INQUEST
TRUTH, JUSTICE & ACCOUNTABILITY

INQUEST submission to Review of the Hillsborough Families' Experiences by the Rt Rev Bishop James Jones

April 2017

POLICY • ADVICE • CAMPAIGNS

INQUEST provides specialist advice and a complex casework service to people bereaved by a death in custody/state detention or involving state agents and works on other cases that also engage Article 2 of the European Convention on Human Rights and cases that involve multi agency failings and/or raise wider issues of state and corporate accountability. INQUEST's evidence based policy, research 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 future deaths.

This report was written by Nogah Ofer, Vic Mcnally and Deborah Coles. With thanks to solicitor Charlotte Haworth Hird and barrister Jesse Nicholls for their help and other members of the Inquest Lawyers Group who provided case examples.

Introduction

The legacy of Hillsborough should be improvements across the inquest system to benefit families who are still coming up against many of the same hurdles.

Hillsborough was a lesson in official lies, corruption and cover up. Although the Hillsborough inquests very publicly shook confidence in the legal system, the issues are by no means unique. The legacy of Hillsborough should be improvements across the inquest system to benefit families who are still coming up against many of the same hurdles that the Hillsborough families had to battle against and to continue to improve the experiences of families into the future.

State related deaths (often known as 'Article 2' deaths because of the duties of the state to protect life) draw the most acute public concern about the role of public authorities. From deaths in police, we see the struggles and campaigns of bereaved people against a background of institutional denial and defensiveness in seeking truth, justice and accountability.

We see daily examples of the interests of powerful institutions and individuals prevailing over the access of bereaved people to the truth and transparency over how and why their relative died. State bodies have traditionally approached the inquest as a damage limitation exercise, attempting to close down questioning and narrowing its remit, minimising their responsibility and defending their policies and procedures, even where there is clear cut evidence of systemic or individual failings.

The past few years have seen unprecedented scrutiny of how the state investigates and scrutinises contentious state related deaths, and this review comes at an important time. INQUEST has been involved in a series of reviews and inquiries in an advisory capacity. We have consulted with members of Inquest Lawyers Group. We have organised family listening days to ensure the family voice is heard directly, on their experiences of the current investigation and inquest process.

What often goes unmentioned is the high price paid by bereaved families in remaining involved in the lengthy, complicated investigation and inquest process. The emotional and physical impact of state related deaths on generations of families should not be forgotten, nor the way it is exacerbated by state denial and defensiveness, secrecy, insensitivity, delays, funding problems and lack of accountability.

When they function at their best inquests are a vital way of exposing unsafe practise and shining a spotlight on the state and its agents and holding them to account for abuses of power, ill treatment and misconduct. In other words, inquests can save lives. Defensive attitudes on the part of public authorities undermine the ability of inquest to do this. The issue of contentious deaths, their investigation and the treatment of bereaved people is firmly on the political agenda and presents an important opportunity for fundamental legislative reform and change.

This report's evidence based recommendations and the 'Hillsborough Law', Public Authority Accountability Bill could play an important role in helping citizens find the truth, and help develop real and sustained cultural and political change. At the crux of the issue is the democratic accountability of public authorities at an individual and corporate level.

- **Deborah Coles, Director of INQUEST**

1 Equality of Arms

Inequality of arms is the single greatest obstacle to families securing truth and justice through the inquest system. It runs through every aspect of a family's access to full involvement, information and representation and should sit as a guiding priority for change.

For families the lack of an automatic right to specialist legal representation and the overwhelming and uncertain processes for securing financial typifies a system stacked against them and weighted in favour of state bodies.

Background

Without exception, in every state-related death[1] with which INQUEST has been involved over the past 30 years, the State has been represented by publicly funded expert legal teams, routinely supported by relevant experienced professionals and senior personnel. All of this is automatically in place for state bodies

In contrast, a bereaved family is required to fight at every stage for their right to be represented and heard. A person who has recently lost a child, a partner, a parent, a sibling will be in a state of shock and grief, probably living through the worst experience of their lives. Yet at this traumatic time they are forced to negotiate an alien and complex inquest process that should have the family at its heart but too often leaves them marginalised, confused and frustrated. Many describe this process as re-traumatising: a dry legal process lacking humanity in which they struggle to have their voices heard.

1.1 Specialist funded representation

Families are forced to take part in a process that they have not chosen to initiate, which will take place whether they are able to participate effectively or not, and which affects them more profoundly than any other participant.

Yet while State bodies receive automatic legal representation which is not subject to a merits or a means test, at taxpayers' expense, families have no equivalent right to funded representation.

Instead families are subjected to a distressing, intrusive process of financial assessment characterised by uncertainty about whether funding will be granted, to whom it will be granted, how much will be granted and so on.

The Hillsborough inquest was a highly notable exception, where families were fully funded without having to negotiate the legal aid system. This reduced the distress, complexity and confusion of the inquest process, and ensured that the Hillsborough families had parity of representation. This should be the norm, not the exception.

Exceptional funding is available under the legal aid scheme subject to a complex merits test. The latest figures available from the Legal Aid Agency (LAA) show that approximately one third of applications determined were refused or rejected[2]. The merits test requires families to show not only that the facts of their case triggers the procedural requirements of Article 2 ECHR, but also

1 Throughout this submission we use the phrase "state-related deaths" to refer to deaths which are related to state bodies with a particular focus on detention and in which duties are triggered under Article 2 of the European Convention on Human Rights, the right to life. These cover multiple state bodies and include private sector corporate bodies carrying out state functions in connection with detention.

2 Ministry of Justice (5 December 2016), Legal Aid Statistics in England and Wales July to September 2016, Figure 25, page 35. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/584590/legal-aid-statistics-bulletin-july-sept-2016.pdf>

that legal aid is necessary in order to fulfil those procedural requirements[3]. In reality it is simply not feasible for bereaved relatives to participate effectively alone. Unrepresented families face an insurmountable disadvantage given that state bodies are always legally represented at inquests and frequently there will be multiple lawyers representing a range of state bodies and individuals working for them. In INQUEST's experience, lack of legal representation impacts negatively on all aspects of the inquest process and hearing that follows: lack of disclosure, failure to call witnesses, narrowed scope, hearings listed for hours (as compared to days or weeks), limited exploration of evidence, less likelihood of recommendations and so on.

Financial means assessment

The current system of financial means assessment for inquests causes enormous unnecessary difficulty and distress and in some cases prevents access to justice. It is the very first step that families have to negotiate in their dealings with their lawyers.

The financial assessment process is onerous, intrusive and can take many months. Documents have to be provided on every aspect of the individual's finances such as wage slips, mortgage statements, bank statements, details of all property owned including cars, jewellery, insurance policies, even enquiries about how often a person uses their car. Three months' bank statements have to be provided by every individual within the family and the Legal Aid Agency will frequently raise queries about specific items, even small sums of tens of pounds, for example seeking explanations as to the source of money paid in or out, querying whether the person has concealed a source of income and requiring statements for dormant accounts.

Following her partner's self-inflicted death in prison solicitors spent 18 hours' work obtaining funding for a young mother who worked 12 hours a week in a phone shop but also received child tax credits and housing benefit. She was clearly eligible for legal aid but the LAA raised numerous questions about her finances, so that she had to obtain evidence from a number of agencies such as the local authority, the banks, and her employer. She had to address queries such as a £50 discrepancy in her housing benefit due to changes to benefits as a result of the death.

In most cases it is not only the individual legal aid applicant who has their financial means assessed, but also all other close family members of the deceased, which means parents, siblings and adult children. The partners of each of these people are often also required to complete detailed financial forms for means assessment irrespective of their involvement or relationship with the deceased.

The assessment process creates significant tensions within families where it requires means assessment of:

- family members not involved with the inquest process or who have broken off contact with the legal aid applicant
- families where there has been relationship breakdown, including domestic violence: for example, a mother will have to contact her former partner and secure his participation in the process otherwise her own legal aid application could be refused
- family members who had no relationship or contact with the deceased
- family members who refuse to provide means information
- family members abroad (including those who have never been to the UK)
- family members beyond immediate family e.g. from nieces and nephews, aunts, grandparents.

3 Funding can also be granted on wider public interest grounds but in reality this rarely happens.

The sister of a woman who died in HMP Peterborough, had to decide against having legal representation as her mother's new partner did not want to get involved in the inquest proceedings and refused to fill in legal aid means assessment forms.

One solicitor was told by the LAA that they had no option but to attend a family member who was not engaging in the process whilst he was in hospital recovering from a back operation to have him complete a means form. Given his profession there was no indication that he had money to fund the inquest in any event.

The family of a suicidal man who was hit by a train following a psychiatric detention have felt unable to engage with the means assessment process and are currently attempting to represent themselves, with advice and assistance from an INQUEST caseworker. There are six other interested parties of which the mental health team, hospital and NHS Trust have each instructed separate private solicitors firms to represent them.

The mother of a man who died following restraint by members of the public and later police was eligible for legal aid but was unwilling to complete the forms because of concerns about her immigration status (despite the fact that she had residency).

The family of a man who died after being transported in restraints in a police vehicle approached a local solicitor who was not a specialist in inquests and wrongly advised them that they would not meet the financial eligibility tests for legal aid. The sister-in-law of the deceased represented the family at a three-week inquest where multiple barristers represented the police force and individual officers. She questioned witnesses to the best of her ability, which she has described as "the most terrifying thing I've ever done in my life".

There are multiple practical hurdles surrounding the grant of funding which make it difficult for lawyers to represent their clients effectively, or which require extensive pro bono work. This can be a very stressful period for the family who are left in limbo not knowing whether they will be granted legal aid or will have to try to raise the funds themselves, or what steps can or cannot be taken on their behalf.

The usual legal aid rules on financial eligibility are relaxed for inquest funding and the LAA have a discretion to waive the usual legal aid thresholds. This discretion, which is unique to inquest cases, is not based on any guidelines other than the general question of whether it is considered reasonable for a family to pay, taking into account all the circumstances. This means that it is not possible for lawyers to advise families at the outset whether they will be granted legal aid if they have a particular level of savings or a particular income.

When funding is granted following the lengthy means assessment process it is no longer back-dated to the date the legal aid forms were initially signed. This means that funding does not cover initial work carried out, which can include urgent work such as obtaining a second post-mortem or

attending a pre-inquest review hearing. Lawyers either have to work pro bono or they will not carry out the work and case preparation will suffer. It should be noted that inquest preparation work is already funded at the lowest legal aid rates, significantly lower than other forms of legal aid, and that lawyers have to wait until after the inquest is concluded to receive any payment at all (including payment of experts' fees and other disbursements), which can be several years after the work begins. Therefore, some lawyers will be reluctant to also carry out a large amount of pro bono work.

In practice the majority of family members of those who die in state-related deaths are of modest means. An FOI request made by INQUEST to the LAA in February 2016 disclosed that for the year ending September 2015 **no** applications were refused on the basis of financial ineligibility. **Therefore, families are put through an extremely distressing and intrusive process for little purpose.** Some families disconnect from the process at this stage, remaining unrepresented.

Operating the scheme in this way is also not cost-effective for the LAA, which currently carries out hundreds of unnecessary means assessments and then grants a waiver in almost every case. In the year ending September 2015, 108 inquest applications were granted, each one of which will have involved multiple means assessments of numerous family members and their partners. The entire system is illogical and should be replaced by a simple entitlement to representation for the limited number state-related deaths.

There is a parallel to be drawn with other areas of legal aid funding that is not means tested. For example, there is no means assessment for public funding for public law care and supervision proceedings in relation to children (i.e. when children are to be removed from their parents) and for child abduction cases. This no doubt reflects the importance of the issues to those families, the public interest in funding legal representation in such cases and the fact that the participants are involved in a process initiated by the state which will occur irrespective of their wishes. There is also no means assessment for certain cases under the Mental Health Act and Mental Capacity Act, which no doubt reflects the fact that such applicants are unable to represent themselves and in the majority of cases have little means[4]. Many of these considerations apply to inquests into state-related deaths.

