

INQUEST family evidence submission to the Justice Select Committee Inquiry into the Coroner Service

September 2020

Introduction

1. This family evidence submission brings together input from 51 bereaved family members who responded to a questionnaire sent by INQUEST to gather input for the Justice Committee's inquiry on the Coroner's Service.
2. INQUEST ensures the family voice is heard by those with power and influence, with the aim of bringing about meaningful policy and practice change to prevent future deaths. INQUEST has made a separate submission to the Justice Committee's inquiry which also draws from family evidence, but this submission is based entirely on their input and sets out a selection of quotes from them.¹
3. Different families experience the coronial system differently. Their cases are unique and the inquest process is a deeply personal and raw experience, linked to traumatic bereavement, and though there are some common themes, their experiences cannot be generalised. In this submission, we demonstrate a range of positive and negative experiences, which is highly relevant to the Committee's focus on the inconsistencies of the coronial system.
4. Families are supposed to be at the heart of the inquest process but in reality, as this evidence submission shows, they are forced into a legal process that can - and in too many instances in fact does - add to their trauma. INQUEST is deeply grateful to the bereaved families who have contributed their time, experience and analysis to this process, as many of them have already done so to other processes aimed at strengthening the investigation of state related deaths.
5. Families are experts in their own experience and we encourage the Justice Committee to put these experiences at the heart of this inquiry. As stated in INQUEST's separate submission, we urge the Justice Committee to take oral evidence from families, to ensure that their first hand experiences of the inquest process inform your conclusions.
6. The submission focuses initially on the need to put families and their need for truth and justice at the heart of inquests, and subsequently on the specific areas of inquiry set out in the Committee's terms of reference.

¹ See INQUEST, *Submission to the Justice Select Committee Inquiry into the Coroner Service*. We also encourage the committee to consider the accounts of bereaved families from INQUEST family listening days: <https://www.inquest.org.uk/family-listening-days>. Where families have requested, or if the comments relate to an open inquest, we have anonymised the quotations.

Putting families and their need for truth and justice at the heart of inquests

7. Families are given inquests as their means to find out how their relative died. They want the truth and routinely describe the need for accountability, for any mistakes to be acknowledged in the hope that future deaths can be prevented. Yet overwhelmingly, families tell us that their need to find out what happened to their loved one is at odds with the approach of state representatives. Some families feel it is them and/or their loved one who are on trial.
8. While some families are satisfied with the outcome of their inquests and describe good practice, many are not and feel failed by the inquest itself, particularly the lack of accountability and learning. We are keen for the Justice Committee to grasp these issues, which the terms of reference do not capture, as the failure to do so will fail families and undermine the potential of inquests to prevent future deaths. They are inextricably linked to the issues around inequality of arms and funding set out later in this submission.

'Yes we got some answers...but no accountability.' Derek Blackman

'You never get the answer you want which is 'what really happened'. You don't see anyone punished for lax behaviour or poor management.' Anon

'We got answers due to the access to the paper work and the PPO report. We did not get the outcome we felt we needed from the inquest.' Donna Mooney

'Deaths by suicide inevitably leave the bereaved with the question of 'why?' Often there is no straight forward answer and as a parent I continue to wrestle with this.' Lee Fryatt

'I did not expect the inquest to fully answer the question of why, but I did expect it to ask whether in the 'how and when' if there were opportunities to intervene or do something differently that might have prevented Daniel's death on that particular day. This was not my experience. Instead I still have many unanswered questions about the actions taken by individuals and organisations during Daniel's life and am now unlikely to have a platform in which to ever ask them.' Lee Fryatt

'There is a lot more to do to understand and improve the way that the NHS and other services care for those with autism and/or personality disorders and to try and prevent them from taking their own lives. We felt that events in the months before Lindsay's death were relevant to her suicide.' Rob Edwards

'I was bitterly disappointed with the final outcome, I feel there were clear failures by the ambulance and police services, they really escaped any responsibility or liability as national guidelines were not in place. Question? why!!! Had there not been enough previous failures, misery and heartache inflicted on families. Guidelines had previously been issued to the above to prevent these types of failures occurring again, and they had been ignored, not implemented or adopted and still haven't 3.5 years on. Shame on all!!! The jury were unable to have an active part in the proceedings, due to a previous ruling and the coroner had to follow this even though I don't think she believed that was right, hence her very comprehensive list of failures in her section 28 report. We as a family and the jury were flabbergasted at this, we had all spent six weeks listening to all the evidence. Things will never

improve in this country for the good of all with rulings like this. Failure is a failure and action should be taken, those responsible should be brought to account.' John Oak

