INQUEST response to Justice Committee inquiry The Coroner Service: follow-up

January 2024

Introduction

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media, and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question, such as the Hillsborough disaster or Grenfell Tower fire. INQUEST sits on the cross governmental Ministerial Board on Deaths in Custody. Until recently, INQUEST's Executive Director Deborah Coles was a member of the Independent Advisory Panel on Deaths in Custody and led their recent work on coroners' Prevention of Future Death reports.[1]

2. INQUEST has dedicated much of its policy and research work to efforts to improve the coronial system for bereaved families. This work is informed by our engagement with families and their lawyers.[2] INQUEST welcomes the opportunity to respond to this important follow-up inquiry. We hope it will provide useful examination of the government's progress in improving the Coroner Service since the committee's call for "*major reforms*".[3]

[1] IAPDC, "More than a paper exercise" – Enhancing the impact of Prevention of Future Death reports, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/653241e711e65b7d37b95d70/1697792489185/IAPDC+PFD+project+report+September+2023+-+FINAL+FOR+PUBLICATION.pdf, September 2023

[2] We worked closely with parliamentarians and civil society organisations during the passage of the Coroners and Justice Act 2009 which ushered in reforms to the coroner service, including the establishment of the Chief Coroner role. In addition, we have worked with Chief Coroners to highlight concerns arising from our casework, presented at the judicial college coroners training programme, conducted several Family Listening Days which provide testimony on families' experience of the Coroner Service, engaged in this committee's 2020 inquiry into the Coroner Service and briefed parliamentarians on changes to the inquest process introduced by the Judicial Review and Courts Act 2022. INQUEST briefing on the Coroners and Justice Bill 2009, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=d0dfa105-4579-4cc3-8080-b1a751ae9839, February 2009; INQUEST submission to the Justice Select Committee Inquiry into the Coroner Service, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e404f863-cdfb-47b6-8e34-a65118520331, September 2020; INQUEST and Inquest Lawyers' Steering Group, Judicial Review and Courts Bill, Briefing for Second Reading, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=3a6d4d87-b534-454c-8d46-a41351c2646c, October 2021. See also INQUEST Family Listening Day report with Birkbeck's Institute for Crime & Justice Policy Research in partnership with the Centre for Death and Society at the University of Bath on Families' experiences of the coronial process following deaths in police custody or prison, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=aad6f0dd-8b4c-46d2-a84b-20c64fb7a197, September 2023 and INQUEST's Family Consultation Day report on deaths of people with mental ill health, a learning disability or autism, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=6f8b416f-adce-4c5e-9a9b-3c435f71d767

[3] Justice Committee, The Coroner Service, https://committees.parliament.uk/publications/6079/documents/75085/default/, May 2021

3. The information set out in the below submission is based on findings from INQUEST's policy work and casework service. As far as possible we refer to inquests which took place after 2020/21. We also refer to the responses received from bereaved families to a survey we launched on their experiences of the Coroner Service.

4. Overall, we believe there has been a reluctance to engage in the reform of the Coroner Service which is greatly needed. Where the government have accepted substantial recommendations – such as on legal aid for families at inquests or the duty of candour – their proposals have fallen short of what was recommended by this committee and in other reports or reviews. In other areas requiring fundamental change there has been little to no progress to improve the experiences for bereaved families, such as on strengthening follow up to coroners' concerns. The result of this, according to our evidence, is a service which still leaves too many bereaved families poorly served, undermining their trust and confidence in the process.

5. Our key findings are as follows:
    - More needs to be done to strengthen the follow up on inquest conclusions and Prevention of Future Death reports.
    - There is limited evidence of progress in putting bereaved families at the heart of the coroner service, which was this committee's over-arching recommendation from its previous inquiry.
    - Unfair restrictions remain in the legal aid scheme for bereaved families' legal representation at inquests, in contrast to the unlimited funding available to public bodies.
    - There has been a lack of discernible progress to tackle inconsistencies across the coroner service.
    - Many coroner areas have experienced acute delays in recent years, often exacerbated by the Covid-19 pandemic. This has had a significant impact on bereaved families' wellbeing and has undermined the preventative potential of inquests.