1.2 Multiple state lawyers

In most state-related inquests families will routinely have just one lawyer (if lucky enough to secure representation) against a multitude of lawyers for the various state detention and health bodies, custody-related services and employees, often represented by their trade union or professional association[5]. Increasing privatisation has added significantly to those numbers.

For example, in a prison death it is common to see separate lawyers for the prison, the private escort company, the private healthcare provider, the nursing staff, the NHS Trust which supplies external medical input, and for individual prison staff and doctors.

Families feel heavily outnumbered when they see banks of lawyers and cannot avoid the conclusion that the process is stacked against them in the face of such a flagrant imbalance.

At an inquest into the self-inflicted death of a 17-year-old girl on the day of her release by the court from police custody the following bodies were represented:
- Greater Manchester Police
- Lancashire Police
- Medacs Healthcare

4 Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013 section 5(1)

5 For example, Police Federation, Prison Officers Association, General Medical Council

- Penine Care NHS Trust
- Lancashire County Council
- Thameside Council

At the inquest into the death of a young man who died in prison after he was taken into custody in severe mental health crisis the following bodies were represented:
- Essex Police
- Ministry of Justice representing the prison
- NHS mental health team
- Care UK, the private healthcare provider in prison

At the inquest into the death of a 14-year-old girl in a privately run mental health hospital the following were represented:
- The Priory hospital
- West London Mental Health NHS Trust
- London Borough of Hounslow Social Services
- Two individual doctors

At an inquest into the death of a suicidal man who was hit by a train following a psychiatric detention, where police failed to take steps to locate him, the following were represented:
- Mental health team
- Hospital Trust
- Surrey and Borders Partnership NHS Foundation Trust Psychiatric Liaison Service
- British Transport Police
- Thames Valley Police
- Independent Police Complaints Commission

Multiple lawyers for state bodies and staff will generally close ranks and support each other in promoting a damage limitation agenda before the coroner, whilst the family's representative often remains a solitary voice pushing the family's need for truth and for a process that ensures learning and accountability.

Less experienced coroners unfamiliar with this complex and highly specialist area of law can fall prey to these majority positions and pressures and adopt the approaches and legal interpretations being urged by state lawyers.

State lawyers will consistently argue for narrowed questions and issues being left to the jury. Multiple teams for state bodies are also able to split the work between them, for example, each team concentrating on a different area of expert evidence, or conducting legal research for different aspects of a legal submission. In contrast a single family lawyer has to cover the same ground alone, often under significant time pressure, for example, submissions concerning directions to the jury may have to be prepared overnight.

1.3 Funding levels

Even when funding is granted this is often not on an equal footing with lawyers for state bodies.

It is common for state bodies to be represented by QCs and junior barristers. Frequently there will be multiple legal teams for the range of state bodies, private companies and individuals employed by these organisations. For example, almost all police deaths now routinely involve QC level representation. In the case of Olaseni Lewis currently underway, the MPS, individual Bromley police officers and SLAM are all represented by QCs.

Yet for the families, Legal aid for QC and a junior barrister is often refused, even in more complex and contentious cases.

The LAA guidance specifically states that the fact that the state party is represented by a QC is not sufficient reason to grant the family funding for a QC. The family barrister has to work within a highly restrictive framework (for example very low ceilings for fees, limited amounts of time allowed for complex work, pre-inquest review hearings not always separately funded) and is usually the only advocate pushing for a thorough exploration at the inquest as against a team of other advocates seeking to restrict the scope of the inquiry. A system where all participants are funded on a roughly equal basis is the only way to address this fundamental imbalance.

Difficulties also arise where there are splits within a family which mean that different family members cannot work together and cannot instruct lawyers jointly. This can arise because there is a dispute relating to the evidence in the case or because of a serious breakdown in relations between different family members. The LAA routinely refuses to grant legal aid for two sets of lawyers.

The mother and sister of a man who died immediately following police restraint were refused funding after legal aid had been granted to two women who were the mothers of the children of the deceased. Due to a professional conflict the same solicitor was unable to act for all the family members. This left the mother and the sister attempting to participate unrepresented at a lengthy inquest where there were multiple lawyers for state bodies, including the police force, individual officers and healthcare bodies.

In a police-related death two sides of the family of the deceased (with shared father but different mothers) had bitter disputes predating the death, as each side blamed the other for the deceased's mental health difficulties and homelessness. They could not work together and instructed separate solicitors and barristers, however only days before the start of the inquest funding was refused for one legal team.

Again this is in contrast to the multiple legal teams commonly funded for state bodies and their employees, often pursuing the same interests.

There are also difficulties in obtaining public funding to enable family members to attend the inquest by meeting their travel expenses, and where necessary accommodation and subsistence. Given the fact that many Article 2 inquests go on for a number of weeks, family members simply cannot attend where the inquest takes place some distance from their home.

This is especially common where deaths have occurred in prisons or mental health units, which can be in geographically distant locations due to the nature of those systems. Decisions by the LAA on such expenses are inconsistent. In one case travel expenses were allowed for the legal aid applicant but not for the parent of the deceased. The LAA suggested that the applicant could pass information on to the rest of the family and therefore the Article 2 obligation for family participation had been met.

1.4 INQUEST's Recommendations

What is clear is that families are routinely and critically disadvantaged by the current funding regime in place and by the failures to ensure anything like a level playing field. INQUEST urges the following necessary changes to address this fundamental inequality of arms:

- Automatic non-means tested funding to families for specialist legal representation immediately following a state related death;
- Funding to an equivalent level to state bodies, with reference to: funding for silks and juniors, rates and brief fees, attendance at Pre Inquest Reviews;
- A relaxation of the current rules to enable funding of more than one family legal representative where a real and insurmountable conflict exists;
- Funding support for family, with reference to: travel and subsistence, overnight accommodation, loss of wages;
- Extension of the Victim Support Scheme to include family members going through state related inquests to enable provision of specialist support and financial help provided through the scheme (families are currently only able to benefit from the VSS scheme once a criminal trial is underway).

2 Conduct of State Lawyers

State related inquests are almost always experienced as adversarial. Families essentially enter an unknown process seeking to understand what happened and get to the truth, whereas the clear agenda of a majority of state lawyers is to conduct a defensive damage limitation exercise and seek to deflect criticism as far as possible. This approach can fundamentally undermine the inquest function, which is to uncover the facts and prevent future deaths. The Hillsborough experience is probably the most clear-cut example of how defensiveness can infuse the entire process and how state lawyers can seek to distort the facts, prolong the process and end up adding further pain to already bereaved and often traumatised families.

INQUEST believes that a culture change is required to embed openness and lesson learning at the heart of the process, with coroners setting the tone and reigning in inappropriate conduct by state lawyers. The Hillsborough coroner asked state lawyers on a number of occasions whether they were adopting a particular line of questioning on instructions from their client and INQUEST considers this to be a helpful way to pin down responsibility for a particular approach being taken. Coroners need to be clear about whether (and on whose instructions) a particular public body is adopting a particular stance and to deter lawyers from inappropriate and unacceptable lines of questioning.

State lawyers seeking to place blame onto families and the deceased

A particularly unacceptable practice by state lawyers, which is becoming increasingly common, is to go on the attack and subject family members to hostile and highly insensitive questioning about whether they bear a responsibility for the death. For a bereaved relative this experience can be devastating and is a wholly unacceptable way to treat a grieving family member. It is also invariably a diversionary tactic where the deceased was in the care of the state, and therefore the primary duty of care is clearly upon the detaining body.

At the inquest into the self-inflicted death of a young man at HMP Winchester, his girlfriend and mother of his baby, a young woman with mental health difficulties, was subjected to upsetting prolonged questioning from the morning and going over lunch by a senior barrister for the prison. Some weeks before the death she had had a difficult emotional phone call with her boyfriend and it was repeatedly suggested that she should bear some responsibility for his death because of her phone call and lack of contact with him afterwards.

The mother of a young man who was suffering a mental health crisis and was transported in restraints to a police station and died shortly after, was questioned for several hours by a barrister about her own care for her son, though she had pleaded with officers to take him to hospital. She collapsed following this ordeal. This is how she described the experience:

"I was a witness and the police barrister had me on the stand for three and a half hours. He battered me literally with questions. He accused me of not caring about my son, he was shouting at me, slamming books, was so aggressive. The coroner did nothing for a long time, he was asking very offensive questions and only after three and a half hours the coroner said 'okay that's enough now'"

The mother of a vulnerable 17-year-old who died at HMP Hindley, who had a history of being bullied and was taking medication due to his mental health needs, was questioned at length by a barrister for the prison on why she had not taken action and raised concerns with the prison. She eventually responded that she had kept her son alive for 17 years, whereas he had been in the care of the prison for only a few weeks and been neglected and died.

The mother of a 21-year-old man who died in police custody was questioned to such an extent by the state barrister that she was reduced to tears. She was repeatedly asked if she was being truthful when recounting the events which led to the police being called to her house.

At the inquest into the death of Cheryl James, who died at Deepcut Barracks, her father Des James was questioned by a very experienced QC to the effect that his repeated correspondence and complaints to the police over the course of a year about the investigation into his daughter's death had distracted them from investigating the disappearance of Millie Dowler. The following is a transcript:

Q. Mr James, you know also, don't you, that whilst this 15-month investigation was being carried out, it just so happens that Surrey Police were also dealing with other very major investigations? A (Mr JAMES). Yes, I am very clear on that. Q. Because when they launched the investigation, the reinvestigation into your daughter's death, on or about 9 July 2002, you know, don't you, that Millie Dowler was still missing and yet to be found? A. Yes, I do now. Q. You also know that a notorious serial rapist had got going and Surrey Police were one of two forces in particular the M25 rapist, Surrey Police were having to deal with this horrendous serial rapist, weren't they? A. Yes, indeed. I actually made the point, when Chief Inspector Denholm told me he was involved in the Millie Dowler case that they were stretched, their resources were stretched and that they needed help, but I was told that they didn't need any help. Q. They were doing perhaps their valiant best, but did it ever occur to you in the numerous emails, letters and other complaints that you wrote over that 15-month period, did it ever occur to you that you yourself might have been distracting Surrey Police from what some might have thought were even more pressing enquiries -- THE CORONER: No, I am not very happy with that. A. That is a very strange question. MR BEGGS: Perhaps it is strange because -- A. Well, I do think it is strange. THE CORONER: It is all right. I am not happy with it. I am ignoring it. I would like you to move on from there, thank you.

Following the inquest Mr James issued a public statement saying "My wife and I were made to feel as though we were on trial and we felt as though our family was undermined at every opportunity. Naively, we really did believe we were there to work together and we found Mr Beggs' approach to be unnecessarily adversarial and unpleasant".

Coroners are in a position to curtail this practice by being alert to such tactics and ensuring that family members are treated with respect and dignity. There should be guidance to coroners to take a robust position and step in to protect family members to stamp out unfair and hostile questioning.

Another tactic in diverting attention from the responsible state body is to seek to blame the deceased, echoing the attempts at the Hillsborough inquest to blame the fans for the disaster.

This is often seen in cases involving mental health, particularly where there is a dual diagnosis of a mental health condition and substance misuse. Drugs and/or alcohol are often used by those

suffering mental health difficulties to self-medicate and the two elements are usually closely inter-related. However, barristers for state bodies will seek to focus on the deceased's use of drugs or alcohol as the most central feature in the death, possibly in the hope of influencing the jury to view the deceased in a more negative light.

2.1 State lawyers and Prevention of Future Death reports

One of the gravest concerns for INQUEST is the concerted attempts routinely made by state lawyers to persuade coroners not to make a Prevention of Future Deaths (PFD) report at the conclusion of the inquest. This attitude flies in the face of the purpose of an inquest, namely its important preventative role and in the identification of learning to safeguard lives in the future. It is also inconsistent with the ethical and professional duties of both public bodies and lawyers to act in the wider public interest. It also means that the opportunity for learning not just at a local but a national level is lost.

