

INQUEST Lawyers' Group response to Ministry of Justice's Review of legal aid for inquests - call for evidence

September 2018

About INQUEST Lawyers' Group

The INQUEST Lawyers' Group (ILG) is a national group of more than 250 solicitors and barristers who act in the field of Inquest law predominantly for bereaved families.

The ILG provide specialist legal advice to many families going through the inquest process and are also involved in policy work surrounding issues which affect bereaved families, including amongst other issues coronial reform and legal aid. ILG support INQUEST's objectives in relation to:

- Access to justice for families
- Visibility with respect to all systems of care
- An end to all institutionalised forms of discrimination
- Accountability for institutional failings and the failure to act

The ILG's response to the MOJ's call for evidence includes examples from ILG members across the country. It is intended to provide a wide range of examples of the difficulties faced by practitioners representing families on a daily basis. The ILG have a vast amount of experience of the funding process from the initial attendance with clients, the application process and the consequences (both positive and negative) of decisions made in relation to the availability of funding to enable families to be legally represented.

In view of the vast experience of ILG members, we consider that our response to the MOJ call for evidence raises many concerns in relation to the current funding regime. We hope that our concerns and suggestions for reform are heard and action is taken to ensure access to justice for bereaved families.

Access to non-means tested funding for families

The ILG supports the proposal made by INQUEST and in a number of recent reports¹ that families should have access to automatic non-means tested legal aid funding following state-

¹ See for example Dame Elish Angiolini, Report of the independent review of deaths and serious incidents in police custody; Bishop James Jones, 'The patronising disposition of unaccountable power: a report to ensure the pain and suffering of the Hillsborough families is not repeated'; Report of the Chief Coroner to the Lord chancellor: Fourth Annual Report 2016-2017.

related deaths and those deaths that engage the wider public interest. In this context ‘state-related deaths’ refers to deaths that have occurred either during or following contact with state agencies, including those carrying out the functions of the state.

As a matter of fairness and basic human decency, such funding should be made available given that a family is seeking to ascertain the circumstances of their loved one’s death and the benefits that effective inquests can achieve in preventing future deaths. Such funding should not be dependent on whether or not other Interested Persons are represented.

Definition of Article 2

The MOJ call for evidence provides a definition of inquests where the investigative Article 2 obligation is engaged, as follows:

Where Article 2 of the ECHR may have been breached, the state has a duty to investigate to determine whether it failed in its duty to protect that person’s life. The coroner’s inquest meets this responsibility by investigating all deaths that occur in state detention or where a state agency, such as a health or social service is adjudged to have held a duty of care to the person who died.²

Further, examples of inquests where Article 2 may be engaged are listed in the MOJ’s call for evidence.³

The ILG are concerned with the definition provided and wish to raise the following issues. The Article 2 obligations that may give rise to an obligation to investigate under the Article 2 investigative obligation are:

- (1) The obligation on the State to prevent and guard against the creation of risks to the lives of its citizens⁴;
- (2) The systems obligation, which requires the State to put in place systems, precautions and procedures which will protect life⁵;
- (3) The operational obligation to protect those whose lives that are at real and immediate risk from a threat that is known (or should be known) to the authorities⁶;
- (4) The obligation on the State to protect people from risks arising from dangerous or hazardous activities, particularly where the activity is regulated by the State⁷; and

² Paragraph 7, p6, Review of legal aid for inquests - call for evidence

³ Paragraph 24, p8, Review of legal aid for inquests - call for evidence

⁴ *Mastromatteo v Italy* (Application No. 37703/97), at [69], [74]; *Sarjantson v Chief Constable of Humberside* [2014] QB 411, at [22]; *Cevrioğlu v Turkey* (App. No. 69546/12)

⁵ *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, at [30]; *R (Middleton) v HM Coroner for the Western District of Somerset* [2004] 2 AC 182, at [2]; *Öneryıldız v Turkey* (2005) 41 EHRR 20, at [73], [89]-[95]; *Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681, at [30], [45], [50], [97]; *Smith v Ministry of Defence* [2014] AC 52, at [68]; *Cevrioğlu v Turkey* (App. No. 9546/12)

⁶ *Osman v United Kingdom* (200) EHRR 245

(5) The obligation on the State to investigate where a death occurs in suspicious circumstances⁸.

There are certain deaths in which the investigative obligation will be automatically triggered. Such cases include any death as a result of force used by the police and violent or non-natural deaths of those detained by the police, in prison or under the Mental Health Act 1983. In other cases, it is important to emphasise that the trigger for the investigative obligation is only where there is an 'arguable breach' of one of the Article 2 obligations. 'Arguable' is anything more than 'fanciful' and is a low threshold.⁹ The threshold can also be reached when there is an issue that requires investigation or where further inquiries may reveal an arguable failure.¹⁰ Further, the Supreme Court in *Rabone* identified factors for consideration as to whether the Article 2 'operational duty' applies in the context of persons who are not detained by the state.¹¹

However, not *all* deaths which occur in state detention or which involve a state agency, or those carrying out the functions of the state, are carried out by the Coroner as an 'Article 2' Inquest. In fact many families, particularly in the latter category, will be required to make lengthy and detailed legal arguments to the Coroner on the engagement of Article 2. Quite frequently, the Legal Aid Agency will refuse a Legal Help waiver or an Exceptional Case Funding application until there has been a positive ruling on the engagement of Article 2 by the Coroner. Even when Article 2 has been found to be engaged by the Coroner, funding will not necessarily be granted to the family if the Legal Aid Agency is not satisfied that the 'operational duty' has been breached. The appeal process available to bereaved families who are refused the Legal Help waiver is unclear.

Wider Public Interest

ILG would like to note that the fresh Inquest into the death at Hillsborough Football Stadium in April 1989 was an Article 2 Inquest and although it is our view that the wider public interest element was also relevant in that case, the funding for the Inquest was provided for by the Home Office under a separate funding scheme.

⁷ *Öneryildiz v Turkey* (2005) 41 EHRR 20; *Kolyadenko v Russia* (2013) 56 EHRR 2; *Vilnes v Norway* (App. No. 52806/09); *Gorovenky and Bugara v Ukraine* (App. Nos.36146/05 and 42418/05); *Kayak v Turkey* (App. No.60444/08); *Rajkowska v Poland* (App. No. 37393/02); *Brincat v Malta* (App. No. 60908/11)

⁸ *R (Litvinenko) v Secretary of State for the Home Department* [2014] EWHC 194 (Admin), at [52]-[54]; *Angelova and Iliev v Bulgaria* (2008) 47 EHRR 7, at [92]-[97]; *Menson v UK* (2003) 37 EHRR CD 220

⁹ *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453 (Admin) para 59

¹⁰ *R (Moss) v HM Coroner for the North and South Districts of Durham and Darlington* [2008] EWHC 2940

¹¹ *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72

Question 1: Do we need to make changes to the existing financial means assessment process to make it easier for applicants to complete?

It is ILG's position that families should receive automatic non-means tested funding in state-related deaths and those deaths in which the wider public interest is engaged. If such funding were made available, it would not be necessary for families to be subjected to the distressing and onerous financial assessment process currently required by the Legal Aid Agency (the LAA).

Inquests are legal proceedings that families have not chosen to be involved in – they will occur in any event and are often the only means by which a family can effectively participate in an investigation into the circumstances of their loved one's death. The nature of inquests is such that, as a matter of principle, a family should not be required to pay for legal representation. They are analogous to other types of cases in which non-means tested legal aid is currently available such as for legal reviews of those detained under the Mental Health Act, those subject to Deprivation of Liberty Safeguards and for individuals involved in care proceedings initiated by a local authority. It is therefore unclear why there is a reluctance to provide non-means tested funding to bereaved families in circumstances where inquests are aimed at understanding whether there has been any state culpability in a death and in ensuring that future deaths are prevented.

There are two stages of legal aid funding for inquest: the first is Legal Help which funds solicitors' work involved in preparing for the inquest and the second is Exceptional Case Funding, which covers the costs associated with representation at any hearings, including counsel's fees. Therefore, any family seeking to obtain legal aid to be represented at an inquest is required to go through two funding applications.

The Ministry of Justice's introduction to this question sets out various types of evidence that an applicant for legal aid *may* be required to provide. This is incorrect; the current legal aid rules *require* applicants to provide such evidence. What this means in reality is that at the first meeting with a family, it is necessary to spend a lengthy period with them discussing how their case will be funded but moreover, going through an extremely invasive application process in which they are required to provide details of every single aspect of their finances, including their outgoings. This is in stark contrast to state bodies and their employees who are automatically granted legal assistance at inquests and who are never required to disclose information about their personal finances.

The application process is lengthy and invasive. Following recent changes, applications for Exceptional Case Funding now need to be made online in the client's presence, unless specific and limited circumstances apply. If a person's financial circumstances are relatively straightforward, they are required to complete the equivalent of an 18 page form with approximately 50 questions regarding every aspect of their financial circumstances. These forms are

complicated and the questions raised are unclear. In addition, they are required to provide evidence in response to the majority of these questions including payslips, bank statements, maintenance agreements, details of living costs etc. If a client is self-employed, lives abroad, is a partner in a business or has a shareholding, then further questions need to be answered and evidence supplied. This information and evidence is being asked of families at a time when they are grieving and not only are they having to attend to matters such as funeral arrangements but they are also often dealing with investigations related to the inquest such as police, IOPC, PPO and NHS trust investigations. To require them to then seek out detailed evidence of their financial circumstances can be incredibly distressing. This distress is exacerbated by the fact that they are aware that other Interested Persons will automatically receive legal assistance.