Prevention of future death reports and inquest conclusions

6. The committee asks "*[w]hether more can be done to make best use of the Coroner Service's role in learning lessons and preventing future deaths*." The extent to which Prevention of Future Death (PFD) reports and inquest conclusions are effectively contributing to the preventative potential of an inquest is a key concern for INQUEST and the families we work with. It is our view that much more must and can be done by government to strengthen the oversight and effectiveness of PFDs.

7. In response to this committee's previous recommendation that government "*consider setting up an independent office to report on emerging issues raised by coroners and juries*", the government said they could not accept this recommendation but

"*recognises that there is more that can be done in this space to ensure that PFD reports actively contribute to improvements in public safety*".[4]

8. We note there have been some improvements in the publication of PFDs and their responses on the Judiciary website, and an improvement in the ease with which the public can search for reports. However, inconsistences in the categorisation of PFDs on the Judiciary website makes the identification of key information difficult, such as on protected characteristics.[5] Overall, however, we believe since this committee's report there have been no improvements made in strengthening the oversight of PFDs to improve their preventative role.

9. Investigations into deaths involving the state can result in recommendations made with the aim of preventing future deaths. As a bereaved parent said: "*Nothing can bring your child back. All we can do is help them ensure it does not happen again*". In contributing to that objective some meaning can be given to their loss. A PFD has the potential to make the inquest a more fulfilling process for families who can see judicial recognition where there were failings or concerns and assist them in coming to terms with a traumatic bereavement. PFDs are in the public interest as they can inform improvements on public health and safety. For example, PFD's have been crucial in shining a light on areas of concern in state care and detention as well as other areas of public importance such as fire safety, NHS failures, university student deaths and terror attacks.

10. However, the preventative potential of parts of the UK's investigatory framework is currently undermined, including inquests, public inquiries and official investigations such as those led by the Prisons and Probation Ombudsman (however, for the purposes of this submission we focus only on inquests).[6] As the IAP highlighted in their recent report on PFDs, only 55% of coroners and senior coroners surveyed agreed that "*PFD reports are effective in preventing future deaths*".[7]

---

[4] The Coroner Service: Government Response to the Committee's First Report, https://committees.parliament.uk/publications/7221/documents/77640/default/, September 2021

[5] In their recent report on PFDs, the Independent Advisory Panel on Deaths in Custody note the Chief Coroner's Office has made improvements to its online database "enabling users to search for PFD reports by thematic and subject area on the Judiciary website" but that "the website still lacks fully comprehensive tagging functions: for example, no distinction is made between deaths of those detained under the Mental Health Act and those receiving voluntary and community-based mental health services" para. 63, IAPDC, "More than a paper exercise" – Enhancing the impact of Prevention of Future Death reports, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/653241e711e65b7d37b95d70/1697792489185/IAPDC+PFD+project+report+September+2023+-+FINAL+FOR+PUBLICATION.pdf, September 2023

[6] For more information, see INQUEST's briefing "No More Deaths. Learning, action and accountability: the case for a National Oversight Mechanism", https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b480f898-7fbd-4c9c-a948-50dd3fad3a04, June 2023

[7] IAPDC, "More than a paper exercise" – Enhancing the impact of Prevention of Future Death reports, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/653241e711e65b7d37b95d70/1697792489185/IAPDC+PFD+project+report+September+2023+-+FINAL+FOR+PUBLICATION.pdf, September 2023

11. There are also fundamental gaps in the legislation around post-death processes. With regard to inquests, a coroner is required to make a PFD under Schedule 5, paragraph 7 of the Coroners and Justice Act 2009 where the evidence suggests that future deaths may be prevented. Although the recipient of the report is under a legal duty to consider and respond, there is no sanction if they do not properly consider and act on the report, or indeed if they do not respond at all.

12. As a result, a large proportion of public bodies who receive recommendations from coroners do not even bother to respond: an analysis using the Preventable Deaths Tracker developed by researchers at the University of Oxford found that only 33% of all PFDs reports issued by coroners had expected responses published, with 29% of responses overdue.[8] Further, the researchers found that response rates to PFDs examined in 25 of their studies ranged only from approximately 10% - 60%, with no study resulting in an 100% response rate.[9] Often responses appear to be generic and formulaic and do not address the specific issues raised by the coroner. Some PFD responses reiterate existing policies despite the fact the policy failed to prevent a death occurring. This can prevent meaningful engagement with the concerns identified and hinder the implementation of effective solutions.