For example, the website of a firm of solicitors who are regularly instructed by health and social care bodies has a section on inquest services headed "Protect your reputation, support your staff" which lists its pre-inquest services including "advice on risk management and avoiding a prevention of future deaths report"[6].

Very frequently submissions will be made to the coroner by state lawyers (presumably acting on instructions) that changes have been made since the death to address any deficiencies and therefore there is no need for a PFD. This is often asserted anecdotally without adequate evidence in support and is impossible to challenge. At times witnesses, such as prison Governors will give evidence to this effect and the coroner will not go behind their assertions.

In a recent self-inflicted prison death inquest, a key issue arose over whether crucial risk information was being shared between prison staff and healthcare staff when prisoners arrived into custody. The head of healthcare explained that this had not been happening at the time of the deceased's death, and that he had checked and this was still not happening. He accepted that this posed an ongoing risk to the lives of prisoners. The prison Governor stated that he did not accept the evidence from healthcare. He said that he had spoken to a few staff members who reported that this issue wasn't a problem at the time of the death, and was not happening now either. When asked how he accounted for healthcare's evidence he simply said that he disagreed with it.

In numerous recent cases, state lawyers have persuaded coroners to give them additional time (often 14 or 28 days) after the end of the inquest to put in further written submissions seeking to dissuade a coroner from making a PFD report (ignoring the time frame given for the coroner to make a PFD within 10 working days of the conclusion of the inquest). These submissions consist of accounts of improvements that are said to have been made since the death, so that it is argued no PFD is required. They amount to further evidence being put in after the hearing has finished, which cannot be tested by questioning.

At the conclusion of an inquest into a prison cell fire death (jury finding that neglect contributed to the death with a critical narrative) and notwithstanding the fact that the Ministry Of Justice (MoJ) had formally conceded 'neglect' during the course of the inquest, the coroner allowed further time for the MoJ to provide written submissions in relation to whether a PFD report was necessary and in the end no PFD was issued in

6 See Capsticks solicitors website http://www.capsticks.com/assets/Uploads/Inquest-Services.pdf

relation to the main jury findings (unsafe fire detection system), only in relation to secondary issues.

At an inquest involving a self-inflicted death in prison the jury concluded that neglect contributed to the death with dozens of serious contributory failures identified in a highly critical narrative. Submissions on behalf of the family were made arguing for a PFD on the basis of those conclusions. The coroner insisted that the barrister for the family make oral submissions immediately following the jury's findings but then provided the state bodies a further 28 days for written submissions on measures they claimed to have already taken.

It is difficult for families to avoid the conclusion that statements which say failings have already been remedied are being made purely with the intention of avoiding public criticism. Both state bodies and coroners should be trying to find ways to promote learning emerging from inquests by taking positive steps to improve systems at both a local and national level. PFDs should be treated as part of a concerted and coordinated attempt to learn lessons across the board to eradicate the common causes of state related deaths (this is dealt with in more detail below in relation to national mechanisms).

The Coroners and Justice Act 2009 changed the previous discretion for a coroner to make a report to a duty to do so where a concern is identified. This reflects the importance of this aspect of the inquest process and its wider public role. It should not be a matter of coroners having to be pushed into making PFD reports in the face of active opposition by state lawyers.

Following an inquest into the death of a man in psychiatric detention the coroner allowed the NHS Trust 14 days to make submissions on PFD issues. The Trust made submissions that steps had been taken therefore a PFD report was unnecessary but despite this the coroner decided to make a PFD report. The response to the PFD from the Trust provided no further information on steps to avoid further deaths than had been included in the submissions made earlier.

INQUEST is aware of lawyers who represent state bodies by taking a measured approach, admit mistakes and do not try to defend the indefensible. It is difficult to know to what extent this depends on the particular barrister or the instructions they receive. Such a constructive approach is welcome and should represent the norm. It would be helpful to pin down whether it is the state body or their legal representative responsible for such marked and different approaches.

Ultimately it is for those within leadership positions within state bodies to set the tone, to adopt a constructive approach towards inquests in order to learn lessons and to require their lawyers to do so on their behalf. This would demonstrate their commitment to an open and transparent process, and their public responsibility to maximising the preventative potential of the inquest process.

2.2 INQUEST's Recommendations

- INQUEST supports the newly proposed 'Hillsborough Law' contained in the Public Authorities Accountability Bill concerning the conduct of state lawyers and an overriding duty of candour applying to state related inquests.

- A culture change is required to embed openness and lesson learning at the heart of the inquest process, with coroners robustly setting the tone and reigning in inappropriate conduct by state lawyers.

- Coroners should hold responsibility for establishing whether (and on whose instructions) a state's legal representative is choosing to adopt and pursue inappropriate and hostile lines of questioning.

- Senior personnel (Chief Constables, Prison Governors, NHS Chief Executives) should hold clear lines of responsibility for the conduct of their legal counsel, including for the adoption of specific strategies and questioning and the treatment of family witnesses.

- Coroners should be required (through guidance and training) to ensure that family members are treated at all times with respect and dignity. Coroners should be required to take a robust line and intervene to protect family members from unfair and hostile questioning.

- A similar robust line should be adopted by coroners in response to attempts by legal representatives to discredit the deceased.

- Standards should be introduced identifying the collective responsibility of state bodies and their legal representatives to fully enable and facilitate the preventative and learning function of the inquest process, including around the Coroner's Regulation 28 'Prevention of Further Death' duties, designed to eradicate the common causes of custody deaths.

- State bodies should not have the option to present further submissions (post inquest hearing) in opposition to PFD recommendations. Any such evidence should be required during the course of the hearing when witnesses can be questioned and evidence scrutinised.

3 Coroners and Coroner Courts

The problem of inconsistency across the coronial system

The inquest system has been described as a post-code lottery in death. The lack of consistency between different coroners and coroners' courts is a key feature of the coronial system which undermines its ability to deliver justice and accountability to families and hampers the learning of lessons nationally.

Whilst there is good practice in some courts families continue to experience difficulties in others, similar to those raised by INQUEST repeatedly over many years. Since the Coroners and Justice Act 2009 and the introduction of the role of Chief Coroner there have been improvements but the overall picture still remains extremely patchy. It is often very difficult for lawyers to advise their clients on what to expect at a time when they are grieving and looking for some certainty. INQUEST is particularly concerned about the experience of families who do not have any legal representation.

3.1 History of coronial reform

The current coronial system should be seen in the context of a long period of reform over the last 15 years, which began with the 2003 Fundamental Review chaired by Tom Luce[7]. This was a comprehensive review (INQUEST were on its reference group) running over two years, at a cost of £1.1 million, resulting in a report of almost 300 pages with extensive recommendations.

Taken from the Luce report[8]:

> *There are widespread criticisms of what is seen as the disparity of practice between coroners in the conduct of inquests and more generally in the way in which they do their work. This is perhaps the most frequent comment that we have heard from families and by organisations such as Railway Safety who work nationally and therefore experience the different handling procedures followed by different coroners.*
>
> *The phrase we have heard more than any other during the Review is "the coroner is a law unto himself". Virtually every interest has complained of inconsistency and unpredictability between coroners in the handling of inquests and other procedures. Many of those who have experienced the system, whether families, lawyers and doctors who work alongside it, the police or voluntary bodies with concerns over the handling of deaths with a mental health element, child deaths or deaths in prison, have all made the same point.*
>
> *It is obviously desirable that there should be more uniformity of process and approach. The issues cannot sensibly be regarded as being about apparently idiosyncratic behaviour by individuals. They are at heart structural – involving the lack of any consistent training and appointment processes, the loose and inconsistent procedural framework, the absence of any dedicated higher court structure of the kind which in other areas of justice provides*

7 Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003 <http://webarchive.nationalarchives.gov.uk/20131205100653/http:/www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf>

8 *ibid,* Chapter 7: paragraphs 7, 23 and 25

accountability and a means of rectifying mistakes, the emphasis on process rather than a more general investigative function in the legislation and rules, and the absence of clear objectives.

The Luce report recommended a national service stating that[9]:

> *In our view the role of local authorities in the support of the coroner service should cease and the coroner service should be re-sited within the national justice services. The arguments for this change are:*
>
> > *- the coroner service is essentially a judicial, investigative and public safeguarding or regulatory service, which should in all its functions work to judicial standards. It is more likely to develop such standards reliably and consistently if it has a structure similar to and linked with those of mainstream judicial services, which are organised into national jurisdictions and are led by the higher judiciary;*
> >
> > *- the service should so far as possible be structurally separate from executive and service-providing authorities so that it is and is seen to be independent of the services in which the deaths it investigates occur.*
>
> *We therefore recommend that:*
>
> *a. the coroner services should be remodelled into national coroner jurisdictions covering England and Wales, and Northern Ireland, respectively;*
>
> *b. the responsibility for appointing and supporting coroners in England and Wales should pass from local authorities to the Lord Chancellor who broadly speaking should exercise the same responsibility for the judicial aspects of coroners' work as he has for the mainstream judiciary;*

INQUEST has consistently called for a National Coroner Service as necessary to address fundamental problems inherent to the current piecemeal system. Coroners courts are the only courts which are not funded or administered by central government and as a result the resourcing and practices of coroners courts are inevitably highly inconsistent.

In addition to the Luce report, numerous other public figures and bodies have called for a national service: the Shipman Third Inquiry Report 2003[10], the House of Commons Constitutional Affairs Committee report on reform of the coroners system 2006[11], and the previous Chief Coroner Peter Thornton QC before the All-Party Penal Affairs Parliamentary Group 2013 and in his annual report 2015-16:

"There have in the past been calls, as in the report of Tom Luce's Fundamental Review, Death Certification and Investigation in England, Wales and Northern Ireland, for a national service, with coroners to be appointed and the service funded and run centrally, like other judicial services. But that has not happened.

9 *ibid,* Chapter 15: paragraphs 181 and 182

10 Dame Janet Smith DBE (2003), The Shipman Inquiry, Third Report: Death Certification and the Investigation of Deaths by Coroners. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273227/5854.pdf>

11 House of Commons Constitutional Affairs Committee (2006), Reform of the coroners' system and death certification: Eighth Report of Session 2005–06. <https://www.publications.parliament.uk/pa/cm200506/cmselect/cmconst/902/902i.pdf>

"The Chief Coroner supports these calls for a national service. Much would be gained, in terms of standardisation, consistency and the implementation of reform, by a national structure."

For a national structure to function as an effective judicial system the Luce report also recommended an independent statutory Coronial Council[12], a small Coroner Service Inspectorate[13], and a Coroners' Rules Committee[14] to keep the evolution of the Coroners Rules under review, similar to other areas of judicial practice, for example the Civil Procedure Rules Committee. Rules on document disclosure were noted in the Luce report as requiring more detail if coroners are to have clear guidance on handling these often complex issues in a consistent way. The discussion below on disclosure highlights the continuing glaring need for such structured rule development. It is only through the creation of a proper judicial framework that many of the inadequacies in the current system identified throughout this submission can be overcome.

The Luce report was presented to Parliament and resulted in the Coroners and Justice Act 2009, which came into force in 2013. This Act adopted many of the recommendations of the Luce report, but not others. Some were initially included in the Bill but discarded during the parliamentary process. The existing system is therefore a patchwork implementation of a reform programme, with many of the historical difficulties within the coronial system remaining, though in a less extreme form than before. The Home Office conducted a post-implementation review of the Coroners and Justice Act in 2015 which has never been published. Whilst there have been many very real improvements since 2013, the reform of the inquest system remains unfinished business.

INQUEST has been calling for many of these reforms long before the Luce report came about, continued to call for them whilst the Justice and Coroners Bill was going through Parliament and continues to call for a fundamental change to the structure of the coronial system.

3.2 Role of the Chief Coroner

Even within the existing structures there is enormous scope for improvement through increased intervention at a national level. The Office of the Chief Coroner has already carried out good work and INQUEST considers that there is much that can be done, though we are aware that the Office of the Chief Coroner requires increased resourcing to do more.