There remains an ongoing issue with regard to delays in decision making by the LAA with some ILG members waiting several months before a decision is made by the LAA. This is of particular concern in cases where a financial waiver is sought (as addressed below) but also exists in cases in which a client is financially eligible for legal aid but a determination is needed from the LAA for Exceptional Case Funding to be granted. Whilst the LAA has the discretion to backdate such grants of funding, if a decision is not made prior to a hearing taking place, families are either left without legal representation or lawyers are required to work at risk of not being funded. This can be very stressful for families, and removing means testing would undoubtedly reduce delays and importantly this impact on recently bereaved families.

At paragraph 32 of the MOJ's call for evidence, it is stated that some applicants may be required to pay a contribution to the costs of funding their representation and that this will depend on their income. This is inaccurate. The requirement to pay a contribution is determined in accordance with both income and capital. There has been a recent deterioration in the LAA's decision making in this regard with some families being required to make contributions of 50% of their legal costs or several thousands of pounds. In circumstances where state agencies and their employees are funded by taxpayers' money in order to be represented at the inquest, it is wholly unfair that families who are seeking to understand the circumstances of their loved one's death are required to pay such contributions. Further there is a complete lack of transparency in relation to how contribution decisions are made, with applicants with similar means being offered public funding on different terms.

The ILG is aware that a recent update to guidance means that the LAA will now generally only assess the applicant's means, rather than the wider family's circumstances. This is a recent introduction and it is too soon to say whether this approach is now being applied as a matter of course by the LAA. In any event, one family member at least is still required to go through the financial assessment process and so the concerns set out above remain.

The ILG can provide the following examples:

- Case study 1 - The partner of DS sought Exceptional Case Funding in order to be represented at the inquest into the self-inflicted death of her partner in prison. DS's partner worked part-time in a phone shop. As a result of his death, she had become a single parent and therefore, numerous changes had occurred to her benefits. She was in debt and had a very low income so was clearly eligible for legal aid. However, 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, her bank and her employer. She had to address queries such as a £50 discrepancy in her housing benefit which had occurred due to changes in her benefits as a result of the death. She was required to do this in the months immediately following the death. Over 18 hours of work was undertaken seeking to obtain legal aid for DS's partner.
- Case study 2 - The relatives of a vulnerable adult who died as a result of neglect were required to provide evidence running to well over 350 pages in support of their application for ECF and legal help waiver. They were a working couple, very near retirement, of modest means and clearly unable to afford legal representation for a 4 day Inquest. The LAA raised multiple queries in relation to entries on the bank statements, and demanded further documentation before finally granting the waiver.
- Case study 3 - In the context of an inquest into the death of a young woman who took her own life in psychiatric detention, in the connection with which Article 2 is plainly engaged, the Legal Aid Agency have asked the deceased's parents for a significant contribution to the Exceptional Funding costs of the inquest, apparently as a result of an administrative oversight by the Legal Aid Agency. The deceased's father is a wheelchair user with significant physical care needs and his partner (the deceased's mother) is his sole carer. Neither will work again and their relatively limited savings are required for his care needs.
- Case study 4 – The niece and next of kin of a man who died in prison wished to be involved in and legally represented at his inquest. There were no other family members who were interested in taking part at the inquest. Her husband however refused to provide any information about his income and did not wish to be involved in the process. It was not possible as a result to progress her application for funding and she was unable to pay privately and therefore proceeded unrepresented.

**Question 2: Do we need to make any changes to the current legal help process
Where a waiver is being sought? If so, please provide suggested changes.**

As set out above, it is ILG's position that families should receive automatic non-means tested funding in state-related deaths and those deaths in which the wider public interest is engaged. If such funding were available, it would not be necessary for families to seek a Legal Help waiver.

As confirmed in the call for evidence, since April 2017, the LAA has stated that Legal Help waiver grants cannot be backdated. Waivers are required where applicants would not otherwise be financially eligible for Legal Help. This was a material change in approach on which stakeholders were not consulted. The impact of this change has been significant. Practically, what this means is that a substantial amount of work is required before any form of legal aid funding is in place and therefore, before any substantive steps can be taken on behalf of the family. At present, this work either has to be funded privately by the family or conducted for free by lawyers. Such work includes meeting with the family, reviewing relevant disclosure in order to make an application for funding, liaising with relevant parties including the Coroner in the event that insufficient disclosure has been provided and preparing the detailed application for funding. In cases which are not straightforward this also includes making substantial representations in respect of the applicability of Article 2.

Unfortunately, there is currently no formal process for such applications to be expedited. Whilst the LAA has sought to introduce a process whereby an application for a Legal Help waiver is emailed to the LAA, there continue to be delays in such applications being considered, delaying when substantive work can be undertaken. There is also a further issue in that there has been a recent deterioration in the quality of decision making by the LAA's inquest team such that initial applications for Legal Help waivers are being refused irrationally. It is then necessary for appeals to be submitted, which are usually successful, but this causes further delay and distress to the family and prevents work being undertaken during the period that an appeal is being considered.

The impact of the inability to backdate Legal Help waivers on families is considerable, particularly in cases where a family is seeking legal assistance shortly after a death: those first few weeks can be crucial in terms of preservation of evidence: in contentious cases, second post-mortems need to be obtained; documents including CCTV and medical records (some of which are routinely destroyed within 28 days) need to be obtained; and initial meetings with those undertaking investigations into a death need to take place. Until legal aid is granted, a family cannot be supported in these processes.

If the Legal Help waiver provisions are to remain, rather than making non-means tested funding available to families, then there should be a change in the relevant regulations to enable the grant of such waivers to be backdated to the day on which a legal aid provider first meets with a bereaved client.

It's important to also stress that the Legal Help waiver process has added significantly to the workload of the LAA. Previously lawyers would make applications for a waiver at the same

time as an application for ECF was made. Now however their work in such cases has increased putting more pressure on a team which is clearly struggling with the amount of applications they receive. This can not be cost effective.

One recent example was in the case of LD. LD's mother had a low income job from which she was signed off sick following, the self-inflicted death of her daughter whilst detained under the Mental Health Act. She was just over the legal aid eligibility limits and so it was necessary to apply for a Legal Help waiver. This took 3 months to grant. During that period, crucial CCTV was destroyed and LD's mother had to engage in a variety of internal investigations herself and without legal support, including by an NHS Trust and by the private provider where her daughter died. She has since been diagnosed with PTSD, which is in part attributed to the stress of having to engage in those investigations including receiving correspondence from those organisations and attending various meeting at which she was required to interact with individuals who she considered responsible for her daughter's death. This could have been avoided if legal aid was in place.

Question 3: Are you aware of any cases where it would have helped to have had a lawyer assisting the bereaved family at the point at which a coroner is making a decision to trigger Article 2?

There are numerous types of cases in which it would assist a family to be represented at the stage when a coroner is making an Article 2 decision. As set out in our introduction, there are some types of death in which the Article 2 investigative obligation is automatically triggered. In any other case, the coroner, following representations from Interested Persons will be required to assess the evidence available to decide whether Article 2 is triggered. Examples of such cases can include deaths of non-detained mental health patients, deaths following police contact, non-self inflicted deaths of individuals in prison; and deaths of victims of domestic violence in which the victim has previously sought assistance from agencies such as the police.

The call for evidence states that an Article 2 decision by the coroner is necessary to demonstrate that a "case meets the Article 2 part of the ECF case". This is incorrect. The LAA has made clear that whilst a coroner's decision is relevant, it is not determinative and instead, the LAA will come to its own decision as to whether Article 2 is engaged. As set out below, this is apparent as there have been cases in which the coroner has determined that Article 2 is engaged but the LAA has disagreed and refused funding, and vice versa.

If unrepresented, a bereaved family will be placed at a distinct disadvantage and will be excluded from this decision-making process. The coroner will be entirely reliant on submissions from other represented Interested Persons. It is often the case that at the first Pre-Inquest Review Hearing, state agencies and other service providers are legally represented, often funded by the public purse, and seek to argue that Article 2 is not

engaged. It is impossible for families to respond to such submissions in circumstances where they are not legally trained and have insufficient understanding of the inquest process, and are of course grieving. An incorrect or delayed decision on Article 2 at the beginning of a case can have a significant impact. It can increase the costs to the public pursue significantly, including in court time, as if funding is eventually made available to a family, then such decisions have to be revisited. This affects related decisions such as decisions on the scope of an inquest, disclosure and witnesses.

The ILG can provide the following examples:

- Case study 1 - Connor Sparrowhawk was an 18 year old who drowned in the bath on a NHS unit following an epileptic seizure. Connor had a learning disability and was prevented from leaving the unit. At the first Pre-Inquest Review Hearing, the Coroner wished to consider whether Article 2 was engaged. The NHS Trust, who were legally represented by both counsel and solicitor, sought to argue that Article 2 was not engaged. Following submissions by the family's representatives, the coroner decided that Article 2 was engaged. If the family had not been represented at that stage, then the coroner would have been wholly reliant on submissions by the NHS Trust seeking to limit the scope of the investigation.
- Case study 2 - Janet Muller was killed by a stranger after she absconded from a psychiatric hospital where she was detained under the Mental Health Act. Whilst an individual was found guilty of her manslaughter, the family sought to persuade the coroner that the inquest into her death should be resumed due to concerns about the conduct of the NHS trust. Lawyers for the NHS Trust objected to this and therefore, objected to an Article 2 inquest being held. Fortunately, the family were represented and able to make submissions as to why this was legally incorrect. The Coroner determined that an Article 2 inquest should take place. If the family had not been represented at that stage, then the coroner would have been wholly reliant on submissions by the NHS Trust seeking to prevent the inquest taking place.