'Eventually yes we did but only after over two and three quarter years of fighting and heartache. Bereaved families should not have to go through what we went through.' Andrew McCulloch

'No - it was a totally negative and destructive experience for us which has triggered a severe deterioration in our mental and physical health since the inquest making it difficult for us to function. We felt the way we were treated was tantamount to institutional abuse.' Fiona Laskaris

'As far as I could to see no stones were left unturned [by the inquest].' Errol Clarke

'It is mind-boggling to be dropped in this process. It feels like R is on trial.' Dawn Boyle

'We were able to ask questions and felt the coroner did an excellent job.' Eileen Hunter

'The moment when I felt most involved was at the opening of the inquest, when [the assistant coroner] enquired whether the family wished to give evidence as to who the deceased was as an individual.' Deborah Lockett

The extent of unevenness of coroner services

9. Families' experiences of inquests are varied. Some report excellent interactions with coroners and their staff, smooth arrangements, and are happy with the process and outcome. However, for some the experience is traumatic.
10. Where coroners, their staff and the location work with and for families it helps establish an environment that helped put families at ease and created an empathetic relationship.

'We were nervous and emotional on the day, but the coroner's staff were considerate. We were pleased with the attitude and approach of the coroner, and also found it helpful, if painful, to learn more from the witnesses involved about what had happened.' Rob Edwards

'I had a really positive experience of venue, facilities and communication. I hadn't been to a PIR before and found that daunting but the venue was really nice and the staff were caring and helpful.' Anon

'[The coroner was] professional, calm and compassionate. I felt that by the end she could see exactly what had happened to our family and was truly sympathetic.' Anon

11. However, based on the feedback from the cohort of families, there is no doubting the 'unevenness' of the service which, they assert, acts detrimentally on the experience;

'I visited another coroner's court to see how everything worked and what to expect. I could not believe the difference in approach. The coroner there was a delightful man

who couldn't have been more helpful. I sensed he really cared and tried to help me. There needs to be a national standard of service and a way to complain effectively about an individual coroner. To a family, demeanour means everything.' Anon

12. Various families described the experience as 'distressing', 'unprofessional', lacking compassion' or 'kindness'.

'It was pretty awful. Everybody else had a solicitor and I also had mine. It felt really legal, nothing personal, I had to sit in silence and found the whole thing really upsetting and it took away from what really happened. The Coroners Support Service volunteer was really unprofessional, kept getting things wrong, giggling and talking to us constantly when we wanted to be left alone. His behaviour was inappropriate. This added to our upset.' Michael Thomas Inglis

'The Coroner's Officer insisted that we found a solicitor. However, he said this in an unprofessional way. He said that if it was his daughter he would like to reach across, and punch people and I should not do that and should get a solicitor. This made me really upset. It was not professional at all. The coroner wants to deal with the solicitors and not families and I feel less involved now that I do have a solicitor. It is a huge process. You want it to be about your daughter and it does not feel like it is.' Lynsey Scott

'The treatment of us as a family was distressing beyond words. I've never before experienced such rude and dismissive behaviour from anyone, let alone the holder of a judicial office. It was truly shocking and quite disgraceful. We were shown little respect or consideration throughout the process and felt bullied and belittled by the coroner. There were no vulnerable witness provisions which led to one of the witnesses making a suicide attempt the night before the inquest. There was no support offered to us and our legal team were so concerned by our treatment that they wrote a formal letter of complaint to the Chief Coroner. The staff showed no genuine compassion or kindness, but produced emotionless and unconvincing pre-rehearsed statements expressing sadness for our loss. All in all, a horrific and deeply traumatising experience, which achieved nothing other than adding to our distress.' Anon

'As a family we felt it was one-sided as we had to fund our own legal costs, accommodation and food when all witnesses legal team had expenses paid for. Very unfair. The positives were everyone one was respectful to the family and the help from the volunteers was much appreciated.' Rachel Hammerton

13. To compound matters several contributors commented on the poor communication between the coroners' offices and families, often marked by last minute disclosure. Their responses highlight how important it is to them to have as much time as possible to consider documents and written communication; to prepare for the inquest itself, to plan travel and transport, and how a failure to acknowledge this lacks courtesy and professionalism.