Right of appeal to Chief Coroner

The Luce report noted the absence of any accessible and expedient appeal mechanism against coroners' decisions and recommended the introduction of a right of appeal to the Chief Coroner.

Currently the only avenue to challenge coroners' decisions is to bring a judicial review in the Administrative Court in the High Court. This is a cumbersome, costly and time-consuming process, which can result in adjournments to inquest hearings, and INQUEST considers that it is not a proportionate or cost effective way to challenge a coroner. It is normally only pursued on the most far-reaching points such as attempts to quash the conclusions of an inquest and order a fresh inquest. Judicial review challenges are sometimes brought before or even during an inquest but this is unusual and most routine issues that arise are never tested by judicial review. To bring a judicial review a substantial amount of legal work is required and the family needs to obtain separate legal aid, which can be difficult as there is no waiver of financial eligibility (as exists for inquest funding). Without legal aid fees are high and there is a risk of having to pay the other side's costs. In addition,

12 Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003, Chapter 14 paragraph 24 onwards

13 *Ibid,* Chapter 14 paragraph 38 onwards

14 *Ibid,* Chapter 9 paragraph 14 onwards

the grounds on which the Administrative Court will intervene on a judicial review application are limited and narrower than an ordinary appeal.

INQUEST considers that a right of appeal to the Chief Coroner would enable families to challenge unacceptable decisions by coroners through a simple and efficient route and should result in greatly increased standardisation across the country. Appeal decisions can be published on the Chief Coroner's website, giving coroners and legal practitioners a body of guidance.

The Coroners and Justice Bill originally contained a right of appeal to the Chief Coroner (Clause 30(5)), but an appeal system in Section 40 of the Coroners and Justice Act was repealed in the parliamentary debates on the Public Bodies Bill.

In its submissions and briefings on the Coroners and Justice Bill, INQUEST continually called for the introduction of a simpler appeals procedure which would allow bereaved people to raise concerns in a more informal manner[15].

When making submissions on the Bill in 2009 INQUEST specifically raised the fact that the Chief Coroners' role should be filled by a High Court judge in order that the standard of review for appeals should be that of an experienced judge who has held high judicial office. The current position is that the Chief Coroner is required to be a High Court judge, which means that in practice the role is filled by an individual without experience within the coronial system, however as there is no right of appeal the benefit of having an experienced judge in this role is lost.

INQUEST proposes that the right of appeal be revived, given the fact that inconsistency across the system remains such a fundamental problem.

Training and guidance by Office of Chief Coroner

The introduction of Chief Coroners' guidance notes, law sheets and written advice (all available on the Chief Coroner's website) is extremely welcome. However, INQUEST considers that there is scope for a great deal more to be done in the way of guidance and training for coroners. In particular, given that state-related deaths are relatively rare, many coroners will not be familiar with core issues that arise in such cases and the application of Article 2 ECHR.

Many of the concerns raised within this submission could be addressed effectively through more robust and consistent practices on the part of coroners, for example control of inappropriate questioning of bereaved relatives by lawyers for state bodies.

Mandatory training for coroners is limited to only two days per year and written guidance from the Chief Coroner covers only a limited number of areas. Increased training and guidance, with input from a broader range of organisations, groups and individuals, is required for increased consistency and the raising of standards nationwide.

INQUEST considers that there is an urgent need to involve families directly within coroner mandatory training in order to share the inquest experience from the family's perspective. Only through hearing from families in their own words will coroners truly appreciate the nature of the experience and the impact of their decisions and behaviour. Efforts to humanise the process can make a fundamental difference. INQUEST is experienced in arranging family listening days[16], and

15 See:
- INQUEST Briefing on Coroners and Justice Bill (2009)
<http://inquest.org.uk/pdf/INQUEST_briefing_on_coroners_and_justice_bill_feb_2009.pdf>
- INQUEST Briefing on Coronial Reform (2013)
<http://inquest.org.uk/pdf/briefings/INQUEST_implementing_Coroners_and_Justice_Act_2009.pdf>
- INQUEST Response to Ministry of Justice Consultation: Post-implementation Review of the Coroner Reforms in the Coroners and Justice Act 2009 (2015)
<http://inquest.org.uk/pdf/briefings/Post-implementation_Review_of_the_Coroner_Reforms_in_the_Coroners_and_Justice_Act_2009.pdf>

16 For example, with the Independent Police Complaints Commission, the Care Quality Commission, the independent review into deaths in police custody chaired by Dame Angiolini, the Independent Advisory Panel into deaths in custody, the Equality and Human Rights Commission, the Harris Review and the current review

has received positive feedback on this as a profoundly meaningful way of sharing families' views and experiences.

INQUEST is also aware that training provided to coroners is often delivered by lawyers who routinely act for state bodies. To redress this imbalance and provide a more rounded perspective a conscious effort should be made by the Office of the Chief Coroner to utilise lawyers who primarily act for families within training programmes and when obtaining specialist input to Chief Coroner guidance and law sheets.

More generally, the Office of Chief Coroner should be more open to input from other stakeholders across the inquest system. Before the Chief Coroner role was created there was a Coroners' Stakeholder Forum with the relevant Minister and the MoJ Coroners Unit at which a range of non-governmental organisations were free to raise concerns and engage in a shared discussion and dialogue. In contrast since the first Chief Coroner took up his role in September 2012 there has only been one such meeting bringing together bereaved people and organisations that support them. With the second Chief Coroner having no background experience within the coronial system there is an even greater need for direct and regular engagement and dialogue with stakeholders across the inquest system, including those outside governmental structures. This should be formalised, for example through regular stakeholder forums, along with other feedback mechanisms to allow the Chief Coroner to hear directly from families about the process.

More initiatives by the Office of the Chief Coroner and increased coroner training naturally have resource implications (as do the proposals in the section on sustained lesson learning below) but there is no escaping the fact that a poorly resourced coronial system produces poor outcomes for families and, in turn, for the wider public interest.

Where families wish to complain about improper conduct by a coroner (as distinct from challenging a judicial decision by a coroner) the Judicial Conduct Investigations Office, which is responsible for coroner complaints, provides poor redress with little effect and most families are unwilling to waste their time going down this route.

3.3 Resulting Inconsistency

The lack of national standards and practises continues to generate inconsistency in coroner approach impacting across all key aspects of state related inquests:

- Decisions on whether Article 2 is engaged.
- Some coroners put questions to jurors at the selection stage on their personal connections to the witnesses or to the state body generally (to identify potential conflicts) whilst others do not.
- Some coroners require witnesses such as police officers to wait outside court during their colleagues' evidence whilst others refuse to do so;
- Coroners' openings to the jury: some set the scene clearly and fully whilst others provide a minimal picture and little guidance on the importance of a jury's role in an Article 2 inquest.
- Coroners' summing up and directions to juries: The quality and clarity vary between coroners. Some coroners are unfamiliar with the complex law that arises in state-related death inquests. The imbalance in numbers between police and other state bodies' legal representatives and that of the family means that some coroners can be persuaded to adopt a legally incorrect or overly narrow approach.
- Narrative conclusions: coroners' approaches to jury conclusions vary greatly, with some adopting detailed questions with possible "yes or no" answers whilst others invite a jury to write their own narrative with varying degrees of guidance on what are the central issues that should be addressed. Directions to juries about the kind of wording that may be used around state failings can often be confusing.

We will go on to address further specific examples of inconsistency impacting most significantly on families.

3.3 Access to the body and information about the post-mortem

Information from the Coroner's Court, generally via the Coroner's Officer, is the first and critical step immediately following a death. Many families suffer from a lack of information in this early period.

Some families experience a distressing search ringing round simply to find out where the body of their loved one is.

Many families have been told that they cannot view the body or can only view it from behind a screen. Although in law the body is the property of the Coroner the needs of the family should be the primary concern at this critical point. Being able to say farewell in dignity is crucial to the grieving process. For a bereaved person to face obstruction and a disregard for their emotional needs at a time when feelings will be very raw undermines dignity and respect and sets the tone for the way the family will feel within the coronial system. For many it can also raise suspicions about the circumstances of death.

Initial steps should be taken immediately after a death has taken place to give the family the opportunity to attend the mortuary to see the body. Arrangements can be made to ensure that forensic evidence is not compromised and families will understand the need for caution to ensure this, if things are properly and sensitively explained.

Families are rarely told their full rights surrounding the post-mortem. Many families have reported that by the time they were told about the post-mortem it had already taken place. The family have a right to be present at the post-mortem or to arrange to have a representative such as a lawyer or independent pathologist present. However, there is no opportunity to do this if they are not made aware that the post-mortem is being conducted.

Families do not always have the post-mortem procedure or their rights under the Human Tissues Act explained to them so that they often remain unaware that organs such as the brain and the heart have been removed for examination. Some may wish to have these returned to the body prior to burial, sometimes for religious reasons, and would delay the funeral if made aware. In some cases, families do not know that they have buried the body incomplete and are deeply distressed when this then emerges later.

The mother of a baby who died in a cot death signed a form under the Human Tissues Act without the contents being explained to her and was deeply traumatised when six months after the death a police officer appeared at her door to ask what she wanted done with the remaining body parts.

Some families are informed of their right to obtain a second post-mortem by the Coroner's Officer whilst others are not. There is no consistent guideline or practice. Such information is essential very early on because any further post-mortem needs to be carried out speedily, obviously before the body is released for burial. This is particularly important in deaths following the use of force where sometimes key investigations are not carried out during the first post-mortem.

In some cases, there is a lack of sensitivity towards the needs of families who wish to arrange a speedy burial for religious and cultural reasons. Families are not routinely informed of the option of a non-invasive post-mortem (which involves a CT scan and has to be paid for privately by the family) which is desirable for some families for religious reasons.

3.4 Information on specialist support and the right to legal advice

Families routinely report a lack of clear explanation about the process that is to come. It is critical that in the early stages they are not left feeling bewildered and are speedily connected to specialist advice and support. Coroners' Officers have a central role in signposting families in the immediate period following the death as they are an early point of contact in every case.

However, a great many families report that they were not provided with any information about obtaining specialist support and legal advice. One family recalls asking whether they need a solicitor and being told "it's up to you, most families don't have a solicitor". Some families report being told by the Coroner's Officer that they do not need a lawyer because the coroner will look after the family's interests, or that the inquest is an informal and straightforward process. This is fundamentally misguided in state-related deaths.

In state-related deaths the inquest process will be far from straightforward. As noted above, public authorities are invariably represented by lawyers and there are bound to be extensive documents, policies and procedures to be considered, with evidence given from a large number of professional witnesses. No grieving family will be in a position to address this adequately and most will be bewildered and alienated by the process. The inquest needs to comply with Article 2 of the European Convention on Human Rights (ECHR) which requires a thorough and effective investigation, which will generally take several days, if not weeks. It is common from an early stage for state lawyers to argue against the application of Article 2, to argue against calling a jury, to try to narrow scope or resist the resist the need for certain witnesses, including expert witnesses.

Even where the coroner is sympathetic to the family's views s/he needs to adopt an impartial role in the eyes of all the participants and cannot be seen to be 'batting for' the family. In many cases the coroner will simply not be taking on board the family's concerns and will only do so when experienced lawyers put the arguments strongly and clearly.

It is crucial that families are told of their right to receive legal advice, to be represented by lawyers at the inquest and of the availability of legal aid. Standard guidance should make clear that legal aid is often granted and that families are frequently represented by lawyers in state-related deaths. Families should also be told that the detaining state body will inevitably be represented by lawyers at the inquest. Specialist information should be given to families in state-related deaths and other complex cases so that these families receive appropriate guidance, rather than the usual information provided to families in more routine inquests. Families should also be spoken to by Coroners' Officers and a careful explanation given. To ensure that they are properly assisted through the process this should include information about specialist support organisations, such as INQUEST.