Question 4: Are you aware of any cases where there have been difficulties in establishing whether Article 2 has been triggered? What sorts of cases are these?

Question 5: If yes to question 4, what impact have these difficulties had on the bereaved family's experience of the proceedings and the legal aid application?

In ILG's experience a good proportion of cases where there have been difficulties in establishing Article 2 has been triggered, follow legal submissions made by the legal teams for the state agencies or public service providers at the outset of an inquest investigation that

either Article 2 is not engaged or that it is too early for a Coroner to make a ruling to that effect. This then has a significant impact on the bereaved family's ability to apply for funding and take part in the initial investigation stages, obtaining and reviewing relevant disclosure, making submissions on the need for expert evidence and witness evidence.

The ILG can provide the following examples of where there have been difficulties in establishing Article 2 and the subsequent impact that this has had on the family;

- Case Study 1 - AC died, of a heart attack caused by a thickening of his arteries whilst in prison. He had experienced unexplained weight loss and had several medical appointments cancelled while in custody at HMP Rye Hill. His blood pressure and blood sugar levels were not being monitored. On the day he died, AC had to wait for 49 minutes for an ambulance to arrive. It was discovered that the ambulance crew made the decision to refuel and clean the ambulance prior to attending the incident, meaning they did not begin their journey toward the prison until 32 minutes after the initial call had been received. The LAA rejected the application for Exceptional Case Funding (ECF) on grounds that the death did not require an Article 2 inquest, stating that it was neither violent nor unnatural. The LAA also stated that there was no evidence of 'gross negligence or systemic failings'. The decision was appealed, highlighting concerns around poor care and treatment alongside an unjustifiable delay in emergency assistance. It was also argued that the inquest involved proper analysis of complex medical evidence, which the family alone could not assess. Following these submissions, the ECF application was eventually granted.

However, it is worth noting that supposed 'natural causes' deaths are often devoid of proper scrutiny due to the absence of legal aid at inquests, meaning concerns about poor healthcare are not properly addressed. ILG members have had a number of similar cases where we have had to appeal applications to obtain funding for "natural causes deaths" in custody.

- Case Study 2 – The deceased was found hanging in his room at a transitional supported housing unit funded by the local Council. He had a history of significant contact with mental health services from 2014 until his death in 2016. He had a history of previous detentions under the Mental Health Act and also multiple presentations at various A&E departments due to threats of self-harm and suicide. Four days before his death he presented at A&E having taken an overdose and was assessed as being a significant suicide risk. He was discharged back to the housing unit and staff remained concerned. His family also contacted staff in the days leading up to his death to convey their concerns about the risk he posed to himself. Funding was granted by the Legal aid Agency early on in the process as it had been accepted that Article 2 was arguably engaged. The Coroner then ruled that Article 2 was not engaged. The family attempted to Judicial Review the decision, however, one of the reasons it was refused is that it was an academic application as the Coroner had also ruled that he would consider all the

circumstances leading up to TMs death and would consider any potential systemic failings by the various state bodies involved and it would be before a Jury. Their funding certificate is now “show caused” pending appeal.

- Case Study 3 - An extremely vulnerable man with significant physical health problems, learning difficulties and very limited communication skills sustained an unexplained catastrophic injury, which caused his death, whilst deprived of his liberty pursuant to Schedule A1 Mental Capacity Act 2005 (deprivation of liberty safeguard; “DOLS”). In the inquest proceedings following his death, the Senior Coroner declined to rule on the engagement of Article 2 until over two and a half years after the date of death and over two years from the first pre-inquest review, despite four pre-inquest reviews being held in the intervening period. In that period, the deceased’s family suffered significant anxiety and distress as a result of the uncertainty as to whether the inquest would be conducted in accordance with Article 2 and the resultant funding implications.
- Case Study 4 - Road traffic death on a stretch of road caused by flooding when there has been heavy rain. The argument was with regards to systems failings by the LA and water authority in failing to maintain the roads, sewers and gullies when it was known that the area was prone to flooding. On the facts of the death there was also an issue that the flooding had been reported by drivers to the police as a danger/hazard on that night but no action was taken or followed up by the police. Ultimately the Coroner was persuaded that Article 2 was engaged and funding was secured from the LAA. However it was an extremely stressful and difficult period for the family who were dealing with the death of their son. They had to borrow money from family members to pay for counsel to attend at the PIRH to make the arguments for article 2 and this added extra strain at an already difficult time. They faced uncertainty about whether they would have any representation at the inquest hearing as they would not have been able to raise funds to pay counsel for the full inquest. But for the arguments to the Coroner and the wider investigation that then followed many of the issues raised are unlikely to have been investigated. At the conclusion of the inquest the Coroner issued a Reg 28 Report. Without LA funding and counsel for the family, the issues may easily have been missed and the matter treated as a one tragic death.
- Case Study 5 - Road traffic death where a police car has lost control and collided with another vehicle. The police officer and passenger of the other vehicle both died. The Coroner has determined that article 2 is not engaged and in these circumstances the family will not be able to secure ECF. The other IPs are Sheffield City Council, SYP and the family of the police officer. The other family have representation through the Police Federation.
- Case Study 6 - Road traffic death where police had attended an accident at the same scene less than 1 hour before. There was a very specific hazard of ice local to the area and had the police attending the earlier incident properly and examined the scene the

road would have been closed or a warning erected and the accident in which two people died may have been avoided. In summary driver A lost control on the ice and went to the opposite carriage way where there was a head on collision. Both drivers died at the scene. There were 3 PIRHs before the Coroner accepted that article 2 was engaged and at that stage it was possible to secure ECF for the inquest hearing. It was a 4 week inquest and the other IPs were TVP, Thames Water, Bucks CC, Ringway Jacobs and the family of the other deceased (represented by the insurers defending a potential civil claim). The family had BTE that initially agreed to fund inquest costs on the basis that they might reasonably be recovered as part of the costs of the claim. However, when they the BTE insurer was advised that there were risks with recoverability of such costs they declined to fund further representation. Even if they had agreed the indemnity within the policy was insufficient to cover the costs of a 4 week inquest. Due to uncertainties with the prospects of the civil claim, the volume of documents and the complexity of the issues with the various IPS meant the legal representatives were unable to secure counsel that would agree to undertake the inquest under a CFA. All the other IPs had representation and the family were at risk of not having funding in place. ECF was secured following the article 2 determination by the Coroner but it was a difficult and stressful time for the family when they felt very uncertain about whether they would have representation. Ultimately failures by the police attending the first accident were identified by the jury as contributing to the deaths. The Coroner issued a Reg 28 report. Without ECF the family would have been unrepresented in a long and complex inquest.

- Case study 7 – The death of a disabled child who died while under the care of a hospital trust. The hospital trust is a charity and having obtained advice from Counsel it was not possible to argue that the hospital trust is a public authority under the Human Rights Act. Therefore it was not possible to argue that Article 2 should be engaged due to arguable systems failures by the Trust. Consequently the mother who is vulnerable herself does not have access to Legal Aid and unlike all the other interested parties does not have access to representation at the inquest.
- Case study 8 – one ILG member had two cases where there has been difficulty establishing Article 2 has been triggered and the conduct of the Coroner, particularly in one of these cases, has made it extremely difficult for the family. The Coroner in one case went as far as insinuating that the family had left their son alone and this was a factor contributing to his death. The impact of this on the family has been that they have felt they have not been listened to and kept at the heart of the inquest, although in both inquests thankfully the scope was kept quite wide, the families have felt that the verdict has not reflected the evidence and this has led them both to pursue complaints after the inquest.
- Case Study 9 – One ILG member advised the bereaved family of a young man with complex needs who died while living in supported accommodation with 24 hours care

funded by the local CCG. Despite submissions to the Coroner that Article 2 was engaged, the Coroner did not agree and attempts to obtain ECF also failed. The bereaved family had serious concerns about the care and treatment their son had received, and were unable to afford the cost of private representation yet were faced with the prospect of only a very narrow Inquest due to the Coroner's ruling on Article 2. An ILG member advised there were reasonable grounds to challenge the Coroner's decision however they were unable to afford a judicial review/bear any financial risk of litigation. Having received the advice and the decision of the LAA, they instead disengaged from the process as they could not face the prospect of the inquest without representation, especially given the other 2 Interested Persons were legally represented. This is illustrative of the experience of many bereaved families whose vulnerable loved ones have died while receiving care and treatment in the community rather than in a formal hospital setting.

- Case Study 10 - The parents of Colette McCulloch also faced an uphill battle to secure an Article 2 ruling from the original Coroner (HM Acting Senior Coroner for Bedfordshire) presiding over their daughter's death. It took almost 9 months from the first PIR for the Coroner to make a decision on Article 2 and he ruled negatively. The family were devastated and crowdfunded to pay for a judicial review – the Coroner thankfully reversed his decision following pre action correspondence however he then refused to reconsider the scope of the Inquest (i.e. widen it to ensure the circumstances of Colette's death were investigated) and threatened to seek his legal costs from the bereaved parents if they pursued the judicial review. The family felt they were financially bullied by the Coroner and it was a very stressful period which caused unnecessary delay.