'Initial communication with the office was appalling/almost non-existent however once we got a solicitor it changed and he always got a response to his letters. The court itself was in a village – that was ok for us, but difficult for anyone travelling by public transport.' Anon

'Communication was stressful, often erroneous and very tardy. Evidence arrived literally as we were about to undertake the long drive to court.' Anon

The coroner's role in the prevention of future deaths

14. The strength of the coroner's role in preventing avoidable future deaths was of serious significance to the families who responded. For those who had an experience of the inquest where the coroner was thorough, and took time to examine the evidence, their positive experience of the process ended when it came to post inquest follow-up. Many of the families that responded spoke of Prevention of Future Death (PFD) reports. Some were pleased that the coroner had issued them and felt that this went some way to feeling like the inquest was worth the effort. However, the lack of scrutiny, accountability and involvement the coroner has with follow-up of said PFDs left those with positive experiences of the inquest, and its findings, disillusioned with its ability to influence change.

Scope

15. Many felt that the scope of the inquest was too limited to be able to grasp all relevant issues, with a need also to hold institutions to a higher standard, and that this limited their ability to prevent future deaths. In some instances, families thought this was because the coroner lacked the depth of knowledge in a particular area.
16. Families expressed a desire to broaden the scope of the inquest process suggesting consideration should be given to the lead up to the death of their loved one and the context in which they were living to be explored alongside the immediate cause of death. Going further families also felt that coroners were weighted in favour of the state institutions in which deaths occurred and allowed them to limit the scope/remit.

'For the coroner to have allowed more information regarding my brothers case to be allowed to be explored in the inquest - To have had more relevant witnesses give oral evidence - For the family to be more involved and be able to submit when they felt that IP's had over stepped the mark with 'suggestions' - The coroner to have an awareness of the IPP sentence - Not having to wait so long for it to have taken place - Not have to had to apply for legal aid - Automatic access to all documents relating to my brother.' Donna Mooney

'I believe that all deaths by suicide present an opportunity to learn lessons and so prevent future deaths. In Daniel's case the opportunities were missed. I was left feeling that the coroners attitude was that suicides are not preventable and that Daniel was just another sad statistic.' Lee Fryatt

'The restrictions on scope prevented proper scrutiny of the university with the result that there was a lot of emphasis on Avon and Wilshire Mental Health Trust for failing to save her when she became suicidal, however there was minimal consideration of the factors that caused our daughter's distress in the first place.' Anon

'There is a lot more to do to understand and improve the way that the NHS and other services care for those with autism and/or personality disorders and to try and prevent them from taking their own lives. We felt that events in the months before L's death were relevant to her suicide.' Rob Edwards

'From the documentation, we gained a deeper understanding of what led to my brother's death Cons: Families feel like bystanders rather than participants. It felt like my brother was vilified, in the name of the other IP's 'protecting' themselves rather than just finding out the truth. The coroner limiting the evidence to only include the few days before my brother's death, rather than other aspects that clearly impacted his death.' Donna Mooney

Prevention of Future Death Reports

17. There is scepticism about the potential impact of PFDs to really bring about change and reduce future deaths.

'The problem is the dissemination of those outcomes. Does the Chief Coroner really have the impact he could have if Regulation 28 PFD notices carried more wait and obligation?' James Murray

'PFDs seem nothing more than a paper exercise at present. Organisations are under no duty to implement any changes following a preventable death and there is no scrutiny or audit to ensure any promised changes ever materialise. [The coroner] did write a PFD document, but as usual, this bears no weight, and there are no checks that things have changed in police behaviour towards people having a mental health crisis in a dynamic situation, or in support from an NHS trust for families trying to cope with a person in the midst of a mental health crisis. PFDs are not worth the paper they're written on, because they are ignored.' Lee Fryatt

18. Some felt that the coroners' PFDs alone were unable to ensure lessons are learnt and recommendations are taken up following an inquest. Some suggested more rigour was required in the form of Parliamentary oversight and scrutiny.