13. Another major impact of the current lack of oversight and follow up is that bereaved families are left unaware as to whether progress has been made following the death of their loved one. This can have a considerable emotional toll on families and the impact of hearing about another similar death cannot be over-stated. As the father of a man detained in a Priory run mental health setting who died from neglect said: "*The coroner issued an excellent, comprehensive Prevention of Future Deaths Report (PFD) covering the Priory and the Department of Health. The coroner provided me with their letters of acknowledgement, but I have no idea if any of the recommendations have actually been implemented*."

14. Some of the feedback on PFDs to our survey is included below:

We were given the report but it lacked little weight after the event with no follow up from official departments who had created the report.

I was sh[o]cked at how little was done and how poorly the PFD was managed.

There's no follow up, no action, no urgency, no one takes responsibility.

Once there is a response there is no follow up and no way of chasing if the trusts […] have had similar PFDs.

[8] Richards, GC. The Preventable Deaths Tracker: Responses to PFDs. 2023. https://preventabledeathstracker.net/database/responses/
[9] Richards, GC. The Preventable Deaths Tracker: Research using coroners' PFD reports. 2023, https://preventabledeathstracker.net/research/

PFDs need to be accountable and this needs to be governed, with penalties for those organisations who do not comply. Lessons really do need to be learned and acted upon country wide as we are seeing far too many repeats of similar incidents.

15. Yet another impact of the lack of proper follow up on, or oversight to, PFDs and inquest conclusions is that warnings from coroners go unheeded and similar deaths keep happening. INQUEST has worked on many cases in which the same or similar issues have been raised at inquests as contributing to a death. Recent examples of such cases include:

Epilepsy in prison

INQUEST is aware of at least 18 epilepsy related deaths in prison since 2005.[10] In a number of these inquests coroners have raised, among other issues, concerns regarding Cell Sharing Risk Assessments (CSRA).

For example, David O'Garro died at HMP Pentonville in June 2012. He suffered a sudden death in epilepsy and the coroner noted that, because he occupied a single cell, "*nobody was with him to raise the alarm when he suffered what is likely to have been a final seizure*." The PFD report issued following his inquest raised several concerns with the CSRA process: staff did not complete a CSRA for David despite knowing that a person with epilepsy should not occupy a cell alone, and a nurse appeared "*completely unfamiliar*" with the CSRA and "*unclear*" on how to ensure a prisoner with epilepsy could have a cellmate.[11]

Nine years later in June 2021, Amarjit Singh died at the same prison. The coroner ruled his death was epilepsy related. The PFD report issued in September 2023 once again noted a concern with the CSRA, which was described by the nurse who completed it as "*careless*".[12]

On the same day the PFD report on Amarjit's death was issued, the inquest into the death of Trevor Monerville began. Trevor died from sudden death in epilepsy at HMP Lewes in April 2021. The inquest revealed that a CSRA completed in January 2021 concluded that Trevor was suitable for cell sharing, however this decision was overridden by either healthcare or prison staff and Trevor was in a cell on his own. The coroner is in the process of obtaining submissions on a potential PFD report in Trevor's case.

It is clear from all of these inquests that there was a lack of understanding on how to manage prisoners with epilepsy. Had there been more knowledge of this across the

[10] This figure comes from INQUEST casework and monitoring.
[11] For more information, see the PFD issued following the death of David O'Garro, https://www.judiciary.uk/wp-content/uploads/2015/01/OGarro-2014-0270.pdf
[12] For more information, see the PFD issued following the death of Amarjit Singh, https://www.judiciary.uk/wp-content/uploads/2023/09/Amarjit-Singh-Prevention-of-future-deaths-report-2023-0342_Published-1.pdf

prison service and greater accountability to ensure such issues were addressed, these preventable deaths may not have occurred.

Deaths of children and young people with autism and/or a learning disability

Deaths of children and young people with autism is a growing concern for INQUEST. In 2023, a BBC investigation found coroners had made 51 PFDs following the deaths of autistic people who had experienced serious failings in their care. INQUEST's work with families has shown a lack of transparency or timely follow-up to coroners' concerns.[13]

INQUEST has worked with two families who had repeatedly requested further support for their teenage sons. The PFD reports in both cases, made by the same coroner, raised concerns over the lack of appropriate support provided for children, young people and their families.