Question 6: Are you aware of any cases where an applicant has applied for and not been awarded legal aid for legal representation for a case where Article 2 has been triggered? Please provide details.

The ILG are aware of a number of cases in which the LAA has refused funding to a family despite the fact that the Article 2 investigative obligation has been triggered. This includes cases in which the Coroner, who has access to all of the relevant documentation, has determined that Article 2 is engaged. Unfortunately, there appears to have been a recent deterioration in the decision making by the LAA in this regard as ILG members' experience is that an increasing number of applications for Article 2 inquests are being refused.

Some examples of cases in which funding has not been made available include:

- Case Study 1 - 36-year-old DT died on 22 September 2015, whilst in supported accommodation ran by Mencap (commissioned by York Council). DT was diagnosed with autism, epilepsy, severe learning disabilities and had previously self-harmed. On the morning he died, DT was given medication and then left for half an hour with the room

door closed. His parents understood that he was supposed to be on 5-minute observations. He was subsequently found dead in his bed. While doctors believed he died from an epileptic fit, Daniel's parents had longstanding concerns about the quality of care he received whilst in the home.

Originally an inquest was not going to be opened and the family had to privately pay solicitors (at a reduced cost) to convince the coroner an inquest was necessary in bringing concerning practices to light. Following considerable legal submissions and representations, the coroner agreed to an inquest, however it then took another 5 months of legal work for it to be ruled as Article 2.

The family managed to obtain a legal help waiver but were then refused exceptional case funding. The decision came only weeks before the inquest hearing and family lawyers agreed to offer legal aid rates, which amounted to £7,500 instead of £30,000 (private fees). Among the other interested persons being legally represented were, Mencap, the City of York Council and the Care Quality Commission.

- Case study 2 – Dr Jeroen Ensink was killed in December 2015 after he was stabbed by a mentally ill stranger whilst posting cards announcing the birth of his daughter. Returning a narrative conclusion of unlawful killing, the jury highlighted failures and inadequacies by Metropolitan police officers, who had previously arrested the stranger for possession of a knife months earlier.

Dr Ensink's wife was granted an Article 2 inquest by the coroner but was refused funding by the LAA on the basis that the LAA did not agree with the coroner's decision that Article 2 was engaged. This decision was upheld on appeal. The coroner herself expressed concern about the rejection of funding stating: "I regard this as an extremely complex inquest ... It raises not simply the emotional backdrop, which is devastating for those concerned, but it raises complicated legal issues."

To enable their participation at the both the pre-inquest and inquest hearings, Dr Ensink's family had no option but to crowdfund up to £55,000 to cover legal fees which they themselves could not afford. This was in sharp contrast to the two other interested persons, the police and the Crown Prosecution Service which received automatic funding for legal representation. In the crowdfund appeal, Dr Ensink's wife described the family's need for answers and to ensure vital learning that prevents a similar tragedy from reoccurring.

- Case study 3 - 23-year-old CN took his life on the third day of custody in Liverpool prison, 6 October 2017. HMP Liverpool has been the source of recent controversy due to the high number of deaths there, of which many are linked to inadequate healthcare provisions.

CN had a history of self-harm and was subject to an ACCT, a self-harm and suicide preventative mechanism operating in prisons. Self-inflicted prison deaths are routinely subject to an Article 2 inquest, where there is a positive state obligation to protect detainees' lives.

Despite this, the LAA assessor rejected the family's application for funding. In his response, the LAA assessor stated that he did not see the 'seriousness of the allegations' which would merit a legal aid grant, and that 'from the limited information provided we [the LAA] are as yet unable to see that they are more than fanciful'. The decision was subsequently overturned following a request for a review by the family lawyer.

- Case study 4 - One ILG member had a recent example of where the LAA has refused funding on an inquest where the full application was made before the first pre-inquest review, and it was initially refused the day before the hearing. At the pre-inquest review it was determined by the Coroner that Article 2 was engaged. This was communicated to the LAA along with a considerable amount of additional disclosure and a review of the LAA decision to refuse funding was submitted. The funding refusal was upheld and clear reasons were not given but the LAA caseworker re-stated the conclusions in the police internal investigation report which are under dispute by the family. Furthermore, the law on Article 2 was completely misinterpreted and confused, and there was an attempt to assess whether the substantive Article 2 obligations had been breached, on the untested evidence, which is clearly not the role of the LAA when deciding whether to grant exceptional funding for an inquest. The legal representative had to send a pre-action letter following which the LAA conceded that funding should be granted but this gave our client significant additional stress and of course was a drain on time and additional public money in what is quite a clear-cut case.
- Case Study 5 – one ILG member was very recently initially denied ECF funding for a bereaved family in circumstances where the Coroner had ruled Article 2 was engaged. The inquest concerned the self-inflicted death of a man with a history of mental health illness, who had self-discharged from a general hospital shortly before his death. The two NHS Trusts involved were represented and internal investigations had already highlighted serious concerns with the treatment and care the deceased was provided with prior to his discharge. ECF was obtained on appeal however the initial refusal caused considerable distress to our bereaved client. The reason for the original refusal was on the basis that the LAA decided that Article 2 was not engaged, however this was reversed on appeal.
- Case Study 7 - The McCulloch family were also initially refused ECF on the basis that the LAA stated that Coroner had decided Article 2 was not engaged, despite making this decision after the Coroner had conceded the position & accepted Article 2 was engaged in judicial review pre-action correspondence.

- Case study 8 – BR died after he absconded from a psychiatric hospital whilst detained under the Mental Health Act and was subsequently killed during the course of a police pursuit. There were a number of serious failings in the care that the deceased received. At the first Pre-Inquest review Hearing, the Coroner determined that Article 2 was engaged. However, the LAA refused the initial application for funding on the basis that “the complexity of the allegations are not of the most serious nature”. This is a case in which at present, the Coroner has identified approximately 25 witnesses, there are numerous expert reports and documents to consider and there will be a 10 day jury inquest. Fortunately, this decision was overturned on appeal. However, the initial decision by the LAA caused the family a huge amount of distress.
- Case study 9 – family of LE were initially refused ECF funding despite the LAA appearing to agree that Article 2 was arguably engaged (the Coroner had ruled that it was). This was on the basis that the inquest was only listed for 1 day which highlighted that the case was not sufficiently complex. This case involved the need to cross examine numerous medical professionals. In addition, the family had been involved in finding LE hanging and resuscitation attempts while awaiting assistance from Paramedics. Upon appeal this decision was thankfully overturned however this took a significant amount of additional unnecessary work on the part of the family’s legal representatives and they attended the Inquest at risk awaiting a response to the appeal.

Question 7: In your experience, is Article 2 ever triggered in cases where the death has not occurred in state custody or state detention? If yes, please can you include details on these types of cases?

Article 2 can be triggered in cases where the death has not occurred in state detention and usually involves issues of wider state and corporate accountability. Cases the ILG have experience of include but are not limited to:

- a) Deaths of people with learning disabilities in care;
- b) Deaths of mental health patients receiving care or treatment in the community;
- c) Deaths following contact with the police (but not detained);
- d) Deaths following the attendance of emergency services including ambulance and police;
- e) Cases where there is an allegation that the deceased should, if properly treated, have been in state custody at the time of their death, for example, where the deceased has been recently assessed for detention under the MHA but not detained and/or the death occurs while waiting for an MHA assessment);
- f) Deaths occurring outside state custody/detention but where the deceased was in a form of supported accommodation or care home with 24 hour care;
- g) Deaths of those under the care of probation services;

- h) Deaths of individuals who have recently been released from prison;
- i) Homicides in which the perpetrator has been receiving mental health services;
- j) Homicides in which the perpetrator has recently been released from prison, police custody or is under the care of probation services;
- k) Deaths of service personnel;
- l) Deaths of individuals in foster care or receiving services from the local authority under the Children Act 1989.

These cases are far from straightforward and may involve questions relating to local authorities, private sector bodies and other agencies. Specialist case law knowledge is required to be able to successfully secure the triggering of Article 2.

Examples of cases that the ILG have dealt with that have not occurred in State detention are;

- Case study 1 - suicide in the community of a 17 year old girl within 24 hours of being in police detention. This was a complex inquest involving 10 IPs all of which were state bodies.
- Case Study 2 - drug related death of a young man following contact with the police and NHS services. The Coroner made numerous criticisms in her conclusion.
- Case Study 3 - suicide of a father following contact with the police during a Missing Persons Enquiry. Numerous failings were found in relation to procedures not being followed.
- Case Study 4 – ED died after being impaled by a tree that fell down in strong winds. The tree had for the 3 years prior to the death been reported as diseased and the council failed to do anything about it.
- Case Study 5 - GB died from self-inflicted gunshot injury after police had seized the keys for his gun cabinet due to expressing thoughts of suicide/self-harm and then handing them back over without further assessment or referral to the licensing dept. for firearms.
- Case Study 6- 36-year-old DT died on 22 September 2015, whilst in supported accommodation ran by Mencap (commissioned by York Council). DT was diagnosed with autism, epilepsy, severe learning disabilities and had previously self-harmed. On the morning he died, DT was given medication and then left for half an hour with the room door closed. His parents understood that he was supposed to be on 5-minute observations. He was subsequently found dead in his bed. While doctors believed he died from an epileptic fit, DT's parents had long-standing concerns about the quality of care he received whilst in the home.

