so they would not be releasing the body after all. AA was not informed of this until he contacted the coroner’s officer. INQUEST wrote to the coroner’s officer again seeking information on behalf of the family.

This situation went on for over 8 months. AA complained and asked for details of the formal complaint procedure. This request was ignored. The complaint was followed up again by INQUEST.

His uncle’s body was finally released for burial 9 months after his death with no apology from the coroner or the coroner’s officer. Details of the formal complaints procedure were not provided to AA and he never received a response to his email setting out his concerns.

INQUEST is working on two other cases where similar issues around communication have emerged:

- We are working with the family of a man who died in HMP Gartree prison on 3 September 2012. Relatives were not informed of the post mortem date and of a subsequent delay in them receiving the body. There was no contact from the coroner for 8 days and family had to get in touch with coroner’s officer to find out how to view the body and get the body released;

- We are working with the family of a man who died on 2 May 2015 in circumstances involving restraint by bouncers and the police. The family felt they were provided with very little information from the coroner’s office about the post mortem procedures i.e. when it would take place, where and who would conduct the post mortem. The family were not advised of their rights to have a representative present or entitlement to a copy of the report. A few days later the family were informed that there may be a delay in releasing the body as the police may request an independent post mortem. However, the family were not informed of their rights to an independent post mortem. They were only made aware of this after speaking to INQUEST.
It is important to realise the wider significance of delays and poor communication. The inquest system is alien to many families and they often feel anxious, confused and or sometimes mistrusting of the authorities - particularly if their relative has died in state custody/detention or care. Failure to provide timely and correct information can seriously jeopardises the confidence families have in the coronial system - both in terms of its impartiality and effectiveness. It also undermines the notion that families are at the heart of the system, and that their experiences help to inform the inquest process.

3. Disclosure of information and inquest recordings

There has been a mixed picture with regards to disclosure. In a recent survey of INQUEST Lawyers’ Group members reflected a difference of views about whether the right to disclosure had made the disclosure process easier, and whether lawyers received more disclosure under the new regime than the old. A large proportion seemed to consider that coroner’s officers had a good understanding of the new disclosure regime and that an increased number of families had reported better access to information.

This is a welcome improvement; however there are still residual issues of concern. Families and their legal representatives still express their frustration at having to ask for documents and not receiving adequate explanations as to why certain documents are not disclosed. Moreover, families are not provided information in a timely fashion (i.e. in advance of the pre-inquest review hearing). This has impacted on the family’s ability to participate effectively at these hearings.

There is also no uniformity across coroner jurisdictions and the experience of families still largely depends on where their relative died. Two such cases, which were represented by INQUEST Lawyers Group members from Bhatt Murphy, illustrate this point:

- KB, who died in 2011, following prolonged restraint by police while receiving psychiatric care as a detained patient;
- JM, who died in 2013, after she ingested a quantity of drugs whilst in police custody.

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3 The INQUEST Lawyers Group is a national pool of lawyers who provide preparation and legal representation for bereaved families during inquests.
In JM’s inquest, the coroner made an assumption of full disclosure. There was an agreement of the bundle of core documents, and with submissions to be made only in respect of those documents which were not agreed for inclusion, or were not ruled as admissible. By contrast, in the KB inquest a very restrictive position was taken and the lawyers were directed to make submissions as to the potential relevance of every additional item of disclosure sought.

Needless to say, pre-inquest disclosure is fundamental to ensuring a death in state detention or care is properly investigated. This allows for issues to be identified at an early stage and to influence the questions to be put to witnesses. If families are given information well in advance of the pre-inquest review hearing, it helps assuage their fears or suspicion of a potential ‘cover up’ and enables them to participate effectively from the outset. It enables them to address the coroner on relevant issues on an informed basis and at the earliest opportunity.

Lastly, the coroner should make special efforts to ensure unrepresented families have sufficient disclosure of relevant statements and documents before the inquest. In the KB case, the unrepresented half of the family were expected to print, order and index reams of scanned documents that were emailed to them in chunks over a period of many months, and they were simply unable to do this. This caused a huge amount of distress and delay.

INQUEST was contacted by the mother of a psychiatric patient who was hit by a train after he was discharged from hospital. The mother contacted us 15 months after the death of her son and when caseworkers asked about her specific concerns she could not answer this question, as she had not received any documents from the coroner. The mother told us that she had insisted on the disclosure of documents, but the coroner’s officer responded by telling her that this was the coroner’s inquest, and not her inquest. This kind of communication was deeply upsetting to the mother and family. Only after she attended the pre-inquest hearing and INQUEST got involved did she start receiving documents such as, her son’s medical records.