INQUEST produces a Handbook designed as a detailed guide for families, intended as a model of good practice. INQUEST notes that in Scotland a Family Liaison Charter on access to information and liaison has been introduced by the Crown Office and Procurator Fiscal Service which contains specific commitments to provide families with specified information within specified time periods[17]. The adoption of stated commitments or pledges is a helpful way of embedding this practice and giving families a sense of entitlement (though the Scottish Charter itself has serious shortcomings, for example it does not mention legal advice for families at any point).

Leaflets and on-line information currently provided by the Ministry of Justice (MoJ) and NHS are highly misleading when it comes to state-related deaths and if followed can totally undermine the ability of a family to obtain the support and legal representation they need.

The MoJ leaflet "Coroner Investigations A Short Guide"[18] states:

17http://www.crownoffice.gov.uk/images/Documents/Deaths/COPFS%20Family%20Liaison%20Charter%20September%202016.pdf

18 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283937/coroner-investigations-a-short-guide.pdf

Legal advice

Instructing a solicitor to represent you at an inquest is not necessary in most cases, although you may do so if you wish. An inquest is a fact-finding process and the coroner will ensure that the process is fair and thorough, and that your questions about the facts of the death are answered.

The only contact details given for further information and bereavement support are governmental sources (NHS, police and Department of Work and Pensions).

The NHS Choices website has a section on inquests[19] which states:

Relatives

Relatives of the deceased can attend an inquest and are able to ask the witnesses questions. However, they're only able to ask questions relating to the medical cause and circumstances of the death.

It's also possible for a relative of the deceased to be represented by a lawyer. This may be particularly important if the death was the result of a road accident, an accident at work, or in other circumstances where a compensation claim might be made. However, legal aid isn't usually available for legal representation during an inquest.

By way of comparison, on-line guidance from Manchester City Council[20] does explain that in complex cases families may wish to instruct a lawyer and that the state body will be legally represented. However, it stops short of explaining that there is in fact a legal aid scheme specifically for inquests, which should form a part of any guidance to a family.

Legal representation and legal aid

Properly interested persons at an inquest are entitled to be legally represented if they choose.

At most inquests where there are no controversial issues, family members do not have a lawyer present. They are able to ask questions themselves if they wish.

However, in more complex cases, families may choose to use a lawyer, and other properly interested persons such as the hospital where they were treated may have representation too. The lawyers will ask questions on behalf of the party they are representing and can address the Coroner on matters of law.

Legal aid funding is not usually available for representation at inquests. Families have to pay for legal help themselves. The best thing to do is to speak with a firm of solicitors and take advice from them about what is possible. At a very few inquests that are so complex it would be unmanageable if the family were unrepresented, the Coroner can request that funding is given. Your solicitors would approach the Coroner about this for you.

Many families report that their route to obtaining specialist advice, practical support and legal representation was a matter of luck and word of mouth. Other families find INQUEST through google and are then referred to specialist lawyers. Frequently by the time lawyers are contacted the funeral has been held so that it is too late to arrange a second post-mortem, or other important steps such as pre-inquest review hearings have already taken place. In some cases, families locate INQUEST only a week or so before the full inquest hearing, not knowing that they could have

19 http://www.nhs.uk/conditions/Inquest/Pages/Introduction.aspx

20 http://www.manchester.gov.uk/info/626/coroners/5533/the_inquest_system

sought legal advice and representation much sooner. It is often difficult to find lawyers to step in on the eve of an inquest and sometimes adjournments have to be sought, prolonging the whole process.

Families report the importance of early contact with INQUEST and with the specialist advice and guidance provided in the early period following a state related death: they receive reassurance, are not isolated and can begin the practical tasks associated with bereavement. Knowing that a specialist caseworker is available to speak to and that a lawyer is carrying our preliminary work makes a real difference at this state helping the family to feel empowered.

3.5 Role of Coroners' Officers

Many Coroners' Officers are seconded from the local police force or are employees of the local authority, which raises concerns in some cases that they may have a continuing link to the organisation being investigated. This creates a perception for families of a lack of impartiality. They usually have police or local authority e-mail addresses and, given that much family contact with the Coroner's Officer is through e-mail, in deaths involving police or local authority failings this gives the impression that the investigative system is not independent. At the very least, Coroners' Officers should have e-mail addresses which reflect the fact that they work for the Coroner's Court.

The funding of Coroners' Courts underlies the appointment of Coroners' Officers and under a centrally funded National Coroners Service they would naturally be employees of the Court.

A great many families are under the impression that the Coroners' Officer, with whom they have had direct dealings, is in fact the coroner. This must stem from a lack of adequate explanation by Coroners' Officers and reflects a confusion about the process. It is important that families are provided with clear information so that they can ensure that requests that they make are forwarded to the coroner for a decision, and not dealt with by the Coroners' Officer.

3.6 Court facilities

There are significant problems at some courts with securing a private space for the family to use during the course of an inquest. It is essential for the family to have somewhere where they can go during distressing periods and to speak to their lawyers in private. Families usually find the inquest hearing itself deeply traumatic and to have a place to retreat when family members feel overwhelmed, wish to comfort one another or just have a quiet moment with a cup of tea, can make an enormous difference to the inquest experience, which can go on for many weeks in some cases.

During a Pre-Inquest Review in a case of a young woman who died in HMP Holloway, the family and the legal team had to all crowd into the court kitchen to look at a file of pictures as there were no family room facilities in the court building. Pictures included distressing images of their daughter lying on the floor of her cell shortly after being found and this was the first time the family had seen these.

At a four-week inquest into a police shooting at St Pancras Coroners Court although there was a family room it was only available for a short period before the inquest started each morning and at the end of the day for, again, a limited period because the jury had access to the same toilets as everyone else. During the lunch break everyone

had to leave to allow the jury to remain in the building and the family had to hold discussions with their lawyers in a next door park. There are no refreshment facilities on the site or nearby. A request had been made to move the inquest to larger premises but refused by the coroner.

Hertfordshire Coroner's Court is in a newly built building, however there are no private rooms available. The family have no option but to go to the café to have confidential discussions with their lawyers, which is also frequented by all the other participants at the inquest.

In small courts there is often no space reserved in the courtroom for the family to sit without being in close proximity to state witnesses such as police or prison officers. This can be extremely stressful and difficult. In highly contentious deaths there are difficulties in smaller courts accommodating extended family, community supporters and press. Families need to able to feel emotionally comfortable and to be able to speak to their lawyers confidentially during the course of the hearing.

At the same police shooting inquest at St Pancras Coroners' Court, which is a very small old building, the family and police officers were sitting on crowded church pew style benches in rows behind one another. There was no space for solicitors to sit next to their barristers and they also sat on these benches, writing on their laps. Although the family and officers sat on separate rows it meant that the officers were behind the families and their solicitors removing any privacy for taking instructions.

3.7 Coroners' decisions on scope

There is inconsistency in coroners' approach to the ambit of the inquiry. Some coroners adopt a narrow remit requiring a close causal connection to the death, which hinders lesson learning and makes families feel that important issues are being brushed aside. State lawyers argue against a broader remit, seeking to restrict the exploration of evidence.

For example, in many cases involving deaths in prison, coroners will not allow evidence which relates to the decision to impose a custodial sentence, earlier periods of imprisonment or events pre-dating the imprisonment. In other cases, such as deaths in mental health units, coroners do not wish to look at certain practices, e.g. the use of restraint, which are not directly linked to the death but which form an important element of the deceased's day to day experience.

At an inquest into a self-inflicted death at HMP Glen Parva the first coroner ruled that a separate period at the same prison three months earlier was out of scope, even though the deceased clearly presented a self-harm risk on arrival as he entered prison with visible ligature marks on his neck following a suicide attempt the night before sentence. A different coroner who later took over the case was unable to go behind this ruling but did introduce evidence from the ACCT self-harm risk form during the previous period of imprisonment.

In a death following a police pursuit the coroner refused to include within the scope of the inquest a separate IPCC investigation into the fact that the deceased had been

stopped by the police over 30 times during the previous year. The family argued that this would have been relevant to the information known to the officers and what was in their minds at the time of the pursuit

Despite the important developments in case law, some coroners dealing with prison deaths rule, with the encouragement of state representatives, that only constant supervision can prevent a prisoner from suspending her/himself, disallowing a jury from consideration of other systemic defects, e.g. within the suicide prevention ACCT process, which may have contributed to the death.

In contrast other coroners cast the ambit more widely and are able to address issues which have an important bearing on the death and are key concerns for the family.

At the inquest into the self-inflicted death of a 15-year-old boy at a Young Offenders' Institute the coroner allowed exploration of the role of the social services department responsible for the deceased during the 9 years he spent in foster care before his imprisonment. The jury found systemic failings by social services. Also, within the PFD report the coroner raised her concern that the boy had been given a custodial sentence without the benefit of a forensic psychiatric assessment. The coroner noted that she was aware of a number of other deaths of children in custody who had similarly not had forensic psychiatric assessments, thereby highlighting an important issue.

At the inquest into the death of a woman in prison following her arrest on a mental health ward the coroner allowed the inquest to consider the events leading up to prison custody. The jury made critical findings which were a public recognition of the inappropriateness of prison for the deceased.

3.8 Inquests heard before a jury

The Coroners and Justice Act 2009 removed the mandatory requirement for a coroner to summon a jury in any case which could impact upon public health and safety. There is now a general discretion for a senior coroner to summon a jury if s/he thinks that there is "sufficient reason for doing so". However, this significantly waters down the previous provision under the 1988 Coroners Act under which a coroner had no choice but to summon a jury where the death "…occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public".

INQUEST considers this to be a serious concern, given that the cases where future public health and safety issues arise are precisely the cases where lesson learning is paramount. INQUEST raised this omission in our briefings during the passage of the Coroners and Justice Bill[21].

The inquest into the death of five men who drowned at Camber Sands beach in August 2016 raises issues about whether Rother District Council should have taken action to enhance safety at the beach following a death in 2015 and two more in July 2016. The coroner has refused to summon a jury.

21 http://inquest.org.uk/pdf/INQUEST_briefing_on_coroners_and_justice_bill_feb_2009.pdf

The inquest into the death of a seven-year-old boy found that his death was the result of carbon monoxide poisoning from a petrol pump brought in to get rid of floodwater. The family argue that hydrogen cyanide fumes had been released from a lake built over a former landfill site and that the inquest was deficient and they call for a further independent inquiry. The inquest was heard without a jury.

A woman under the effects of drugs and alcohol was brought by officers to a police station to provide a witness statement as a victim of a sexual assault. She was left in an interview room for a very long time slumped forwards onto a table and was found to have died. Had she been a detainee she would have been subject to regular rousing checks and it is likely that her partial airway obstruction and reducing consciousness levels would have been picked up. However, there was no force policy requiring rousing checks for a person who was in a police station but not detained.

As the deceased had not been in custody at the time of the death the only mandatory provision for a jury under the Justice and Coroners Act 2009 was under Section 7(2)(b) if the death resulted from an act or omission of a police officer. When deciding that she would not hear the inquest with a jury the coroner effectively prejudged the issue of whether the death had resulted from any such omission. She also refused to exercise her discretion to summon a jury. The family brought a judicial review challenge and the Administrative Court held that the case should be heard with a jury[22]. At the inquest in 2016 the jury prepared a detailed narrative in which they identified failings by individual officers, failings in officer training and failures in force policies, along with a clear causal link between these failings and the death. The coroner prepared a PFD report.

The Hillsborough inquest provided the clearest of examples of how a jury can engage with complex evidence and reach bold conclusions. The following is a recent example in a more routine case of how a jury can make a very real difference to an inquest outcome.

3.9 Coroners conducting their own investigations

Pressures on time and limited resources almost certainly play a significant part in a Coroner's approach to an inquest.

The vast majority of coroners routinely rely upon the evidence gathered within the state investigation and do not generally conduct their own investigation, or even seek to fill gaps in the evidence or to expand upon the investigation, for example by instructing their own experts or seeking additional statements from relevant witnesses. The inquest is therefore limited by any limitations in the original investigation, whether this be by the Independent Police Complaints Commission, Prison and Probation Ombudsman, or NHS investigation. Coroners are severely restricted by the resourcing available to them. This makes the role of family lawyers, probing the evidence and sometimes obtaining their own expert evidence, particularly important.