Sammy Alban-Stanley's family had been fighting for disability care for over six years which never came. Sammy was diagnosed at birth with the genetic disability Prader-Willi syndrome and later with autism. After a year with no schooling and a tribunal battle, he finally got a place at a Special Educational Needs school. Just 12 months later he died aged 13 in April 2020. A PFD was issued in March 2022, in which the coroner stated that more practical support for Sammy and his family may have made a difference.[14]

Stefan Kluibenschadl, aged 15, died in March 2022. Stefan was diagnosed with high functioning autism at age six and attended the same school as Sammy. Following Stefan's inquest, in February 2023 the coroner issued a PFD noting that evidence from the inquest identified "*a large number of young people with a learning disability and/ or autism would not have a key worker nor would they be expected to have one*." The PFD also stated that if every autistic child or young person had a key worker this "*may prevent others from encountering the issues faced by Stefan's family and ultimately prevent future deaths*."[15]

However, the NHS Trust were delayed in providing a full response to the PFD report issued following Stefan's death. The coroner stated they had no further powers to follow up on this, meaning Stefan's family had to repeatedly chase the Trust for their response, which they believe fails to address some of the fundamental issues or the coroner's concerns.

[13] BBC, 'Young autistic people still dying despite coroner warnings over care', 7 September 2023 https://www.bbc.co.uk/news/uk-66731265
[14] See PFD into the death of Samuel Alban-Stanley, https://www.judiciary.uk/wp-content/uploads/2022/03/Samuel-Alban-Stanley-Prevention-of-future-deaths-report-2022-0082_Published.pdf
[15] See PFD into the death of Stefan Kluibenschadl, https://www.judiciary.uk/wp-content/uploads/2023/02/Stefan-Kluibenschadl-Prevention-of-future-deaths-report-2023-0068_Published.pdf

While many of the issues raised during Sammy and Stefan's inquests differ, the coroner had repeated concerns about support for children and young people with autism, learning disabilities and conditions such as Prader-Willi syndrome. Further, it should not fall to bereaved families to chase public bodies for a response to a coroner's concerns.

Housing

In 2011, six-year-old Liam Shackleton fell from an 8th floor window in a tower block owned by Leeds City Council. The coroner made recommendations in a Rule 43 letter[16] that there should be fixed permanent window restrictors because "*the safety of a child or vulnerable occupant is of paramount importance*" and that regular inspections should take place to ensure "*furniture was not placed under windows to allow children to climb up*."[17] The response from East North East Homes Leeds (one of three Arm's Length Management Organisations owned by Leeds City Council) set out changes made, including annual tenancy visits. However, they stated it was "*not a feasible option*" to fit fixed restrictors to all windows in high-rise homes.

Eleven years later, 22-month-old Exodus Eyob died after falling from a 7th floor window in a neighbouring high-rise tower block. The window had inadequate safeguards, despite Exodus's mother having requested locks. At the inquest, Leeds City Council failed to produce evidence of annual inspections considering window safety in flats with young children where furniture in front of windows presented a risk. Evidence also revealed that the requested locks were only offered as a "*one-off campaign*" after Liam Shackleton's death. Despite this, the coroner was satisfied that the Council would refresh training for housing officers and no PFD report was issued.

What these two tragic cases show, aside from a regrettable lack of action in between the deaths of Liam and Exodus, is the importance of inquest conclusions particularly in cases where no PFD is issued. The evidence from Liam and Exodus' inquests must be taken forward to ensure change.

INQUEST's proposal

16. To address this clear accountability gap, INQUEST is calling for the government to establish a National Oversight Mechanism, which would be an independent public body responsible for collating, analysing and following up on recommendations arising from four post-death processes: investigations, such as those carried out by the Prison and Probation Ombudsman or Independent Office of Police Conduct or Serious Incident Reviews; inquests; public inquiries; and, official reviews into deaths such as the Angiolini Review into deaths and serious incidents in police custody.

[16] Rule 43 letters were replaced with PFDs following the implementation of the Coroners and Justice Act 2009

[17] ITV, 'Family of toddler who fell to his death from flat window were 'extremely neglected' by Leeds council', https://www.itv.com/news/2023-12-19/family-of-toddler-who-died-falling-from-flat-were-neglected-by-council, 19 December 2023

17. We believe a Mechanism should have the following three core functions:

    - Collation: It should create and manage a new publicly available database which collates all recommendations made following post-death processes, highlighting the public agencies the recommendations are addressed to.