Originally an inquest was not going to be opened and the family had to privately pay

solicitors (at a reduced cost) to convince the coroner an inquest was necessary in bringing concerning practices to light. Following considerable legal submissions and representations, the coroner agreed to an inquest, however it then took another 5 months of legal work for it to be ruled as Article 2.

The family managed to obtain a legal help waiver but were then refused exceptional case funding. The decision came only weeks before the inquest hearing and family lawyers agreed to offer legal aid rates, which amounted to £7,500 instead of £30,000 (private fees). Among the other interested persons being legally represented were, Mencap, the City of York Council and the Care Quality Commission.

- Case study 7 - 18-year-old Connor Sparrowhawk died at a Short-Term Assessment and Treatment Team Unit, run by Southern Health Trust, on 4 July 2013. Connor had autism, a learning disability and epilepsy. He drowned in the bath as a result of an epileptic seizure. In October 2015 an inquest jury concluded that Connor's death was contributed to by neglect. It was also found that six years earlier in the same unit, another man drowned in the same bath that Connor drowned in.

The Trust initially recorded the death as 'natural causes', and the Trust lawyers argued that Article 2 was not engaged. However, following legal submissions, the coroner confirmed that an Article 2 compliant inquest would take place. Numerous significant failings were identified at the inquest. This ranged from a lack of clinical leadership, poor safety and care standards, and inadequate staff training. At the inquest, Connor's family battled to get answers from various bodies and individuals involved in Connor's care. The family came up against seven interested persons, all of which were legally represented.

- Case study 8 - BS was 31-years-old when she died on 14 October 2011. She had been an informal in-patient receiving treatment at Centurion Psychiatric Hospital. The investigation into BS's death was carried out by the same Trust that was responsible for the hospital where she died. The report following the Trust's investigation was very poor, with limited information on the quality of care and clinical approach, and whether policies (including around risk assessment, observations and searches) were followed properly.

Following the *Rabone* case, BS's death should have been a clear example of where Article 2 would apply, yet the coroner concluded initially that an enhanced inquest was unnecessary. The family sought the help of INQUEST and instructed a specialist lawyer. Due to the absence of legal aid, the family had to pay £30,000 for legal fees.

Following lengthy legal arguments and the threat of judicial review proceedings, the coroner finally accepted that an Article 2 inquest was the correct course. Evidence emerged from medical records during the inquest process that, in the ten days before

her death, BS had self-harmed on several occasions and had described her level of self-harm as “overwhelming and uncontrollable”.

While the Trust’s investigation findings stated that all policies were correct and had been followed properly, the coroner prompted action in her Prevention of Future Death report, calling on the Trust to conduct a review of operations and policies applying to patient observations and searches.

- Case study 9- Inquest into the death of a man who died following police contact on the street, having been subjected to multiple and lengthy discharge of a Taser and restraint by officers.

- Case study 10 - Inquest into the death of a man who died following restraint by security personnel and thereafter police officers on a private roadway.

- Case Study 11 – one ILG member has been involved in a case where Article 2 is engaged where the deceased was found hanging in his home and police officers were likely to have been outside when he took steps to hang himself.

- Case study 12 - a case in which the deceased died two days after being released from psychiatric care into the community.

- Case Study 13 - Road traffic death on a stretch of road caused by flooding when there has been heavy rain. The argument was with regards to systems failings by the LA and water authority in failing to maintain the roads, sewers and gullies when it was known that the area was prone to flooding. On the facts of the death there was also an issue that the flooding had been reported by drivers to the police as a danger/hazard on that night but no action was taken or followed up by the police. Ultimately the Coroner was persuaded that Article 2 was engaged and funding was secured from the LAA. However it was an extremely stressful and difficult period for the family who were dealing with the death of their son. They had to borrow money from family members to pay for counsel to attend at the PIRH to make the arguments for article 2 and this added extra strain at an already difficult time. They faced uncertainty about whether they would have any representation at the inquest hearing as they would not have been able to raise funds to pay counsel for the full inquest. But for the arguments to the Coroner and the wider investigation that then followed many of the issues raised are unlikely to have been investigated. At the conclusion of the inquest the Coroner issued a Regulation 28 Report. Without LA funding and counsel for the family, the issues may easily have been missed and the matter treated as a one tragic death.

- Case study 14 - Road traffic death where a police car has lost control and collided with another vehicle. The police officer and passenger of the other vehicle both died. The Coroner has determined that article 2 is not engaged and in these circumstances the family will not be able to secure ECF. The other IPs are Sheffield City Council, SYP and the

family of the police officer. The other family have representation through the Police Federation. (On the facts the ILG member is representing the family under a CFA but it would be preferable for the family to have ECF.)

- Case study 15 - Road traffic death where police had attended an accident at the same scene less than 1 hour before. There was a very specific hazard of ice local to the area and had the police attending the earlier incident properly and examined the scene the road would have been closed or a warning erected and the accident in which two people died may have been avoided. In summary driver A lost control on the ice and went to the opposite carriage way where there was a head on collision. Both drivers died at the scene. There were 3 PIRHs before the Coroner accepted that article 2 was engaged and at that stage it was possible to secure ECF for the inquest hearing. It was a 4 week inquest and the other IPs were TVP, Thames Water, Bucks CC, Ringway Jacobs and the family of the other deceased (represented by the insurers defending a potential civil claim). The family had BTE that initially agreed to fund inquest costs on the basis that they might reasonably be recovered as part of the costs of the claim. However, when they the BTE insurer was advised that there were risks with recoverability of such costs they declined to fund further representation. Even if they had agreed the indemnity within the policy was insufficient to cover the costs of a 4 week inquest. Due to uncertainties with the prospects of the civil claim, the volume of documents and the complexity of the issues with the various IPS we were unable to secure counsel that would agree to undertake the inquest under a CFA. All the other IPs had representation and the family were at risk of not having funding in place. ECF was secured following the article 2 determination by the Coroner but it was a difficult and stressful time for the family when they felt very uncertain about whether they would have representation. Ultimately failures by the police attending the first accident were identified by the jury as contributing to the deaths. The Coroner issued a Regulation 28 report. Without ECF the family would have been unrepresented in a long and complex inquest.
- Case study 16 - Inquest into the death of a man who died following police contact on the street, having been subjected to multiple and lengthy discharge of a Taser and restraint by officers.
- Case study 17 - Inquest into the death of a man who died following restraint by security personnel and thereafter police officers on a private roadway.
- Case study 18 - Inquest into the death of an extremely vulnerable man from an unexplained catastrophic injury whilst deprived of his liberty pursuant to Schedule A1 Mental Capacity Act 2005 (deprivation of liberty safeguard; "DOLS") [NB: pursuant to section 178 of the Policing and Crime Act 2017, deaths of individuals subject to DOLS on or after 3 April 2017 are no longer considered as having been 'in state detention' for the purposes of the Coroners and Justice Act 2009].

- Case study 19 – the deaths of a number of individuals at Camber Sands beach in 2016. The local authority has responsibility for the breach and the coroner determined that Article 2 was engaged.

Question 8: Where applications for legal help and / or legal representations are refused, does the LAA give clear reasons for this decision?

In ILG's experience the LAA frequently does not give clear reasons for its decisions; indeed, the LAA often does not address aspects of ECF applications and the LAA will frequently provide standard refusal responses which are not applied to the facts of the case. Our members also have experience of the following:

- Decision letters containing reference to the wrong facts and/or the wrong names, including the name of the deceased. Such references cause significant distress to family members and suggests a lack of attention by the decision-maker. Given that decisions must be made on a case by case basis this is very worrying, as often it is frequently an indication that a decision has been made on an incorrect reading and/or understanding of the information provided;
- Requests for further information in cases where the information has already been provided on behalf of the applicant.- This again indicates a failure to have regard to all relevant information provided;
- Misunderstanding by the LAA caseworker of the legal framework as to when Article 2 may be engaged, and when funding is required for representation of the family. One of our members provides the example of the LAA refusing funding on the basis that because the deceased was not a detained patient, Article 2 was not engaged. There is, of course, no requirement that the deceased must be a detained patient in order for Article 2 to be engaged.
- The issues raised in the provider's application as to why ECF needs to be provided being ignored or not considered. An example from one of our members is in a case where the LAA had already accepted that Article 2 was engaged and funding has been granted to a family member, and a subsequent application was made on behalf of another family member by another provider due to a legal conflict between the two family members. In our member's experience the LAA simply asserted that there was no conflict, without addressing the detailed reasons provided by the provider as to why, in their opinion, there was a conflict. The issue here is not whether the LAA was in fact correct in its decision, but its failure to address the representations made to it.

- Repeated occurrences of refusals which fail to address the application made on the basis of wider public interest and provide scant/poor reasons only in relation to the Article 2 limb of the application.

ILG members also have experiences of appealing original decisions, with no further information being provided, which has resulted in the decision of the LAA being changed. This clearly indicates that the decision-making in the first instance was incorrect; a lack of clarity and understanding as to relevant legal framework often appears to be linked to this.

Further ILG members have received letters indicating that whilst funding has been granted the amount of funding requested has not been allowed, with no explanation given for this decision.

Question 9: Are there any ways in which the LAA can provide greater clarity regarding their decision-making?