Deaths in NHS settings, such as those involving mental health units, are particularly problematic. There is no independent investigative body and the majority of investigations are conducted internally within the NHS Trust, with only a minority deploying an external investigator. There are

22 R(Fullick) v HM Senior Coroner for Inner North London [2015] EWHC 3522 (Admin)

no clear protocols and families are often not given the opportunity to play a key role within the process.

In cases where families are unrepresented it is not uncommon to see Article 2 mental health or learning disability deaths listed for just a few hours with almost no disclosure, few witnesses and no independent expert evidence.

3.10 Pre-inquest reviews

Pre-inquest reviews (PIRs) play a critically important role in state related inquests, driving the often delayed timetable forward and addressing the often changing picture around disclosure, scope, witnesses and so on. They are now utilised far more extensively than previously, which improves the efficiency of inquests and is welcome. However, there remains inconsistency in practice between coroners, with some circulating agendas and draft agendas in advance whilst others do not, and some circulating a note of the PIR and directions following the hearing and others not.

The usefulness of PIRs depends on the preparation carried out for them. In some cases, legal representatives attend a PIR at which the coroner is not in a position to deal with issues as s/he has not familiarised themselves with the case or identified what needs to be addressed. In many cases critical issues and decisions are still left until late on in the process, not unusually to the first day of the inquest, when they should be resolved in advance at PIRs.

Legal representatives have been facing increasing difficulty in securing funding for attendance at PIRs.

3.11 Pen portraits and photographs

A 'pen portrait' involves a family member providing a personal background statement about the deceased together with a photo for the court and jury to see. The Hillsborough inquest established pen portraits as an essential part of the process, humanising the deceased from the outset. Many families find the inquest to be a dry legal process where their loved one gets lost whilst the focus is on the actions and policies of state employees. The deceased will often be stigmatised through contact with the criminal justice system or mental health issues and state lawyers attempt to pathologise him or her and blame their lifestyle for the death. The ability to share with the jury what the deceased meant to his or her family, as a much-loved son, daughter, mother father, to visualise him or her in their life outside of detention, right at the start, can make a very real contribution to resetting the balance.

There is currently a highly inconsistent practice between coroners on whether pen portraits and family photographs will be permitted.

In an inquest into the death of an 18-year-old in a road traffic collision following a police pursuit the family prepared a pen portrait statement and sent it in advance to the coroner. At the start of the inquest the family solicitor raised this and the coroner said that it should come later in the evidence. Half way through the inquest hearing the coroner read out the statement, not allowing the family to read it themselves as they had prepared to do, and summarising the statement as the coroner saw fit. This was hugely distressing to the family who did not feel that they had been given the opportunity to give the jury a real picture of their son.

At the inquest into the death of a young man following imprisonment who struggled with drug addiction and mental health issues, the coroner allowed the family to read out a pen portrait at the beginning of the proceedings. It was very important to the family to be able to set the scene by telling the jury how their son should not be dismissed as a 'drug addict' and that there was much more to him and he was very much loved by his family.

3.12 Conduct of coroners

Whilst a great many coroners conduct difficult inquests with sensitivity, there are some families who experience discourteous and dismissive behaviour by coroners, making them feel demeaned and undermined. This is wholly unacceptable in a modern coronial system which should have the needs of the family at its heart. Some coroners adopt the attitude that it is 'their inquiry', rather than recognising that the family has the greatest stake in the process, which sets the wrong tone throughout. There is a particular concern that many unrepresented families may face more dismissive behaviour by coroners when there are no lawyers present to moderate the proceedings.

The parents of a young woman, both in their 70s, attended a pre-inquest review unrepresented, before eventually instructing a solicitor. Their daughter, who had complex mental health needs, was killed by a lorry whilst walking on a dual carriageway, raising a range of safeguarding issues with two NHS Trusts. At the pre-inquest review the coroner did not offer condolences, told the parents that they had three minutes to make a point and spoke to them aggressively, ordering that there should be "no shouting" although they had shown no indication of doing so. The family instructed a solicitor who obtained the recording of the pre-inquest review and she was extremely concerned at the coroners' attitude to her clients which would be very unusual if family lawyers were present.

Following the death of a young woman in prison the family met the coroner for the first time at a pre-inquest review. The family were very disappointed by his failure to offer them condolences, the very least that might have been expected from an experienced coroner.

Following the inquest into the death of a man at HMP Birmingham the mother of the deceased was left wanting a further inquest following her experience of a coroner who had been hostile and closed minded. Her barrister had been shouted at by the coroner to sit down and stop asking questions otherwise he would not be allowed to ask any more. She felt that she had not been able to explore issues properly. When she had to leave the court due to her distress the coroner did not stop the proceedings in contrast to when a G4S officer was upset whilst giving evidence. The mother felt that the coroner disregarded her needs and feelings.

3.13 INQUEST's Recommendations

A National Coroners' Service
INQUEST considers a National Coroners' Service is the only change capable of truly addressing the lack of consistency across resources, standards and practises. Coroners courts are the only courts which are not funded or administered by central government. Responsibility for provision, management and financing of Coroners' Officers should be transferred from local authorities to the Courts and Tribunal Service. Coroners officers should be employed directly by a nationally resourced Coroners' Service to avoid bias and conflicts of interest through the use of seconded police officers and local authority staff.

Nationally developed standards
The office of the Chief Coroner should be responsible (with input from specialist organisations and practitioners) for the development of clear national standards and guidance on all core issues relevant to state related inquests and the application of Article 2 ECHR: scope, jury questions, PIRs, application of Article 2, opening and closing to jury, conduct of coroners towards family, conduct of state legal representatives towards family witnesses and so on.

Coroners Officers
The Chief Coroner should prepare standard national guidance for all Coroners' Officers to distinguish state-related deaths and other complex cases from the more routine inquests. Families should be informed of their rights to legal advice and representation and the possible availability of public funding. Clear information concerning the role and remit of Coroner's officers should be provided to families to make clear areas of responsibility and decision making.

Right of appeal
A right of appeal to the Chief Coroner should be introduced to address the absence of any accessible and expedient appeal mechanism against coroners' decisions. INQUEST considers that a right of appeal to the Chief Coroner would enable families to challenge unacceptable decisions by coroners through a simple and efficient route and should result in greatly increased standardisation across the country.

Coroner Training
Increased and more specialised training is needed including on state related inquests, with input from a broader range of specialist organisations, groups and individuals. Coroner training should involve direct family involvement. It should also utilise lawyers who primarily act for families within training programmes to correct the current imbalance resulting from the reliance on lawyers who routinely act for state bodies.

Specialist "Article 2" Coroners
A team of specialist Article 2 coroners responsible for state related inquests would ensure appropriate experience and training needed to manage and effectively deal with these contentious, political and often highly complex cases.

Consultative / stakeholder forum
The Office of Chief Coroner should be responsible for organising a regular consultative forum for users of the inquest system to enable transparency, feedback and input on the experience of and development of systems and practises.

Information and advice
Written information about sources of specialist support and advice including information about INQUEST should be passed immediately to every family by the coroner's court following a state related death.

Post mortems
All families should be given the same clear information immediately following death concerning the post-mortem procedure and a family's full rights under the Human Tissues Act, including rights to access the body, to be present during the post mortem and the right to a second post mortem.

Access to the body
Families should be given immediate opportunity to attend the mortuary to view the body. Any arrangements required to ensure that forensic evidence is not compromised must be justified and should be clearly and sensitively explained.

Photos and 'pen portraits'
All coroners courts should be required to adopt the best practise followed at Hillsborough, allowing all families to produce a photo of the deceased during the inquest and allowing a full and personal 'pen portrait' of their loved one.

Court facilities
Coroners' courts should satisfy minimum physical standards to ensure the needs of families are met, to include: a family room available throughout the inquest, a designated space within the courtroom away from witnesses and lawyers for state bodies, access to refreshments.

Juries
The mandatory requirement for a coroner to summon a jury in any case which could impact upon public health and safety (removed by The Coroners and Justice Act 2009) should be reinstated.

4 Transparency and Duty Of Candour

4.1 Disclosure

Openness, transparency and disclosure of evidence sits at the heart of a family's attempt to find out what happened to their relative. Families face the often insurmountable imbalance in which responsible state bodies hold and control the majority of relevant evidence.

The disclosure process remains highly inconsistent, confusing and in some cases shambolic. Sometimes disclosure is provided directly to the family by an investigating body such as the IPCC, and in others by the coroner. In some cases, there will be parallel investigations by different state bodies uncovering both different and overlapping documents. There is inconsistency and confusion as to who has ownership and management of the disclosure process. Where there are disagreements between different bodies it is not clear who takes precedence and families are routinely denied disclosure at various stages of the process. Frustrated disclosure also causes adjournments and delays.

Obfuscation and inefficiencies throughout the disclosure process invariably work to the benefit of public bodies and hinder the search for the truth. The Hillsborough inquest demonstrates the benefits of full disclosure, where the work of the Hillsborough Independent Panel ensured almost unprecedented disclosure in advance of the inquest hearing.

The proposed 'Hillsborough Law' introducing a duty of candour across public institutions and for all public servants is strongly supported by INQUEST as a tool to promote this crucial principle. However, we raise a note of caution in that while such a duty of candour is already imposed in the healthcare sector[23], serious difficulties remain around disclosure and transparency in that sector.

In INQUEST's view, greater enforcement duties must be attached to any duty of candour to reinforce and make real its implementation. In addition, new structures are needed across the current system to make full disclosure a reality and to bring about the cultural change required to support this principle.

4.2 Disclosure by state bodies

A recurrent problem is the failure of state bodies to provide full disclosure to the coroner in advance of an inquest. It remains common for disclosure to occur just before a long awaited hearing or for new relevant documents to come to light for the first time during the course of the hearing.

The smallest pieces of evidence have the potential to significantly change the picture surrounding a death. Late and erratic disclosure is distressing to families and undermines the legal process. For example, a previously unseen document cannot be explored with earlier witnesses and can result in gaps in the issues before the jury. It also fosters the perception that state bodies are not being transparent and fully open, and feeds family concerns that matters are being deliberately concealed or that other relevant evidence may not to have emerged. In some cases, further material comes to light after the inquest is over.

23 In Regulation 20 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Where an investigation has been conducted by an external body such as the Independent Police Complaint Commission (IPCC) or Prison and Probation Ombudsman (PPO) there are specific systems for document collection, though these are also often floored. Where there is no such investigation, disclosure of documents can be even more haphazard. As in other aspects of the inquest system, there are great inconsistencies in what happens in practice and no standardised approach.

In an inquest into the death of a woman who was killed after she absconded from a mental health unit, where there were serious failings in the security of the unit, the NHS Trust resisted the application for the coroner to carry out an Article 2 inquest. The Trust then disclosed incomplete records; they were directed to disclose all records and statements by a date over four months ago and still have not done so; the family's solicitor has made two complaints directly to the Trust but has still not received the documents or an explanation or apology. The difficulties with disclosure are on-going despite the fact that the duty of candour came into force in the healthcare sector on 1 April 2015.

During a three-and-a-half-day inquest into the death of a man in mental health detention, on the second day of the inquest the hospital's representatives raised the suggestion that some records were still in the possession of the police and had not been returned, but were unable to identify which documents may be missing. This death occurred since the introduction of the duty of candour within the healthcare context.

Before the inquest into the death of a 29-year-old man who died whilst on unescorted leave from a psychiatric unit the coroner was supplied with only a limited selection of prison documents relating to his period in prison during the month before his death. It was only by chance through probation records that a series of e-mails between prison staff and healthcare staff emerged, which the coroner described as "very relevant to issues raised in the inquest". These were seen for the first time by the family's lawyers 72 hours before the inquest.

The NHS Trust disclosed applicable policies on day 3 of the inquest. The prison did not provide the ACCT self-harm risk form until day 6 or 7 of the inquest.