4. Other issues of concern

These include the following:

- The lack of any effective appeal mechanism for bereaved families to challenge poor decision making by coroners
INQUEST was disappointed to see that the original plan for an appeal system outlined in Section 40 of the Coroners and Justice Act 2009 was repealed in the final parliamentary debates on the Public Bodies Bill and the Chief Coroner’s office. We have continually called for an effective appeal system and continue to find the same recurring problems as we had identified in our 2013 briefing, *Implementing the Coroners and Justice Act 2009*.

Due to the absence of an appeal system, families find it difficult to challenge the coroner’s decision. These include instances, where the family feel the scope is not sufficiently wide, important witnesses are not being called, key evidence has not obtained, the coroner has wrongly directed the jury and/or left or failed to leave an appropriate conclusion/determination to the jury by way of example.

Often the only avenue of redress is through the courts and judicial review. Judicial review is a costly and time consuming process, which can result in postponed or adjourned inquest hearings while the issue is dealt with by the High Court. Alternatively if the inquest has concluded, a successful judicial review could lead to the quashing of the conclusion and a fresh inquest being held. Another fact is that judicial review is only available to families that are either financial eligible for Legal Aid or have funds to pay privately. As it stands, judicial review is not a proportionate or cost effective mechanism to challenge a coroner, but it is the only option available to families.

What also appears to be missing here, is an understanding that the inquest is more often than not the only opportunity to discover the truth. For some bereaved people there is no opportunity to take any other legal action, and indeed many do not want to pursue the legal route.

The proposal to have an appeals process would ensure the following:

- Call for the Chief Coroner to assume the role of judicial post-holder and to deploy her/his experience and knowledge to review appeals made against coroners’ decisions;
- 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;
- Offer 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 quickly and efficiently;

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4 Implementing the Coroners and Justice Act 2009 (July 2013)
- Ensure a wider benefit, where the Chief Coroner’s decisions on appeals sets helpful precedents for other coroners, drive up standards and inform best practice guidance - improving the overall conduct of inquests and bereaved families’ experiences.

We propose that the Chief Coroner conduct a number of small pilots to assess the true costs and feasibility of establishing an appeals mechanism. Evidence obtained can then feed into wider conversations about the need for a streamlined system of appeals in relation to the coroners’ courts.

**Failure to address repeated deaths across custodial and detention settings**

As noted in a previous report by INQUEST, *Learning from Death in Custody Inquests*, there are recurring failures in the protection, care and support of individuals who are placed in custody/detention\(^5\). PFD reports, issued by coroners, have been instrumental in highlighting institutional problems; however their ability to prompt systemic reform requires oversight and follow-up. Without such, lessons are not learnt and similar deaths continue.

To highlight one example, INQUEST is working on a number of cases where a series of deaths have occurred in Woodhill prison - each death bearing remarkable similarities. Since 2013 there have been 10 self-inflicted deaths in this prison, the highest recorded across all prisons. Almost all deaths in this institution feature similar failures which include: poor risk assessment and application of ACCT procedures, widespread bullying, and previous self-harm attempts and histories of poor mental health not being adequately recorded by the prison.

Across our casework, we have also seen examples of Prisons and Probation Ombudsman (PPO) reports referring to the same failings in their reports following further prison deaths at the same establishments. This clearly shows a failure by the state to implement earlier recommendations to prevent future fatalities. The above all indicates a complete lack of oversight or positive action being taken to address dangerous practices or effectively deal with risk management in response of both published PPO reports and Coroner Regulation 28 reports.

The issue is that there is no effective method to monitor or audit actions taken in response to inquest findings and conclusions. While the Chief Coroner is expected to oversee the issuing of PFD reports and does publish annual reports based on

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coroner findings, he does not have the resources to ensure recommendations are followed up and that institutions adhere to them. Nor has the Chief Coroner complied with the 2009 Act and reported as expected to parliament. INQUEST has continually called for the creation of a central oversight body which would better enforce coroner recommendations and would be subject to parliamentary scrutiny (i.e. by providing regular evidence to a select committee). The body would:

- Collate, audit and report publicly on the accumulated learning from inquest outcomes and recommendations from PPO investigations and HMIP-CQC/IMB inspections;
- Feed coroner reports into HMIP-CQC inspections and measure progress based on institutional compliance with previous recommendations.

It is important to understand the prevailing feelings of frustration felt by bereaved families who hear of yet another death, which has occurred in the same prison or is due to similar or even the same failings. Families need to feel that the inquest is a meaningful process and that it can fulfil its function of preventing similar fatalities. Without this, many relatives feel that their concerns are pushed to the margins, and that their involvement has not led to any significant change in practice.

**Lack of access to public funding for family legal representation**

The lack of access to public funding for bereaved families at inquest directly impacts on their ability to participate effectively in the legal processes. It also denies families the high quality legal representation which is needed in cases arising from deaths in custody/detention or engaging the right to life.