Further to the answer above in response to Question 8, ILG considers that the following are ways that the LAA can provide greater clarity regarding their decision-making:

- Ensure that the correct facts (and names) are referred to;
- Ensure that all information provided in the Application is considered;
- Ensure a clear understanding of the relevant legal framework and test to be applied in relation to the grant of ECF for inquests and then application of the same to the relevant facts;
- Address each of the arguments made in the application, and not ignore them.
- Publish clear guidance on the wider public interest criteria
- Publish clear guidance on the circumstances in which a contribution will be demanded
- Ensure that decisions are made within the published timeframes and if this will not be achieved, that letters are sent to the provider and applicant.

Question 10: In your experience, have there been inquests where Article 2 is not engaged that have met the criteria considered by the Director? Please provide details.

Following a request for further information, ILG's understanding is that this question relates to inquests where the coroner has determined that Article 2 is not engaged, and our response is provided on this basis. However, ILG has real concerns as to the way that this question has been phrased, as it suggests a misunderstanding of the legal position; simply because a coroner has determined that Article 2 is not engaged does not mean that this is the case; as can be seen by the fact that a number of our members have acted for families who

have successfully challenged by way of judicial review the coroner's decision that Article 2 is not engaged in relation to a particular inquest. It is of note that the only way in which to challenge a coroner's decision is by way of judicial review (for which legal aid is available to those who meet strict financial criteria, but for those who don't, involves significant cost and financial risk), given the lack of any appeal system within the Coronial system.

We have only been able to find two examples of cases in which the LAA has granted funding on the basis that Article 2 is engaged in circumstances where the coroner has determined that it is not.

Question 11: Is the current definition of 'wider public interest' in the context of the granting of legal aid for inquests easy to understand? If not, please suggest areas for improvement.

Section 10(4) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 defines a wider public interest determination as being a determination that in "the particular circumstances of the case, the provision of advocacy under this Part for the individual for the purposes of the inquest is likely to produce significant benefits for a class of person, other than the individual and the members of the individual's family."

It is ILG's view that the Lord Chancellor's Exceptional Funding Guidance (Inquests) is not easy to understand in relation to this issue (paragraphs 27- 35). It is also of note that it is out of date in its references to 'Rule 43' which ceased to be relevant in 2013. However, of even greater concern is the way that the LAA apply this Guidance or, what appears to be more likely in a significant number of cases, simply ignore the question of whether there is a wider public interest in the applicant being represented.

ILG are aware that our members will frequently include 'public interest' arguments in their applications to the LAA, explaining why they consider that the case in question meets the 'wider public interest' test. However, these arguments will frequently be ignored in the response from the LAA; if an application is granted it will almost always be on the basis that Article 2 ECHR requires that ECF is granted, with no reference to the 'wider public interest' and, conversely, if funding is refused it will be said that Article 2 does not require funding be granted, with no reference to the 'wider public interest'. ILG are not aware of any recent cases which have been specifically granted on the basis that the 'wider public interest' test has been met. However, we are aware of an example where ECF was granted under the 'wider public interest' test pre-LASPO; this is addressed in further detail below in response to Question 12.

Our members frequently have cases which fall within the 'wider public interest' test set out in section 10(4) of LASPO. These cases will also fall within the test as set out in the Lord

Chancellor's Guidance, including in relation to the relevant numbers involved (the Guidance states that it will be unusual for significant wider public interest to apply to something that benefits fewer than around 100 people) and the fact that, if the client were not represented, the issues in question would be unlikely to be raised and therefore addressed in the inquest. However, more often than not, the LAA simply does not engage in whether the 'wider public interest' requires the representation of the applicant. It is ILG's view that the Guidance is unclear, and what is more concerning is that ILG members are unable to understand how the LAA applies the same, as it is simply not addressed by the LAA. As a result, ILG considers that, where an argument has been made in an application that the 'wider public interest' test applies, this must be responded to by the LAA, with detailed reasons as to why the definition has not been met (if that is the LAA's view).

Question 12: Are you aware of any inquests that have been awarded legal aid through the ECF scheme under the 'wider public interest' determination? If so, please can you provide details of these cases?

As stated above, ILG is not aware of any recent cases where exceptional case funding has been provided under the 'wider public interest' determination. We are aware of a case where this was granted 4 years ago however the application was made in 2011 which was pre-LASPO. This case involved the deaths of two children whilst on holiday in Corfu, who died from carbon monoxide poisoning. It is our understanding that securing this funding was an exhaustive process, which involved considerable research regarding statistics as to carbon monoxide deaths whilst on holiday, both abroad and in the UK. This research was only possible because the family's local MP's support staff carried out this work; such work would not have been possible if these resources had not been made available.

As we note above there's often a lack of clarity around wider public interest and whether it has been recognised that it has been engaged. For example it is thought such a grant may have been made in the Camber Sands case although the grant is not sufficiently clear.

This demonstrates how difficult the hurdle is for securing funding under the 'wider public interest' test.

Question 13: Do you think that families are still able to understand and engage with the proceedings in cases where they are not legally represented at the inquest? Please provide reasoning for your response.

A bereaved family cannot be expected to have a decent understanding of inquest law and cannot as such adequately respond to any submissions, or indeed get to 'know their rights' at a time they are suffering a bereavement (usually an unexpected one).

Many ILG members have represented families who have started the inquest process without representation, and where the family are facing a listed inquest without having received any of the relevant documents and where key issues such as scope and Article 2 have not been determined. In the worst examples opportunities to engage with the obtaining of post mortem evidence have been completely lost.

On multiple occasions, intervention by legal representatives has led to the listed inquest becoming a Pre Inquest Review hearing and the securing of a full and fearless Article 2 Inquest covering the circumstances of a death. During the preparation, the legal representatives take on the task of reviewing the relevant documents, requesting disclosure, drafting submissions etc. It is inhumane to expect a bereaved family member to be able to fully read the voluminous documents which are often relevant, and the documents are often hard to navigate for those who don't work regularly with the various software used. For example, regarding medical records in an inquest concerning a death of a patient in psychiatric care references may be made to Rio notes, Carenotes, progress notes, GP records, incident reports, Ulysses records, observation records, s.17 records etc.

In anything but the most straightforward inquest, bereaved families cannot be expected to know the type of documents that should be requested and disclosed, and reference is made elsewhere in this document to the need for prompt action in inquests where evidence may be destroyed. Further, even if this was manageable, the purpose of the advanced disclosure is to assist with making legal submissions regarding relevant witnesses and to informing questions to be put to witnesses. Requiring a bereaved family to directly question those they consider responsible for their loved one's death is inappropriate and our members report families, who did go through the process, describe it as incredible difficult and compounding of their suffering.

In relation to consideration of appropriate Conclusions, in ILG members' experience public bodies often use lawyers to argue strongly against wider Conclusions (such as excluding possible causes of death). What must be included in a Conclusion is a matter of law and requiring a bereaved family to make such legal arguments is inappropriate and means they often cannot properly engage with this crucial part of the Inquest process.

Finally, please see below at question 24 regarding the Coroner's ability to protect a family's interests.

Question 14: In your experience, how could we ensure that available legal aid funds provide the most value to bereaved families going through the inquest system?

For the reasons stated elsewhere in this document providing access to legal aid, on a non-means tested basis, promptly and in line with clear guidance will ensure that bereaved families receive the most value from the available legal aid funds.

On a practical level, decisions made more promptly would allow the provider to have the benefit of making travel/ accommodation bookings in advance taking advantage of advance deals.

In addition, the closer to opening of the Inquest that legal aid is granted, the more effective the legal representatives can be and the possibility of having to go over ground already covered is greatly reduced. For example, often bereaved families do not know until they attend the first PIR that other IPs are legally represented and that they may wish to seek legal advice. In our experience decisions made at PIRs where families are unrepresented, in particular in relation to the engagement of Article 2, are often overturned once a family has legal representation. If legal aid were available earlier, the work needed would be reduced and it would also remove some of the strain on Coroners' budgets as there are likely to be a reduced number of hearings.

Question 15: In your opinion, do inquests where the state has legal representation meet the criteria used to determine the need for a financial means test?

It is our understanding that this question is asking whether, in cases where the state has legal representation, the criteria for granting a financial waiver are met. As set out above, it is the ILG's view that families should be granted automatic non-means tested funding in order to be represented at inquests and in such circumstances, it would not be necessary for the family to go through the upsetting and onerous financial assessment process.

However, if families are to be subjected to a financial assessment process, then it is the ILG's view that in circumstances where the state is represented, the family should be granted a financial waiver and should not be required to pay a contribution. However, the ILG do not consider that such a waiver should be limited to cases in which the state has legal representation. Such an approach fails to recognise the importance of ensuring that a family can effectively participate in the inquest and that they can ask the questions they need to in order to understand the circumstances of their loved one's death. In the large majority of cases, legal representation is needed to allow proper participation of the family given the unique and distressing nature of the process. Further, it ignores the fact that many state agencies have access to in-house advice and representation, which bereaved families simply do not have, and for many state agencies they regularly appear in Inquests whereas bereaved families often have a single experience.

Question 16: In your experience, at inquests where both the state agents and the family have legal representation, does the family receive the required level of support and representation from their legal representative to enable them to understand and properly participate in the proceedings? Please give examples where possible.