'Maybe all PFD reports could be sent to a select committee to make recommendations to the government where law changes could be made. Too easy for PFDs to be ignored to just the bare minimum done without addressing the real problems within the organisations.' Anna Susianta

19. Several submissions supported INQUEST's call for a national oversight mechanism.²

'If we are to truly learn then there needs to be some form of scrutiny, audit and inspection of PFD reports. Coroners have an immense opportunity to identify trends and themes that might prevent future deaths, especially suicides that occur in the UK but there is no central oversight, evaluation or analysis of emerging themes. There needs to be some form of national oversight of coroners reports to address this shortfall and to ensure consistency, provide transparency and promote trust and confidence in the service.' Lee Fryatt

² See INQUEST, *Submission to the Justice Select Committee Inquiry into the Coroner Service*, paragraph 35

How the Coroner's Service has dealt with COVID-19

20. Most of our respondents were not affected by COVID-19 as their inquests have concluded. For those that have ongoing proceedings there was a notable lack of clarity, communication or consistency across the current service. Considering many respondents expressed delays in proceedings as being traumatic and a barrier to the grieving process, there should be real concerns regarding the well-being of families who have proceedings prolonged as result of COVID-19.

21. New ways of working through the pandemic have exacerbated delays in a system that too often fails to deliver timely investigations and inquests as documented by families at the end of this section. The additional strain of remote communications and uncertainty around inquest dates was also damaging for families.

22. In one example, the family had objected to rescheduling the inquest:

'I did however manage to write setting out my objections and was told on the 3rd April 2020 that my letter was passed to the coroner and that they would be in touch with a decision in due course. I was then contacted on 21 June 2020 to let me know that the inquest was now scheduled for the 9 July (the first anniversary of C's death) and that this would occur using Microsoft Teams. I found this to be insensitive and that it did not address my concerns set out in my letter objecting to the inquest proceeding on a documentary basis and again it left me little time to prepare during the COVID-19 restrictions.' Anon

'Due to COVID-19, we never actually went to the venue. Communication was awful. This was my 16-year-old child, and we just got a very curt letter advising us of the date of the inquest (which we'd already found out from the public domain) No support was offered at all.' Sara Emery

'The inquest was to have taken place on 20 July 2020 but was postponed due to the pandemic... It took five emails to get an answer from the court at the very last minute to the effect that the inquest would not be going ahead.' Maggie Brookes

23. Those families who were negatively impacted by the pandemic felt this placed them at a disadvantage when engaging with a complex and alien process, compounded by poor communication from the coroner's office.

'I feel that the COVID-19 restrictions that led to the inquest hearings, so far, being conducted over Microsoft Teams negatively impacted my experience of the inquest. I was not able to confer face to face with my solicitor, I was unfamiliar with the format and this was not explained to me by the coroner's office and hence I felt dislocated from the proceedings.' Fergus Daly

24. COVID-19 played no part in the inquests for most respondents but observations about delays and the ensuing distress, frustration and strain this causes were commonplace.

'The grief and heartache caused by delays in the system, this urgently needs addressing.' Ann Edgeller

'It was hard, and sometimes difficult to navigate at first, often because of the lack of responses from the coroner's office and the long delays. The INQUEST group were a great help.' Rob Edwards

'Our first dealings with the coroner's office were horrendous. We were calling 2-3 times a day to find out what we had to do, and no-one got back to us. We eventually gave up after 5 days and went to their office where we were told they were sorry but did not have enough staff. The last thing a grieving parent wants to hear even if it is true. We had no idea how long we would have to wait for the autopsy and toxicology results and again there were long delays. It took over a year to hold the inquest, whilst we understand there are legal requirements to then read very much later some of the details of my son's death and the circumstances surrounding it was like losing him all over again.' Shirley Beard

Training and guidance for coroners

25. Many families identified the need for training aimed at coroners and their officers on matters of communication, sensitivity and respect for people coping with traumatic loss and bereavement. Specific concerns about misspelling of names, key inquest processes scheduled on the anniversary of a loved one's death, and lack of awareness of transgender issues, could all be tackled through better training that ensures coroners and their officers understand the implications for families in making mistakes.

'When the Coroner's Officer sent me the fact of death certificate C's name was spelt incorrectly. When I rang to point this out I was told this was just a mistake but no apology was offered. When a replacement arrived it was accompanied by a letter addressed to another bereaved family which gave personal details about their case. When I rang the Coroner's Officer to complain I was again told it was a mistake but no apology was offered. When I stated that under the circumstances I didn't think this was good enough I was asked by the Coroner's Officer in a rhetorical manner 'well what do you want me to do about it?'' Anon

'I think all staff, including all coroners, should have relevant training on how to deal with and speak to bereaved, often shocked, and grieving families as compassion and sensitivity would go a long way to slightly easing our pain and would be appreciated rather than increasing the trauma because that is what I feel it has done. It could all have been so different with a little understanding especially since the coroner is a senior coroner and of course has come across many bereaved families - perhaps he is too nonchalant and desensitised.' Anon