    - Analysis: Building on the information collated in its database, the Mechanism should issue regular reports to analyse the emerging themes and patterns in recommendations issued.

    - Follow up: Due to its collation of information and analysis, a Mechanism will have oversight of the implementation of recommendations, or lack thereof. The Mechanism should then follow-up and alert the relevant bodies to escalate its concerns which could include government departments, select committees and, where appropriate, organisations with prosecution powers.

18. In terms of the powers a Mechanism might have, while decisions on actions following official recommendations is a democratic process for public or private bodies to take, they must be accountable for their action or inaction in response to life-saving recommendations. This means publicising information on action taken in response to recommendations, within a reasonable time, or issuing statements on the reasons for a rejection to a recommendation. INQUEST believes there should be sanctions on public bodies who do not disclose this information.

19. In this way, we believe a National Oversight Mechanism would enable accountability by increasing transparency on the action, or inaction, of state and corporate bodies.

20. We would also like to draw this committee's attention to the recently established domestic homicide oversight mechanism which has been set up by the Domestic Abuse Commissioner to take forward the "*vital learning to prevent future deaths*" contained in domestic homicide reviews. Recent evidence on behalf of the Commissioner and Manchester Metropolitan University shows how the vast majority of victims of domestic homicide were in touch with public services before their death. The Commissioner is now launching a mechanism "*to ensure public bodies and national government learn from these reviews*."[18]

Current practice

21. In addition to concerns regarding the follow up to, and implementation of, PFDs, INQUEST has concerns regarding the consistency with which coroners issue PFDs. Many of these and other concerns were raised in the Independent Advisory Panel on Deaths in Custody's recent report on enhancing the impact of PFDs.[19]

[18] For more information see https://domesticabusecommissioner.uk/services-should-do-more-to-stop-domestic-abuse-killings-says-domestic-abuse-commissioner/. INQUEST met with the Domestic Abuse Commissioner to discuss this proposal in advance of it being set up.
[19] Independent Advisory Panel on Deaths in Custody, "More than a paper exercise" Enhancing the impact of Prevention of Future Death Reports, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/653241e711e65b7d37b95d70/1

22. We are aware of some very good practice with regard to the drafting of PFDs. Increasingly, we see coroners referring to previous and/or similar PFDs to highlight the recurrence of issues contributing to a death. In one PFD relating to an alcohol and drug-related death in HMP The Mount, the coroner noted evidence on the wide availability of drugs in the prison and that there had been a further four substance-related deaths at the same prison.[20] Another coroner made concerns about the drug clozapine and an NHS Trust's monitoring systems of it in 2020. Three years later, following an inquest into another clozapine related death, she made another PFD noting concerns that the Trust had not learnt from her previous 2020 report.[21]

23. We have also seen positive practice in cases where coroners have issued PFDs at the pre inquest hearing because of ongoing risks, acting in effect as an early warning system before the full inquest is held.

24. However, we are also aware of instances in which coroners identify areas of both local and national concern and do not issue a PFD because of assurances from Interested Persons (IPs) that changes have or will be made. One family told us:

    "[A private healthcare trust] were not issued with a PFD because they had made a spreadsheet of items they felt required improvement so the Coroner felt that they had already done that job for her - however, the CQC inspection conducted […] into [facility run by the private healthcare trust] where my daughter died showed that few, if any, of these recommendations had actually been implemented and the hospital was downgraded."

25. In the recent judgment of *Dillon v HM Assistant Coroner for Rutland and North Leicestershire* [2022] EWHC 3186, which relates to the case of Nile Dillon who died of an asthma attack at HMP Stocken, Nile's family challenged the coroner in this case for not issuing a PFD to the prison, despite the inquest finding staff were not adequately trained in how to respond to a 'code blue' alert. The coroner considered that steps taken by the MoJ in response and commitments to take action by the Prison Service, combined with changes to staff training levels within the prison, obviated the need for a PFD.[22] The High Court found that the coroner's decision was a lawful one and that she was entitled to take into account commitments by the MoJ and Prison Service in her decision that the threshold for a PFD report was not met.