The primary issue faced by those representing families are the restrictions put on the amount of funding that is granted, including in the time allowed in grants for representatives to prepare for and attend conferences with clients and hearings. In our members' experiences the costs sought, which are worked out with the extensive benefit of our knowledge of hearings, are invariably greatly reduced, without any explanation for doing so. The number of hours which are cut for, for example, preparing a brief to counsel to attend a hearing is frequently and significantly reduced. This time solicitors can claim under legal help, albeit at a lower hourly rate. For barristers, their brief fees tend to be insufficient to cover the time and hours needed to prepare for complex hearings. In addition the additional time sought for conferences with families are also reduced – meaning the real time necessary to support families and enable them to properly understand and be involved in proceedings is done pro-bono. This is in contrast to state agencies, who have less restrictions on their time allowed (we understand billing is usually on a fixed hourly rate basis as opposed to fixed fees) giving them the ability to have conferences for example when appropriate) and who, as referred to above, generally already have experience of the inquest process.

Question 17: For cases where the bereaved family has legal representation, do you feel their lawyer(s) are effective in representing the family's interest? Please give examples where possible.

Please see above our response to question 16. In order to be as effective as possible, sufficient funding to cover the necessary time needs to be granted in a timely fashion. As also referred to above, families lawyers are frequently the most proactive in preparatory hearings and full hearings – seeking to widen the scope of inquiries whilst state agencies seek to narrow the issues considered and criticism that might be made of them; the costs sought for families to do so are very rarely granted in full. A further example of how families work proactively, in addition to the points made above regarding arguments as to whether Article 2 is engaged, is that it is often left to families to ensure systems issues are fully explored – it is our experience policies and training records are rarely offered by state agencies, it is for families to explore these issues and persuade coroners to consider them. The restrictions on funding do not ensure an equality of arms when compared to state agencies funding arrangements.

Question 18: In your experience, what impact does the number of lawyers representing the state have on the experience of the bereaved family?

In the vast majority of the cases ILG members deal with there will be more than one state body represented at the inquest. In stark contrast to families it would be rare for state bodies not to be represented where they are recognised as an interested person at an inquest.

The number of lawyers representing the state can lead to families feeling heavily outnumbered and they often cannot avoid the conclusion that the process is heavily stacked against them. This is particularly heightened where multiple state lawyers close ranks and support each other in trying to restrict the scope of an inquest, close down questioning, resist disclosure and generally promote an agenda at an inquest which is not conducive to learning lessons and instead concentrates on damage limitation. Less experienced coroners can be influenced by the fact that numerous bodies are making the same submissions.

Families will frequently hear the phrase ‘whilst not for my client...’ from lawyers representing the state where they support the representations of other state bodies where they have no relevance to their own client.

Also relevant to the number of state lawyers is the difficulty families face in obtaining funding for a QC and junior counsel under Exceptional Case Funding which is in contrast to complicated or merely high-profile cases where there is no barrier to the state’s instruction of numerous lawyers to represent them. Requests to the LAA to authorise the instruction of a QC are often refused even in the most complex and contentious cases and the guidance is unclear as to what circumstances would justify the making of such a grant. The fact that a state party is represented by a QC for example is not sufficient reason to grant the family funding for a QC. This reinforces to the family the inequality of arms which exists between them and the state and the feeling that their point of view is less important.

Generally one grant of Exceptional Case Funding is made to ‘the family’ of the deceased. This is in most cases sufficient, however, difficulties arise where there are conflicts within families or serious breakdowns in relationships. The LAA’s guidance as to when a further grant can be made are unclear and numerous applications for grants for other family members have been refused even in circumstances where those representing the family consider themselves to be professionally conflicted. This can mean some family members do not receive representation. There are however no such pressures on the state where individual police officers for example might also be represented. We accept in certain circumstances this is necessary however in practice we see numerous examples where the position taken by the individually represented state employee is the same as the state body they work for and the need for separate representation is not evident.

Question 19: In cases where there are multiple lawyers representing the state, would the family benefit from receiving information about the role each one plays, and the type of legal position they are assuming? Please give examples where possible.

We consider families might find it beneficial to have information about who the other state Interested Persons are, particularly in cases where the family may not be represented.

Whilst we are not against position statements from state lawyers, and understanding where they accept there have been failings would be helpful, we have concerns that this may in practice lead to restrictions on the ability of families to ask questions about and explore certain matters. For example state lawyers might argue that they have accepted a certain thing is a failing and therefore evidence need not be heard about that. It is however important for families to understand why things happened and this is also crucial if lessons are to be learnt.

We do not consider that families should be required to produce such statements.

Question 20: Can you provide examples of cases where a lawyer has adopted an inappropriate advocacy style or approach? If so, was the lawyer representing the state or the bereaved family?

ILG members are concerned about the following behaviour by state agencies and their advocates:

a) General Approach

Generally the approach taken by advocates for state bodies is that of damage limitation. Their overriding priority is to protect their client from criticism and to defend their policies and procedures which sits at odds with the purpose of an inquest namely that it is an inquiry into the truth and an opportunity for learning lessons for the future. We note for example opposition to coroners making a ruling that Article 2 is engaged in a particular case because of the benefits that may entail to their client namely an inquest with a more restricted scope and the likelihood that the family will not be able to obtain state funded representation.

b) Inappropriate questioning of families and seeking to discredit them or the deceased and defect blame onto them.

A particularly stark example is provided within the submissions from INQUEST; that of the inquest into the death of Cheryl James. The advocate on behalf of the police suggested to the father of the deceased that his complaints to the police about the circumstances of his daughter's death distracted them from investigating other crimes. The advocate responsible

for this line of questioning is known for deploying such tactics and there was criticism of similar conduct during the Hillsborough inquests. We note however that despite such criticism he continues to be instructed by state bodies to represent them, and likely this is as a result of his reputation.

In cases involving juries, lawyers for state bodies frequently try to put before the Jury evidence of the deceased's previous offending or drug taking to try and discredit the deceased in the eyes of the jury. Similarly, there are examples of advocates objecting to photographs selected by the deceased's family to be shown to the Jury.

c) Disclosure

Families often face uphill struggles to obtain proper disclosure in a timely manner prior to inquests starting. State agencies do not adopt positions of full disclosure but will rather disclose only those documents which they are asked to do so by the Coroner. In many cases, state bodies will generally only disclose these to the Coroner on the basis that it is the coroner's investigation. This not only causes delay but fails to recognise their responsibilities under Article 2 and the importance of the family being able to effectively participate. The families' ability to request documents is hampered by their lack of knowledge about what documents there may be. This in particular is an area where early representation of families is very important.

Where internal investigations have been conducted following deaths we see frequent attempts to resist disclosure of these documents to the Coroner or the documents which informed such investigations.

Difficulties with disclosure significantly contribute to families' dissatisfaction and mistrust within the inquest system and causes considerable distress. This can lead to an atmosphere of suspicion and belief that there will be a cover up of the true facts behind the death.

Late disclosure in addition significantly hampers the families' ability to properly engage with the process.

We have attached to these submissions Prevention of Future Death reports arising from the case of Jack Portland (<https://www.judiciary.uk/wp-content/uploads/2017/03/Portland-2017-0049.pdf>) and Sean Plumstead (<https://www.judiciary.uk/wp-content/uploads/2017/12/Sean-Plumstead-2017-0316-Redacted-1.pdf>). In these cases Coroners concluded that problems with disclosure on the part of two prisons created a risk of future deaths as it inhibited investigation and lessons learning.

Question 21: Do you consider that the MoJ Guide meets the needs of bereaved people? If not, what do you suggest?

Although it is a helpful as a general background document, the Guide does not fully meet the needs of bereaved persons for the following reasons:

- Not all bereaved families receive a copy
- The information on legal aid is overly simplistic and does not make it clear financial criteria can be waived (and often are)
- The Standards therein are not upheld by the JCIO or Ombudsman when making a complaint – they are referred to as general guidance only
- The Standards do not always include informing a bereaved family of their full legal rights (for example, see p.9 regarding post mortems)
- It does make clear that other IPs may be legally represented and that at the PIR (section 8.4) legal submissions may be made regarding what the inquest should consider, rather it gives the impression the PIR is an opportunity for a more informal discussion about issues to be considered.
- There is little information about disclosure and a bereaved family's legal rights in this regard – that which is in the Guide comes after the section on the Inquest hearing, despite disclosure being key before a PIR, let alone the final Inquest.

Consideration should be given to referring families to organisations such as INQUEST in section 13.3 of the Guide.

Question 22: Have you found any other information useful? If so, please can you give details?

We consider the INQUEST Family Handbook to be helpful and the resources on their website. In addition, Action Against Medical Accidents (AvMA) provides some helpful guidance for families regarding the inquest process, and many law firms working within this area have basic information sheets on their website.

We are often concerned about state agencies/ Coroner's Officers telling families they do not require representation. An example we see fairly frequently are families being told that Pre-Inquest Review hearings are not important and they do not need to attend these. These hearings are however very important and decisions made at such hearings shape the course of the inquest. Restrictions placed on scope or disclosure at this stage can cause significant difficulties at the final hearing. Additionally, we are aware that a family may be told that instructing a lawyer will delay matters.

Question 23: What else do you think could be done to support bereaved families better throughout the inquest process?

Question 24: Is there anything else you would like us to consider?