'He clearly has no understanding of transgender issues, felt he didn't need the benefit of an expert, as we suggested, then went on to make a very offensive mistake in calling my daughter's condition 'gender dysmorphia' rather than gender dysphoria. He has no understanding of the additional vulnerabilities the transgender community have which affects accurate mental health risk assessments.' Anon

'I think the Coroner's Officer seemed to have no appreciation of what a bereaved family might be going through during the inquest process. Rather than make any attempt at reassurance when I became concerned, he responded with arrogance, rudeness and insensitivity. If this is a common occurrence, I feel that the coroner's staff should be given further training in this regard.' Anon

'The staff were lovely and very sensitive to what we were experiencing, they tried their best to accommodate what we needed throughout. The coroner was very different. He was extremely cold, never gave any eye contact at any point and he seemed extremely uninterested throughout and at points was bordering on bullying the female IP's. We had to push hard to be able to have a pen portrait of my brother included and when I read it, the coroner was busy looking at some notes and not engaging at all, to the point when I had to call him and tell him I was finished as I had no idea if I should sit back down or not. He refused to include any aspect of my brother's sentence (IPP) that directly influenced his death, as highlighted by the PPO report and a number of psychological reports. He also refused to include other aspects of my brother's mental deterioration that happened less than a fortnight before my brother's death. He spoke very rudely to our barrister on a number of occasions and the female barristers for the prison. At the end of the inquest when the IP's were summing up, he appeared to be filling in a personal diary for the majority of the time, again showing very little interest in what was happening around him. It seemed to me that he had already made a decision about my brother's case and this showed in his behaviour.' Donna Mooney

26. Many of the families felt that one of the reasons there was insufficient scope, was that the coroner themselves lacked in-depth expertise in areas of specialist knowledge. Examples of this included knowledge on indefinite public protection sentences; autism; transgender lives and vulnerabilities and the impact on mental health.

'The coroner displayed an astonishing ignorance around the particular vulnerabilities of people with autism, dismissing a detailed witness statement from the National Autistic Society explaining all the relevant issues which should have been taken into account.' Fiona Laskaris

27. One family member listed how the process could have been more reasonably managed:

'For the coroner to have allowed more information regarding my brother's case to be allowed to be explored in the inquest - To have had more relevant witnesses give oral evidence - For the family to be more involved and be able to submit when they felt that IP's had over stepped the mark with 'suggestions' - The coroner to have an awareness of the IPP sentence.' Donna Mooney

'I think that regular ONS statistics on suicide by occupation and age would be helpful to coroners to see trends across the country. This could be helpful in terms of student suicide for example. I'm not clear whether coroners share knowledge or have a central repository for it but perhaps this is required.' Jacquie Shanahan

'I feel I was badly let down by the inquest process. In the first instance, I had reported the death of my daughter as suspicious. I feel that the coroner should have immediately notified the police of this which would have triggered a Home Office post-mortem. Instead, the coroner used a pathologist who conducted a sub-optimal post-mortem which failed to properly identify tissue samples taken. Furthermore, the pathologist correlated his findings with that of the hospital without first having had sight of the hospital records. It became evident during the inquest that this was a crucial point. Why was the hospital allowed to hold onto the medical records following the death? In our case, this allowed the medical team to spoliage the records.' Carole McMillan

'It is impossible for families to challenge systemic failings if they are denied Article 2 which is granted only if you can prove systemic failings prior to the inquest taking place and under reduced scope! It is a nonsensical approach!' Anon