Specialist legal aid lawyers have been vital in assisting bereaved families understand the circumstances behind their relative’s death. Such cases include the shooting of Jean Charles de Menezes, the death of Sean Rigg and the death of Jimmy Mubenga. Moreover their expertise has also informed changes to policies and practices and has played a vital role in making recommendations to prevent further deaths. There have also been developments in inquest law and practice as a result.

Finally as families are expected to go through a protracted legal process in which they have to disclose intimate details about themselves, to secure funding, this is not the case for authorities involved in the death of a person in custody/detention. INQUEST is not aware of a single inquest into a death in custody where the state has not had legal representation.
In the case of Jimmy Mubenga, there were teams of lawyers representing the state and corporate interests, (Ministry of Justice and Home Office), London Ambulance Service, British Airways, G4S, the individual G4S officers. Such cases represent a clear inequality of arms in public funding. Despite repeated claims by the governments that the inquest process is an inquisitorial fact-finding exercise, with no opposing sides, for families the experience is quite the opposite. They have described experiences of personal distress and antagonism between them and authorities being represented.

INQUEST reiterates its longstanding recommendation that families should automatically be eligible for non-means-tested public funding to cover the costs of legal advice, representation and subsistence costs for inquest hearings.

Concerns about the key proposal to make it harder to get inquests in deprivation of liberty cases

INQUEST is concerned by recent proposals, as documented by the Law Commission's consultation on Mental Capacity and Deprivation of Liberty, to restrict the number of inquests into the deaths of people who were subject to Deprivation of Liberty safeguards (DOLS). This is in response to an increase in the number of inquests being held following the judgement of Cheshire West and the greater number of DOLS authorisations.

Under the current DOLS scheme, local authorities, in their roles as supervisory bodies and funders of care packages, are inextricably involved in approving placements of individuals. The fact of state control cannot therefore be artificially removed to reduce the burden on coroners to hold inquests.

The coroner’s investigation is an essential safeguard in ensuring that those who die whilst under the control of the state did not die from deaths that were preventable, and seeks to identify lessons that can be learned to stop preventable deaths from occurring in the future. From our experience, families of those who have died while under a DOLS are often concerned about the possible poor care and treatment of their relative, and a properly conducted inquest provides them with the only opportunity to investigate the circumstances surrounding a death.

INQUEST accepts that coroners will be put under great pressure due to the increase in inquests, and supports their access to additional resources. This will ensure all inquests take place within a reasonable period of time so as to avoid unnecessary delays.

The six months prescribed period for inquests
Based on the feedback from the INQUEST Lawyers Group, there has been some experience of coroners rushing through complex Article 2 deaths within the six months period due to the target timeframe. This is not appropriate as often the PPO in prison deaths will take six months, if not longer, to complete their investigations, and to feed this into the coroner’s inquest. Consequently, key issues are not addressed, relevant expert evidence not obtained and key witnesses not called, thus leading to complex cases not being properly considered in time.

Monitoring the lengths of inquests is important as it helps to ensure unnecessary delays are avoided. However there does need to be some flexibility in relation to complex Article 2 inquests and for six months not to be treated as an absolute deadline. According to a survey the of INQUEST Lawyers Group members (see reference above), 90% felt that six month target was unrealistic and all reported that less than a quarter of new cases had concluded within six months since July 2013. Moreover, families indicate that they would rather wait a little longer for the hearing and for it be thorough and robust rather than the proceedings being rushed.

**Conclusion**

Overall, there have been some important developments since the implementation of coroner reforms in 2013. The appointment of the Chief Coroner has, for example, led to an increased effort to provide national guidance and training to practicing coroners and coroner’s officers. Moreover there have been some positive examples of prompt and full disclosure. However, inconsistencies continue to plague the system and families’ experiences are variable, depending on where their relative died. The lack of uniformity is both unfair and deprives some families of the only opportunity they have to learn about their relative’s death. INQUEST appreciates that poor provisions may be the result of limited capacity across coroner’s offices however this cannot fully explain the problems that exist. Where appropriate we encourage them to signpost families to specialist organisations such as INQUEST. This will help to relieve them of extra work, particularly at a time of local authority cuts.

Finally, there are important points which have not been addressed in this consultation which require closer scrutiny and attention. These include the absence of an appeal system, lack of public funding for families’ representation at inquests, the impact of new proposals relating to DOLS, six month inquest timetables. Perhaps the most pressing issue however, is the prevention of future deaths. Coroner recommendations are hugely important, but only if they can compel authorities to implement procedures which will result in real change and
honour the value of the inquest system - to understand the circumstances behind a death, ensure lessons are learnt and future fatalities avoided.