The coroner addressed inadequacies with disclosure in a PFD report in which he stated that:

"(4) In relation to the coronial investigation and the inquest itself, there were significant concerns surrounding the co-ordination of disclosure by HMP Woodhill, initially by volume disclosure direct to the coroner, and subsequently in a piecemeal, partial fashion via Government Legal Department. Emails in which prison staff and/or healthcare staff were participants and which were very relevant to issues raised in the inquest became identifiable only through probation records and there was a concern that relevant communications should have formed part of the specific prisoner records and been part of the HMP Woodhill disclosure. Whilst significant urgent work was undertaken by Government Legal Department during the inquest itself to assist the court with additional and correct documentation, these concerns, together with late identification of relevant witnesses and provision of witness statement caused delays to the coronial investigation which may also have delayed the overall learning process and compromised the ability of HMP Woodhill to implement change."[24]

24 See section 17.0 below which sets out how HMP Woodhill has seen 18 self-inflicted deaths since May 2013

The following chronology from an inquest into the death of an 18-year-old with a learning disability and epilepsy who drowned in the bath whilst unsupervised on a specialist NHS learning disability unit, provides a flavour of the battles that can occur over disclosure. The detail and the dates over which events unfolded can provide an appreciation of the depth of the problem:

6 Aug 2013: family solicitor writes to NHS Trust stating that records disclosed were incomplete

23 Aug 2013: Trust writes stating that some further documents would be provided, following which the solicitors would be in receipt of all documents relating to the deceased

25 Sept 2013: solicitors request further missing records

3 Oct 2013: Trust confirms disclosure of further records and states that not aware of any other RIO notes other than those already sent

16 Dec 2013: family solicitor writes identifying further missing records

10 Jan 2014: Trust provides further disclosure

Feb 2014: first draft of report by independent investigative consultants Verita revealed that full set of minutes from weekly team meetings had not been received and that Verita had different copies of these minutes to the family and their lawyers

21 Feb 2014: Trust confirmed that medical records had not been disclosed to Verita

Nov 2014: family solicitor provided with further documents not previously disclosed by the Trust, the explanation provided being that the request for records of the deceased had not been interpreted to include these as they were held separately from his records.

28 Sept 2015: letter from a Dr D to mother of deceased apologising that some records had not been disclosed until now

2 Oct 2015: letter from Dr D apologising that they had now discovered “a secondary file of medical records” not previously disclosed. This was on the Thursday before the Monday morning on which the inquest was starting.

During the inquest: Coroner informed about previous deaths on the same unit, including a previous patient who had died in the bath. This had not previously been disclosed to the family, the coroner, Veritas or the police.

Following the inquest: a document “Quality and Safety Review” from August 2012 was leaked to the mother of the deceased which revealed serious concerns about the unit before her son was admitted, which was highly relevant to the inquest. There has been no explanation for the failure to disclose the document.

A further aspect of disclosure by state bodies is redaction, which can prevent the investigation from identifying key information or individuals. Again there is inconsistency, with redaction being carried out by the coroner in some cases and by the Government Legal Department and other state organisations in others. A coroner should never have only seen a redacted version of a document from a state body.

During an inquest into a death at HMP Blundeston the family’s lawyers were supplied with an e-mail that had been redacted in its entirety. The coroner himself did not have

the unredacted version. The family's lawyers had to make a number of legal arguments to persuade the coroner to disclose an unredacted copy, which he eventually ordered "for the sake of transparency".

In a self-inflicted death at HMP Liverpool a range of documents were redacted, including the names of the person who completed the ACCT self-harm risk form and person who carried out observations on the deceased, although they would be key witnesses. The family's lawyers had to repeatedly raise the issue at pre-inquest review hearings, resulting in four versions of the coroners' bundle being produced.

The Coroners Rules 2013 only say that a coroner may disclose a redacted version of all or part of a document, but do not specify who should do the redacting.

4.3 Disclosure to families by the coroner

Coroners vary widely in their approach to disclosure and there is no clarity on what is acceptable practice. The breadth of pre-inquest disclosure to families frequently depends upon the assertiveness and tenacity of the family's legal representative. Unrepresented families are especially disadvantaged when trying to gain access to information and as a result many are hindered in their attempts to secure public funding and legal help (both of which require a clearer picture of the issues and areas of contention).

Problems around disclosure give families the impression that things are being hidden from them and create an atmosphere of suspicion before the inquest. For lawyers they also create a chaotic environment for inquest preparation and can greatly increase legal costs.

In a case involving a patient detained under the Mental Health Act who took his own life, following the inquest the coroner has refused to provide a copy of the record of the inquest, which is its official conclusion, to the family and their lawyers. This would be routinely provided by other coroners.

Following the death of young woman with complex mental health conditions killed by a lorry while walking intoxicated along a dual carriageway the coroner agreed to disclosure of the police collision report to the family's solicitor only and not to the family, which the solicitor could not agree to, given their professional duties to their clients.

A coroner only allowed the family to read a distressing report whilst sitting with a police officer. They were not allowed to take a copy to read in their own time or with their solicitor.

In the lead-up to an inquest into the death of a man who had been restrained by the police and then restrained again within a mental health unit prior to his death there,

the coroner mentioned that she had obtained a second post-mortem, which the family had not known about. Requests by the family's lawyers at a PIR for disclosure of this post-mortem report were refused by the coroner. The report was only disclosed after the lawyers sent a formal letter threatening to begin a judicial review.

During the course of an inquest into the death of a woman who had died in prison after being transferred from a mental health unit, the coroner read a funeral plan prepared by the deceased whilst she was at the hospital. Her family had never known about this funeral plan and it had never been disclosed to them. She had expressed a wish to be buried but her family had had her cremated.

4.4 Coroner discretion

The Coroners Rules 2013 state that there should be disclosure of any document the coroner considers "*relevant to the inquest*". It is common for coroners to refuse to disclose a particular document requested by a family on the basis that he or she does not consider the document to be relevant. The family and their lawyers are prevented from seeing documents to make their own assessment and submissions about possible relevance.

Generally, it is only through considering documents that the family will be able to form a view as to relevance. Given that family lawyers commonly hold greater familiarity with the evidence and issues, a coroner's wide discretionary powers around this issue can seriously hinder a proper, transparent assessment of potentially relevant material.

For families to be able to participate effectively they must have a legal right to see all documents that are "potentially relevant" to the death and not only those that the coroner has deemed relevant. This would enable arguments to be put to the coroner on why a document is relevant, with the final decision still resting with the coroner. Lawyers who represent families consider that an amendment of the Coroner's Rules 2013 Rule 13(2)(d) to "*potentially relevant to the inquest*" would provide a significant step forward.

4.5 Document management

An inquest into a state-related death lasting several weeks can involve vast quantities of evidence and materials. The production of well organised paginated bundles from which all interested persons, their lawyers and witnesses can work is essential for the smooth running of the case and to prevent delay and confusion. However, there is no standard procedure for the preparation of bundles in coroner courts as there are within other courts.

There is inconsistency across the country in how court bundles are managed, often depending on how well resourced the coroner's court is, with some coroners preparing bundles and others not.

With the lack of coroner resources to properly prepare material, it is common for family representatives to take on this (unfunded) time consuming and resource intensive role. This can be a difficult task with many coroners and public authorities providing disclosure late in the day, with sometimes large volumes of material provided within a day or two of the start of an inquest, needing to be categorised, bundled and perused at the eleventh hour.

At a six-week inquest into the death of a man following restraint by police officers in a mental health unit the documents ultimately ran to 10 lever arch files.

The coroner adopted a restrictive view of disclosure and relevance from the outset, stating that any requests for disclosure would be considered only if parties could identify additional documents and make a case for their relevance. However, this would be an impossible task for the family without knowing what documents existed and without being able to see them.

Following repeated representations, the family's solicitor was provided with a list of the documents gathered in the police investigation into the NHS Trust. She was asked to make representations on the relevance of each of the hundreds of documents in this list although in many cases it was difficult to tell exactly what the document was from its title.

The family's solicitor was not provided with a list of IPCC documents from the investigation into the police officers and it was clear that a significant number of standard police documents were missing from the coroner's bundle e.g. use of force reports, officers' notebooks, logs etc. She listed this material by category and repeatedly requested it in a series of letters and also at pre-inquest hearings but did not manage to obtain a clear response, and the documents remained outstanding.

Very shortly before the inquest she attended at the Coroner's Court in Birmingham for an inspection visit where she discovered a box of documents which appear to have been categorised as 'unused material' by the IPCC. These included the core documents which she had been requesting, which were of central relevance to the issues in the inquest.

The coroner was still not willing to accept that full disclosure should be made to all the parties before decisions on whether and which documents were relevant. There was no time to agree bundles before the start of the inquest, so the lawyers managed to create one set of bundles while the coroner had a different and much smaller bundle.

The inquest into the death of an intoxicated man in a London police station was delayed for four years by an unsuccessful prosecution of the forensic medical examiner (FME) for gross negligence manslaughter. Shortly before the inquest the IPCC identified several boxes of papers from their investigation into both the police and the FME which the coroner had never seen. The coroner was forced to adjourn the inquest yet again by a further five months. Further disclosure was provided by the coroner to the family's solicitor in a piecemeal fashion, with a large volume of unsorted documents provided only two working days before the start of the inquest, which had to be considered, indexed, bundled and paginated. The family's barrister was considering fresh material at a time when he planned to be finalising his inquest preparation.

4.6 The need for structured rules for disclosure at inquests

The rules on disclosure at inquests are set out in the Coroners Rules 2013 Part 3 and are very limited. There is no specific legal rule which establishes a duty on state bodies to provide disclosure to the inquest, apart from the general duty to carry out an effective investigation under Article 2 ECHR. The Hillsborough inquest provides the perfect example of why state bodies should be obliged by law to provide disclosure and the examples above show how in other kinds of state-related deaths disclosure can be chaotic, fudged and can allow deliberate concealment.

The duty of candour and 'Hillsborough Law' is clearly critical to this. However, as noted above, a duty of candour already applies within the NHS, but has not prevented the kinds of problems with disclosure set out in the case studies in this submission. The duty of candour needs to be not only a principle, but also embedded within clear disclosure procedures. These should be complemented by sanctions for non-compliance included within the 'Hillsborough Law' Public Authority Accountability Bill.

4.7 INQUEST's Recommendations

- INQUEST supports a duty of candour and 'Hillsborough Law' as critical to bringing about an embedded practise of transparency and full disclosure. These should be complemented by sanctions for non-compliance included within the Public Authority Accountability Bill.

- INQUEST supports an amendment of the Coroner's Rules 2013 Rule 13(2)(d) extending a Coroner's duty to disclose to families all "*potentially relevant to the inquest*".

- INQUEST urges the Chief Coroner to consult with legal practitioners and other stakeholders to develop a formal standardised structure for disclosure. Such guidance to include the following possible ideas and approach:
    - By a particular date a senior individual within each state body must sign a declaration to confirm that they have taken responsibility for a reasonable search for all potentially relevant documents held by that state body. They should set out the categories of documents searched for (e.g. medical records, e-mail correspondence, standard documents and the locations searched). This is the direct application of the duty of candour to the process.
    - By a particular date the state body must produce an itemised list of all potentially relevant documents that have been located.
    - By a particular date the lists of documents produced by each state body should be provided to the coroner and circulated at the same time to all interested persons at the inquest.
    - By a particular date each state body should provide copies of all documents on the list to the coroner (probably the same date as at point 3 above).
    - If a state body considers that there is a need for redaction of any document, it should explain its concerns to the coroner for a decision on whether redaction is required and if so on the criteria and who should carry out this process. The coroner should always receive an unredacted version so that s/he can check that the redactions applied go no further than strictly necessary.
    - By a particular date the coroner should provide an indexed bundle of all the documents s/he considers to be relevant to the interested persons.
    - By a particular date any interested person can request disclosure of any documents on a documents list which has not already been included in the coroner's bundle and following such disclosure can put forward a request to the coroner for any document to be included in the bundle.