Services for the bereaved

28. Where respondents were positive about the venue it seemed to make a real difference to their experience. For those who found the venue overwhelming, unsuitable and unfriendly it compounded their experiences of trauma and loss. Many had been distressed when essential facilities (such as the café or toilets) forced them to come into close contact with witnesses or interested parties in whose care their relative had died and who were challenging their version of events in the inquest.
29. Almost all families are going through the inquest process for first time and the system does not seem focussed on how this experience is for them. Some families flagged the efforts made by the coroner and/or staff to talk them through the process, others had the opposite experience. Many families flagged that their need for information and advice was not met by official provision, and that in many instances this was fulfilled by INQUEST.
30. Some respondents had experienced challenges in getting recordings of the inquest, and were frustrated with the way the narrative conclusions were communicated to them:
- 'It's clear that many relatives don't know they're entitled to the inquest recordings and don't find this out until it's too late to go to JR on the strength of them. Some courts are still offering expensive court-typed transcripts and not mentioning the discs.'* Anon
- 'When we did receive the narrative conclusion (some days after the close of inquest) it was a typed version photocopied (not even straight) onto a plain cheap piece of photocopy paper with no official heading. Totally disrespectful of our family's feelings.'* Ann Power
31. Families should have access to good, independent and accessible information regarding the process, what to expect and the scope of the inquest;
- 'I believe families should be entitled to have free advice and consultation initially giving complete information of options. Free legal representation against the state. I don't think that police officers giving evidence should be allowed to sit in on the court until they have completed their evidence as in our case it led to the Firearms Officer changing what he had put in his statement and he said it was because of what he had heard. I believe that if it has come to an inquest with a jury then the families' legal representation should be allowed to interrogate to get the correct outcome. I personally gave a brief account of my brother and then the police barrister started questioning me as if I was on trial, that should not be allowed, very distressing.'* Lyn Hickman
32. Others identified how daunting the whole inquest process is for families and would have welcomed more information, more explanation around legal jargon and the 'technical' aspects of the court:

'Basic training on how to navigate the system, what questions to ask and how to deal with state legal reps and other parties involved.' Alice Gambell

'There was a lot to learn, and email communication was not easy with the amount of evidence and legal papers to review.' Derek Blackham

33. Whilst seemingly a minor issue the geographical location, quality of venue and initial impression provided by staff play a significant part in how proceedings are perceived. When it was reported as being good, families really appreciated the space, privacy and consideration provided;

'The venue and facilities were good and the staff on the day were professional and kind, explaining about the format. We were sent disclosures in advance and invited to prepare our own questions.' Jaquie Shanahan

'The venue was really helpful and the staff extremely mindful and sensitive to us. This even extended as far as the cafe where we had lunch every day. They ensured that our group had a big table and were served promptly.' Anon

'We had a private conference room near the courtroom where we were able to meet with our Barrister, Anna, and the attending solicitor - Lauren attended for the inquest, and Tom for the Report to Prevent Future Deaths hearing. We met both before and after each day's hearing. This was ideal and worked very well.' Deborah Lockett

'We had been to the venue before for a PIR meeting and had been in contact with the people concerned prior to the inquest. This was helpful for the inquest.' Chris Burgess

34. However, the positive experiences were outweighed by reports of inadequate provision, inappropriate settings and unhelpful surroundings which were felt acutely by families facing an extremely upsetting and intimidating environment;

'Our requests to consider alternative venues have been ignored, facilities are inadequate and communication is extremely slow. In our second hearing the audio recording we'd requested in advance was not checked in advance and didn't work. This is indicative of the wider culture. We still don't know if our next hearing will be in person and if not what measures can be taken to ensure the process remains as open as it's supposed to be.' Anon

'The venue I attended is no longer suitable for what is a stressful, emotional and traumatic process for families. We attended Avon coroners court. It is an old building that is fairly remote and has no immediate facilities for families to attend either before or after a hearing. The waiting areas are impersonal and uncomfortable and there is a lack of adequate private consultation rooms to speak with counsel. The rooms echo and it was not possible to have a private conversation as these could be easily overheard.' Lee Fryatt

'Investment has been made by the MOJ to try and create a supportive and comfortable environment for vulnerable witnesses and victims in criminal courts and I see no reason why similar provision should not be available in all coroner court settings.' Lee Fryatt

'Venue was poor in that it was very hard to hear the evidence and witnesses. I'm in a wheelchair and toilet facilities are a good distance away.' Michael Thomas Inglis

'The facilities were not good. I had to take my ex-husband into an interview room to read the new evidence. We were both sobbing and everyone could hear us...communication was almost non-existent even though I'd rung the coroner's office numerous times. We still weren't made aware or given proper disclosure or asked which witnesses were to attend. Because we didn't get any statements etc. we didn't know who needed to be called.' Liz de Oliviera

'There were two toilets to service a packed St Pancras Coroner's Court every day. It was a nightmare having to queue up, often with one or more of the eight police officers that we felt were responsible for Jack's death. There was no access to the building at lunchtime. So we had to find a cafe in St Pancras station, at a time when I don't know how I was able to walk. It was difficult, seeing and trying to avoid the whole group of police officers also looking for a place to sit and eat. To be in such a busy place was overwhelming, but there was nowhere else to go. Every day of the inquest was like living through the horror of Jack's death again, again being totally powerless over what was going on around me. It was like torture. My friend, who attended the court for one day, is a criminal barrister. She was horrified by the lack of care of, and facilities for, our family, compared to victims in the criminal court.' Anna Susianta