The ILG has had sight of the suggestions made by INQUEST in response to question 23 and fully support those. In addition, the ILG would like to draw the following matters to the Ministry of Justice's attention which continue to impact on families' experiences of the inquest process:

1. **The conduct of coroners towards families and their lawyers** – the ILG have had extremely positive experiences of the respectful way in which coroners treat families, placing them at the heart of the process and recognising how traumatic attending an inquest can be. Such sympathetic treatment includes meaningfully extending condolences to a family; allowing frequent breaks when family members become upset so that they do not miss evidence; explaining the inquest process clearly; and ensuring that questioning by those representing other Interested Parties is both relevant and sensitive. Unfortunately, however, this is not the consistent experience of families, some of whom have found that the conduct of the coroner has exacerbated their distress. Such behaviour includes failing to acknowledge the family in court; bullying the lawyers representing family members; appearing not to be impartial in their treatment of all Interested Persons; shouting at family members; giving the impression that the presence of family members and the asking of questions by them is an inconvenience or a hindrance; and private meetings with other Interested Persons or their representatives. It is perhaps noteworthy that only around 50% of senior coroners responded to the Ministry of Justice's survey on legal aid.

Members of the ILG have provided the following examples:

- In a case concerning the self-inflicted death of an extremely vulnerable disabled man in prison, the family were not represented in the inquest. The recordings of the inquest were subsequently reviewed and that review gave rise to serious concern about the conduct of the Senior Coroner in the inquest. The Senior Coroner failed to explain her reasons for seeking submissions regarding particular issues and repeatedly interrupted submissions made by the bereaved, unrepresented family members with the effect that they were unable to make full submissions and thereby effectively participate in proceedings.
- In a case concerning the self-inflicted death of a young woman in psychiatric detention, the Assistant Coroner with conduct of the inquest declined to respond to correspondence seeking information about the listing of the inquest for nearly a year after the first pre-inquest review.

- In an inquest into the self-inflicted death of a young woman in prison, there were clear non-verbal signals by a Senior Coroner– including eye-rolling and refusing to maintain eye contact with the family’s counsel – of dissatisfaction about the family’s position on a number of issues, in front of the jury.
 - In an inquest concerning the death of a man who died two days after being discharged from detention under the Mental Health Act, the family found the senior coroner presiding over the inquest to display an obstructive, at times bullying and hostile manner to the family and made them feel he did not have their views or best interests at heart. The coroner was personally critical of the family and their legal representation. During the inquest, the family felt that the coroner tried to belittle what they were going through in comparison with the witnesses from the Trust. His behaviour became more entrenched and worse in his written rulings after the inquest, where he sought to imply that the father of the deceased had left him alone on the night he died, which was clearly a veiled criticism. A complaint has been made by the family concerning the coroner’s conduct, who has also been the subject of other publicised complaints.
 - In the inquest into the death of Colette McCulloch, the coroner has now recused himself following an allegation of bias in pre-action correspondence, however it is noteworthy that the neither the JCIO nor the Ombudsman upheld the family’s complaint about his actions, which included allegations that he had shouted at the family and that he had accused their legal representatives of blackmail. The allegation of bias was supported by the repeated terse and rude tone used by the coroner in correspondence with the family, and they alone were singled out and described as having displayed an “outcry of protest” when they were just one of multiple Interested Persons who objected to a re-listing of a hearing without any recourse to lawyers availability and were the only Interested Person to put forward a medical reason for objecting to the revised listing.
 - In a recent jury inquest, the coroner began informing the jury of her views on various matters a witness had said ‘based on her long experience in Inquests involving deaths of mental health patients’. Although this was objected to and the coroner apologised, the comment had already been made to the jury.
2. **The provision of early and simultaneous disclosure by the coroner** – at present, ILG members have varying experiences regarding the provision of documents to the family. Late or incomplete disclosure can make preparation for any hearing very difficult but this is particularly so when representing a bereaved family who need time to consider and process what are likely to be very distressing documents. Even in

cases where coroner's direct disclosure of documents by a certain date, steps are not then taken when this is not provided and explanations are not given as to why such disclosure is delayed, either by a coroner or by the relevant Interested Person. This can be very upsetting for a family not least as it can often feel that others are not taking the investigation into their loved one's death seriously.

For example:

- In an inquest into the self-inflicted death of a young woman in psychiatric detention: there have been repeated failures to seek to ensure compliance with rulings regarding disclosure; some disclosure is still outstanding 1 year and 9 months after it was initially ordered and despite repeated intervening pre-inquest reviews and chasing requests
 - In an inquest into the death of an extremely vulnerable man from an unexplained catastrophic injury whilst deprived of his liberty pursuant to the Mental Capacity Act Deprivation of Liberty Safeguards, there have been repeated failures to seek to ensure compliance with rulings regarding disclosure; some disclosure is still outstanding a number of years after it was initially ordered and despite repeated intervening pre-inquest reviews and chasing requests.
 - In an inquest into the death of a learning disabled man who died on an NHS Unit, there were repeated failings by the NHS Trust to provide full disclosure to the inquest, such that hundreds of pages of documents were still being received on the first day of a two week inquest.
3. **Communication from the coroner's court** – the ILG has had some very positive experiences of good communication from coroner's courts including coroners (and their officers) who provide regular updates regarding the progress of their investigation; the provision of agendas well in advance of Pre-Inquest Review Hearings; and a detailed note of decisions made and directions given at Pre-Inquest Review Hearings. However, unfortunately, in other cases, the experience of families and their representatives has been very poor. A lack of communication from a coroner's office, including failing to respond to correspondence, can be incredibly upsetting for a family and can hinder preparation.

ILG members have provided the following examples:

- In one case, there has been an ongoing failure to assign the inquest into the self-inflicted death of a man in prison to a Coroner for listing of the inquest, nearly two years and ten months after the death.

- In another case, there has been an ongoing failure to list the inquest for over two years and four months since the death, or to respond to the family's correspondence seeking an update as to the position.
- Following the manslaughter of a young person who was resident in a care home, there has been a repeated failure by the coroner to update the family as to the progress of his investigation and the factors preventing disclosure and progression. The death occurred four years ago.
- There have been a number of examples of coroners failing to consult with families regarding the listing of hearing dates and holding hearings on significant anniversaries such as the deceased birthday and the anniversary of the death. This can be very upsetting for families and can often increase the cost to the legal aid fund when it is necessary to find alternative counsel to represent a family.

4. **Provision of a private room-** In ILG's experience, bereaved families benefit greatly from having access to a private room for the duration of the inquest into their loved one's death (many clients have described it as their sanctuary during a difficult process). Such facilities are routinely available across the country, however pockets remain where such facilities are unavailable to bereaved families at all or free of charge. In a current example, the Inquest is being held in the Town Hall and the bereaved family were quoted £1000+VAT (reduced later to around £300+VAT) for the hire of a private room. A request to the Coroner to provide this free of charge was declined on the basis of "certain constraints which include budget" and the Council have stated the Town Hall is run as a "commercial venture" and as such levy a fee for room hire outside what the Coroner needs. An application for legal aid was initially refused (appeal is pending) and a complaint against the Coroner & Council have also been made.

Finally, ILG are aware of suggestions made by both the LAA (in the context of funding applications) and by coroners themselves that the presiding coroner in an inquest can protect a bereaved family's interests; this is often said to be based on the premise that inquests are non-adversarial. It is of considerable importance to all involved and the integrity of the coronial process that coroners are entirely independent and it should be recognised that they cannot act to protect any party's interests nor represent them. Further, it should be abundantly clear from the contents of this document and the case studies provided that inquests are not a non-adversarial forum, rather it is common for Interested Persons to make opposing submissions and have completely different interests in the inquest process.

This submission is supported by the following:

Bhatt Murphy	Bindmans LLP	Birnberg Peirce	Broudie Jackson Canter	Deighton Pierce Glynn
Hickman and Rose	Hodge Jones & Allen LLP	Howells LLP	Leigh Day	Minton Morrill
Saunders Law	Bishop Lloyd & Jackson Solicitors'	McMillan Williams Solicitors	ITN Solicitors	Irwin Mitchell
Liberty	Harrison Bunday	A F Brooks & Co	Matthew Gold & Co. Ltd. Solicitors	Kenworthys
Tuckers Solicitors LLP	Attwaters Jameson Hill Solicitors	Nelsons Law	Simpson Millar Solicitors LLP	Hudgell Solicitors
Imran Khan Solicitors	Southerns Law	Farleys		
Garden Court North Chambers	Doughty Street Chambers – Inquest team	Garden Court Chambers	Cloisters Chambers	Nexus Chambers, the Chambers of Michael Mansfield QC
Alison Macdonald QC Matrix	Hugh Southey QC Matrix	Anita Davies Matrix	Raj Desai Matrix	
Olivia Streater Independent human rights consultant.				

Non ILG member supporters

Shaheen Rahman QC 1 Crown Office Row	Nick Armstrong Matrix	Chris Buttler Matrix	Ben Emmerson QC Matrix	Danny Friedman QC Matrix
---	--------------------------	-------------------------	------------------------------	-----------------------------

Kirsten Sjovoll Matrix	Paul Skinner Matrix	Dan Squires QC Matrix	Janet Kentridge Matrix	Tamara Jaber Matrix
Zoe McAllum Matrix	Helen Mountfield QC Matrix	Blinne Ni Ghralaigh Matrix	Tim Owen QC Matrix	Adam Sandall Matrix
Phillippa Kaufmann QC Matrix	Helen Law Matrix	Angus McCulloch QC 1 Crown Office Row		