- Disclosure rules should include the disclosure of possibly relevant other deaths occurring at the same institution or under the care or detention of the same state body.

- A standard procedure should be introduced for the preparation of bundles in coroner courts similar to rules existing across other court settings.

5 Learning and the Prevention of Future Deaths

Almost without exception, every family INQUEST works with speaks of the overriding need for change, to ensure others do not go through what they have been through. One of the most devastating discoveries for a grieving family is that a similar death has occurred in similar circumstances and that 'lessons were not learned'.

HMP Woodhill has the highest number of self-inflicted deaths in the country. There have been 18 self-inflicted deaths in this prison since May 2013. Coroner's reports and the Prison Probation Ombudsman recommendations have repeatedly set out in clear terms since February 2014 what needs to be changed to prevent future deaths. The same recommendations have been made in case after case. For example, the Coroner's PFD report in relation to Daniel Byrne who died on 27 February 2015 stated:

"My concern is that the reports and recommendations of the Ombudsman and indeed my own Preventing Future Deaths Reports have not been implemented by Woodhill Prison and there needs to be an urgent review as to why the necessary measures to prevent suicides from recently admitted prisoners have not been implemented."

Some of the recommendations which have been repeated most often were in relation to the way the prison staff manage prisoners at risk of suicide and self-harm, in particular the ACCT process. For example, the reports have said that the Governor should ensure that suicide protection procedures are followed. Staff should carry out a full risk assessment of suicide upon reception for a newly arrived prisoner. Staff should take account of all known risk factors and not merely how the prisoner currently presents. The recommendation that the Governor should take action to ensure suicide protection procedures are followed, has been made in all eight of the following deaths:

Kevin Scarlett	22 May 2013
David Hunter	26 May 2013
Sean Brock	10 November 2013
Stephen Farrar	12 December 2013
Dwane Harper	4 April 2014
Jonathan White	14 October 2014
Daniel Byrne	27 February 2015
Ian Brown	19 July 2015

A week after the conclusion of an inquest into the death of a young man who had been detained in a mental health unit the family's solicitor was contacted by the father of another man who had died in the same ward at the same hospital. The earlier death

had raised very similar issues about quality of care, quality of risk assessments and failures in record keeping. The Chief Executive of the NHS Trust had responded to the coroner's report at the end of the first inquest stating that all the recommendations had been dealt with. The second death took take place eight months later.

At an inquest into a death in 2015 of a man who had placed drugs in his mouth when approached by police officers the coroner made a PFD report to address the training of police officers in what to do when someone places a potentially harmful object in their mouth. Almost exactly the same issue was highlighted by the coroner' report at the conclusion of an inquest in 2010 into the death of a man in very similar circumstances involving a neighbouring police force. The coroner noted that:

"It is of concern that there is a 2006 case with not too dissimilar facts in the South Wales Police Force area. In that case, the lack of training in relation to the forced search of the mouth of a detainee and control and restraint where a detainee has been seen to put something in their mouth were issues highlighted by the Inquest. One of the recommendations of the Preventing Future Death's Report in that case was that officers should be trained in the technique of forced searching of the mouth. There is an apparent shortcoming in the cascading of information across the different police forces."

5.1 Structures for oversight and learning

Properly conducted investigations and inquests where families can play an effective part have been crucial in shining a light on the closed world of custody and other detention-related state functions. They can save lives. Inquests should be a forum from which vital lessons can be learned and from which crucial changes can flow.

In his guidance on PFD reports the previous Chief Coroner underlined the significance of lesson learning:

"These reports are important. Coroners have a duty not just to decide how someone came by their death but also, where appropriate, to report about that death with a view to preventing future deaths. A bereaved family wants to be able to say: **'His death was terrible but at least it shouldn't happen to somebody else**". (emphasis added)

The breadth of information uncovered at inquests can help identify trends, the need for improvements to operational policies, practice and training and can impact on wider legal and policy considerations. It can be used to make systems safer.

While the coronial service can and does make a vital contribution to the prevention of deaths, and the conditions of safe custody and detention, that input is at risk of being critically undermined by the failure to recognise the value of properly-collected data or to monitor compliance with and/or actions based on the findings and reports that emerge from inquests.

The current system is failing to maximize the preventative potential of the inquest system and its ability to alert the relevant state and corporate bodies to deficiencies in systems and dangerous practices. INQUEST has long argued for the publication, dissemination and analysis of recommendations, and their implementation. See INQUEST's detailed reports *Unlocking the*

Truth (2007) and *Learning from Death in Custody Inquests: A New Framework for Action and Accountability* (2012)[25].

The current system of learning lessons and implementing changes arising from state related deaths is not fit for purpose and does not adequately meet the needs and hopes of bereaved families, or satisfy wider public need:

- Coroners have no powers to require state bodies to take any particular actions in response to their recommendations. Their role is limited to the sending of a PFD and receipt of a response. State bodies are free to disagree with, disregard or delay their responses to a PFD. Coroners have no enforcement powers or follow-up role.

- Responses to coroners' reports frequently state that a particular issue highlighted by the coroner will be reviewed or that fresh guidance or training is in motion. There is no mechanism to follow up on this, for example to ascertain the outcome of a review or the content or implementation of training. The concern is that these broad assertions can be a way of placating or deflecting coroners' recommendations and proposals.

- In a great many cases INQUEST has observed state lawyers fighting hard at inquests to avoid criticism, whilst witnesses from many levels of the state organisation deny failings in the witness box. It is therefore unsurprising that families remain sceptical about the political will to implement changes. This is not to say that there are not cases where positive changes do flow from coroners' reports and where state bodies accept that failings have occurred and even apologise to families. However, the coroners' report and responses system is essentially dependent upon the goodwill and diligence of the local body without any external monitoring, interrogation or enforcement.

- Recommendations are not monitored or followed up in any systematic way. Learning is fragmented and disparate with the result that we are seeing the same institutional and individual failings time and again across different cases. Some coroners' reports have informed changes to policies and practices but such positive developments have been piecemeal, at best learned within a given institution and often in spite of rather than because of the current system.

- Coroners' recommendations in reports are generally directed to a local body (primarily the local Chief Constable, Prison Governor or NHS Trusts) which means that learning is not shared and applied nationally. There is no guidance to coroners in relation to whom they should direct their recommendations and no consistency of practice between coroners.

- The need to follow up issues arising out of inquests does not sit within the specific remit of any of the regulation, investigation, inspection or monitoring bodies. The public interest requires official responses to state-related deaths to be transparent and accountable but no administrative framework has yet been developed to formalise and realise the potential of this preventative role.

- There is no systematic analysis of inquest outcomes, either of jury findings or coroners' PFD reports. There was some attempt at creating an overview by the Ministry of Justice in their "summary of reports and responses under Rule 43 of the Coroners Rules" produced between July 2008 and September 2013. The summaries covered Rule 43 reports in all deaths, of which deaths in custody and other state related deaths formed a small percentage. They contained no meaningful analysis, consisting only of a statistical breakdown categorizing reports by subject areas. The thematic approach amounted to merely a summary of a particular selected case which raised broader issues, but without any analysis across a number of such cases. The summaries were six-monthly which prevented any analysis of themes or developments over time. This role was purportedly

25 Helen Shaw and Deborah Coles (2007), Unlocking the Truth executive summary, key proposals and recommendations: Families' Experiences of the Investigation of Deaths in Custody. <http://inquest.org.uk/pdf/unlocking_the_truth_executive_summary.pdf>

See also recommendations in chapter 8 of the 2012 report:
Deborah Coles and Helen Shaw (2012), Learning from Death in Custody Inquests: A New Framework for Action and Accountability. <http://www.inquest.org.uk/pdf/reports/Learning_from_Death_in_Custody_Inquests.pdf>

transferred to the Chief Coroner's Office after September 2013; however, the previous Chief Coroner informed INQUEST that he did not have the resources to carry it out.

A key obstacle to reform and sustained change is the lack of rigour, transparency and accountability of state institutions, as well as the relevant government ministers, to take action to rectify identified and dangerous systemic problems and the need for a more co-ordinated response by the regulatory, investigation and inspection bodies.

There are initiatives such as the cross government (Dept. of Health, Home Office, Ministry of Justice) sponsored Ministerial Board on Deaths in Custody and the judiciary website for coroners' reports but these have been established with limited objectives and without significant resources or powers. The Ministerial Council on Deaths in Custody lacks the necessary resources and capacity and independence being sponsored by NOMS and without an independent Secretariat. Its Independent Advisory Panel (IAP) is a limited initiative. It does not have its own staff or resources to devote to in-depth work and is unable to compel the Ministerial Board to accept and act on its recommendations. The Ministerial Board is largely an information exchange forum consisting of quarterly meetings chaired by different Ministers. There is no systematic discussion of inquest outcomes and these are only discussed on individual cases if INQUEST as one of the representatives on the Board tables a discussion. The turnover of Ministers and Secretariat means that it lacks formal organisational memory and many discussions are repeated

Interestingly, following INQUEST's written and oral submission to the Joint Committee of Human Rights Inquiry into Mental Health and Deaths in Prison in March 2017, the Committee have endorsed INQUEST's recommendation for a 'national oversight mechanism tasked with the duty to collate, analyse and monitor learning outcomes and their implementation arising out of custodial deaths.' for deaths in prison. In their letter to the Secretary of State for Justice they proposed the following amendment to the Prison and Courts Bill. [26]

(b) Lesson-learning mechanism

The Children and Social Work Bill contains a lesson-learning mechanism in relation to the deaths of children in care, in response to concerns that mistakes were too often being repeated and lessons not being learnt about such deaths. Lord Harris's Report identified the need for such a national oversight mechanism in relation to deaths in prison. The Committee has also received evidence in its inquiry supporting that recommendation, and advocating the creation of a national oversight mechanism with a duty to collate, analyse and monitor learning outcomes and their implementation arising out of deaths in prison.

Q6: Will the Government consider amending the Bill to provide for a national lesson-learning mechanism analogous to that contained in the Children and Social Work Bill in relation to deaths of children in care?

We would argue that given the importance of learning this should be extended to all state related deaths, particularly those engaging Article 2 of the right to life. This way we can maximise the preventative potential of the inquest system and its ability to alert the relevant state and corporate bodies to deficiencies in systems and dangerous practices so that meaningful and effective changes are made. The current system is failing to meet the needs of bereaved people and the wider public interest and highlights the failure of existing modes of accountability and learning.

26 http://www.parliament.uk/documents/joint-committees/human-rights/correspondence/2016-17/Chair_to_ET_170330.pdf

5.2 INQUEST's Recommendations

- INQUEST believes that there is an overwhelming case for the creation of a national oversight mechanism tasked with the duty to collate, analyse and monitor learning and implementation arising out of state-related deaths. This is the only way to secure proper cross-sector learning and public transparency.

- As well as ensuring vital learning, this would also assist the inspection, monitoring and regulation bodies to fulfil their vitally important function and help play a strategic role in the protection of people in the care of the state. Providing a knowledge and evidence base would help shape and inform their work, ensuring the sharing and dissemination of information, guidance and recommendations.

- Such an oversight mechanism would require the necessary resources and Secretariat. However, the expense involved in taking preventative measures will always be less than the cost – both human and financial – of not taking appropriate measures. Without this mechanism, issues of systemic failure and cross-sector/jurisdiction learning will never be addressed and avoidable deaths will continue to occur.

- Any new framework should also be accountable to Parliament to enable the advantage of parliamentary oversight and debate. Consideration could be given to its reporting annually to Parliamentary Select Committees. The findings of inquest juries and Coroner's reports must be published in a searchable format and should be available to all engaged in thinking about, and legislating for social, health and criminal justice policy.

- Responses and implementation of Coroner's recommendations should be put onto a mandatory footing. Coroners should be given enforcement powers and a clear follow up role.

- Guidance to coroners should be introduced identifying where and to whom Prevention of Further reports should be directed to ensure consistency of practise and to maximise learning and change to correct and address unsafe systems and practises.