'Facilities at court are poor, other than a coffee machine. As we don't live locally it was difficult to find any food as the court is out in the sticks. Also, whenever we arrived the place seemed devoid of anyone to greet us and phone calls were rarely answered.' Anon

Fairness in the Coroners Service

35. Families highlight the different interests of bereaved families and state lawyers through the inquest process and a fundamental inequality of arms. Many point to a feeling of being outnumbered, and concerns about adversarial or confrontational attitudes borne out of institutional defensiveness. Underpinning these feelings is the sense that the state pays to legally defend itself against bereaved families who want answers as to the cause of death and how to prevent them in the future. Families overwhelmingly support legal aid for inquests.

'The inquest itself was at times confrontational with family on one side and police on the other (name tags would have helped).' Derek Blackham

'Change the process from being an adversarial process, led by groups of lawyers sitting in a row. Families cannot find truth to power in this situation.' Anna Susianta

'They were so hostile and yet by the end they were hugging me and crying. They saw me as a mother and not a monster. Their sheer unprofessional behaviour made me weep because these were the people in charge of my daughter.' Anon

'The coroner has too much discretion without accountability. We were at odds with the coroner and do not understand why she placed a much higher level of scrutiny on the health care trust than she did on the university.' Anon

'There is a complete inequality of arms. In our case, this was compounded by the refusal of the coroner to disclose the nursing statements he had obtained. Later on, these were inadvertently disclosed by the Trust, and it became clear that these too were inconsistent with each other and included false information about my late daughter's condition during the admission.' Carole McMillan

'We just had not expected such animosity and adversarial attitudes from the Trust. They were despicably badly behaved. The staff were poorly prepared and unconcerned about talking during the inquest. It all added up to the impression that our daughter's life and death mattered far less to them than possibly acknowledging that they had something to do with it.' Anon

'In hindsight I see that my presence and our lawyers' efforts to seek justice could never breach the wall of defence put up by the legions of lawyers for the state institutions involved. I now wonder whether the presence of myself and my son at the inquest was just window dressing, to make it look like it was an important and powerful process where the truth would be exposed. Actually, it was a complete farce. We didn't realise that the police would do everything they could to defend the indefensible.' Anna Susianta

36. Another recurring theme was a perception of bias by coroners towards state bodies such as the NHS Trusts, prisons and the police. Families felt their concerns, or evidence was not taken as seriously.

'Listen to families, treat their evidence with respect and do not readily dismiss it, provide families with all the evidence the public body provides them with to make it a level playing field. I have a strong suspicion that all the evidence we supplied to the coroner was forwarded to the Trust, thus helping them through the process.' Anon

'Two-year journey with the Ombudsman which can only be described as a delaying process, we managed to end that part of the journey with an independent expert report that stated unequivocal negligence. It was the one area the coroner failed to look at, she looked at the time frame before and after but seemed to block the negligent action out of the inquest entirely. It may be that the trust made sure the coroner was unaware of this part but we certainly made her aware of it which is why I believe our evidence was entirely dismissed.' Anon

'It made us feel pretty certain that a coroner is not going to investigate a healthcare professional in an inquisitorial way and will let them get away with neglect. I started off feeling very open minded and left totally traumatised and disappointed. It was like let pretend to listen to all the evidence but nothing is going to happen to anybody. The reason we went to the inquest was for the failures to be identified and to prevent more young people dying in this way.' Cynthia Jones

37. Respondents who had reasons to complain about their inquest or the conduct of the coroner reported being reluctant to raise a complaint in case it was held against them or they weren't taken seriously. The lack of an accessible process for bereaved families to make complaints was also highlighted.

'It felt at times because I was not a lawyer that when I raised concern I was just an upset family member.' Anon

'There should be more accountability regarding a Coroner's shortcomings. The complaints process is so ambiguous (maladministration vs judicial) in our opinion that we feel it is meant to be this way to discourage complaints.' Ann Power

'I was so stressed with the whole experience, and so worried that the coroner would then hold my complaint against me at the inquest that I did not submit a complaint.' Alice Gambell

'There should be an easily accessible process whereby bereaved families can make complaints about a coroner's behaviour. At the moment you can try the JCIO and Ombudsman but they are difficult to approach. We found them totally unhelpful. After that the only route was a Judicial Review. This is very expensive and daunting. Our lawyers backed us doing it otherwise we wouldn't have dared. It is currently very, very hard for a bereaved family to make a complaint against a coroner. Yet instances of coroners getting it wrong or behaving wrongly are frequent. The coronial service is very uneven. Something must be done to make it more accountable.' Andrew McCulloch

Legal aid for inquests

38. The families' call for legal aid for inquests is one of the most commonly expressed observations from contributors to this submission;

'The unfairness of the whole system is scandalous and funding for inquests should be automatic, especially when the families involved are on a very low income and have absolutely no hope of affording legal representation.' Anon

'Why did the coroner only began to take me seriously after I had found a solicitor? Money shouldn't buy justice or a mother's right to defend her child. Everyone should be listened to, helped, guided and supported.' Julie Palmer

'Change the system so that all families get automatic legal aid. The hospital had 7 of their legal team in attendance as well as an external barrister.' Michael Thomas Inglis

'We haven't had the inquest yet, but I don't have much faith that we will get the answers or outcome we would like because we don't have representation and everything is stacked against us. All the services involved have representation - how can that be fair?' Anon

'It is horrendous and unfair that the process cost us over £30,000. The Trust had a very expensive barrister paid for by our taxes. The thought that justice is not available to families is terrible.' Anon

'Exceptional Funding should have been available but the coroner would not give us time to apply for this. My sister had to ask questions of all the clinical staff and listen to answers which were not true, without herself having the requisite inquisitorial skills to explore these answers.' Janet Brooks

'Without legal aid, people like us would just bury our sons with no questions asked. Legal aid makes a massive difference. Legal aid gives us that voice. Without legal aid, we have to sit back and accept it. We would be even more devastated if we couldn't find any answers.' Dawn Boyle

'The lack of funding meant I had to cross examine the pathologist myself on my dead daughter's body - something no parent should ever have to do.' Liz de Oliveira

'I will say it again, and again, and again, until it is well known: the purpose of Legal Aid funding for inquests is to give the coroner the best possible opportunity to prevent future deaths, by hearing submissions from the family's barrister. There is no way that a family member can fill the professional role of a barrister. The family's barrister is there in court solely to assist the coroner to identify the legal issues in play in the inquest, all for the ultimate purpose of preventing future deaths. This simply cannot be achieved without Legal Aid. Does anyone now think Legal Aid for inquests is unimportant? Who is going to assist the coroner in his/her work if the family don't have a barrister?' Deborah Lockett

Recommendations

'It should not be left to parents to take on the heavy burden of getting the answers as to what really happened and what could have been done differently.' James Murray

As evidenced in this submission, families are calling for:

- I. Improved opportunities to participate in the inquest process. This could be enabled by;**
 - Clear, accessible and independent advice on the workings of the coroners' court, what to expect at an inquest, its scope and remit and their rights as a bereaved person
 - Timely disclosure of documents, statements and other key information
 - Compassion, kindness and empathy from venue staff, coroners' officers and coroners
 - Appropriate, accessible venues that allow for privacy when required, ample toilets and a place to eat

- II. Equality of arms, enabled by;**
 - Access to public funds for specialist legal representation
 - An end to the culture whereby families feel it is they who are under scrutiny
 - A requirement that witnesses attend proceedings

- III. An end to the 'uneven' or inconsistent approaches encountered by contributors. This could be enabled by;**
 - Training provision for all staff working with bereaved people, placing families at the centre of the process
 - Universal standards of professional conduct with a rigorous and accessible complaints procedure
 - Agreed communication standards including face to face, letters, e-mails and telephone calls, including an appropriate response time

- IV. Truth and justice**

- Recognition that those responsible for the care of their loved ones acknowledge failures, mistakes and bad practice and the impact of these on bereaved families
- A sense of fairness; too many families feel they were entering a process that was against them, biased or simply didn't care

V. Accountability and prevention of future deaths was important to the contributors to this submission. This could be enabled by;

- An end to institutional defensiveness
- A duty of candour on the part of state agencies responsible for keeping families' loved ones safe
- An end to the perception of coroners' bias
- Placing the prevention of future deaths as central to inquests where state agencies are involved
- Enforceable PFDs, including parliamentary scrutiny and institutions which fail to comply within a set time frame being held accountable

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3rd Floor 89-93 Fonthill Road • London • N4 3JH • Telephone: 020 7263 1111 • Fax: 020 7561 0799 • Website: inquest.org.uk

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