697792489185/IAPDC+PFD+project+report+September+2023+-+FINAL+FOR+PUBLICATION.pdf, September 2023

[20] The substance in question is redacted in the PFD. For more information, see the PFD issued following the death of Kristopher Tilbury, https://www.judiciary.uk/prevention-of-future-death-reports/kristopher-tilbury-prevention-of-future-deaths-report/

[21] For more information, see the PFD issued following the death of Ian Allen, https://www.judiciary.uk/wp-content/uploads/2020/10/Ian-Allen-2020-0161.pdf and the PFD issued following the death of Mohammed Hussain, https://www.judiciary.uk/prevention-of-future-death-reports/mohammed-hussain-prevention-of-future-deaths-report/

[22] The coroner did however request that the Prison Service write to her within 56 days to confirm arrangements for "spot checks" to ensure all staff had an adequate understanding of emergency procedures.

26. INQUEST's primary concern in instances such as this is that mere assurances from IPs do not have the force or impact of a PFD. Without a publicly available PFD, there is no transparency in the commitments made by an IP, nor is there an avenue, prescribed in statute, through which a coroner or the public can track progress as the IP is under no responsibility to respond to the coroner. The opportunity for more national learning following the PFD is also lost. Further, as the experience in paragraph 24 shows, circumstances which may warrant additional scrutiny and accountability can worsen.

27. The Chief Coroner's guidance on the publication of PFDs makes clear that where a coroner becomes "*concerned about circumstances that create a risk of future deaths, the coroner must make a report to the person or organisation that the coroner believes should take preventative action*".[23] INQUEST's understanding of this guidance is that PFDs must be issued if the evidence gives rise to such a concern *even if* IPs state that changes have or will be made. <u>While we appreciate it is a coroner's ultimate decision whether to issue a PFD, we believe stronger guidance from the Chief Coroner on the importance of PFDs to aid local and national improvements is needed.</u>

28. INQUEST is also extremely concerned that there are several solicitors' firms representing state bodies at inquests that publicise their services in giving advice on the avoidance of PFDs.[24] More concerned about reputation management, this undermines the purpose of inquests and their potential to assist organisational learning.

Placing bereaved families at the heart of the Coroner Service

29. This committee asks what progress has been made in placing bereaved families at the heart of inquests, which was a central concern and recommendation from its 2021 report on the Coroner Service. The government have repeatedly stated their commitment to ensuring bereaved people are put at the heart of inquests and that the inquest process is "*as sensitive as possible to their needs*".[25] In their December 2023 response to the Bishop James Jones Review on the experiences of families bereaved by the Hillsborough football disaster, the government reiterated this commitment.[26]

30. The evidence from INQUEST's casework service shows that the reality of whether families are placed at the heart of the Coroner Service remains a mixed picture. The responses from bereaved families to INQUEST's survey further evidence this: of the

[23] Chief Coroner, Prevention of Future Deaths Reports Publication Policy, https://www.judiciary.uk/wp-content/uploads/2021/11/PFD-publication-policy-9-11-21.pdf
[24] See the following articles: https://www.ridout-law.com/handling-an-inquest-its-all-in-the-evidence/; https://www.hilldickinson.com/insights/articles/challenging-prevention-future-death-pfd-reports-when-and-how-do-it
[25] The Coroner Service: Government Response to the Committee's First Report, https://committees.parliament.uk/publications/7221/documents/77640/default/, September 2021
[26] Home Office, A Hillsborough legacy: the government's response to Bishop James Jones' report, https://assets.publishing.service.gov.uk/media/5a821d79ed915d74e6235dce/6_3860_HO_Hillsborough_Report_2017_FINAL_WEB_updated.pdf, December 2023

15 responses received, six families said they did not feel put at the heart of the inquest into their relative. Five families felt they were "*to some extent*" while only two answered "*yes*" (a further two answered "*other*"). Research carried out by Manchester Metropolitan University, in collaboration with INQUEST, also found families were "*not typically at the heart of the coronial system*".[27] Some families told us their views were heard during the inquest process whereas others felt marginalised. While some families were supported, others felt they were patronised. Families consistently tell us of the stress, agony and re-traumatisation experienced during the inquest process.

31. Various aspects of the inquest process impact on whether families feel prioritised or listened to, including the level of information shared with them on the process and their legal rights, the conduct of coroners and lawyers and the ability to raise complaints or appeal a hearing.

Families' access to information on the Coroner Service

32. An enduring problem for many families is the dearth of adequate or timely information on what to expect from the inquest process and what their rights are – an issue examined in this committee's previous report.[28] In response to this committee's recommendation that Senior Coroners ensure the updated version of the Guide to the Coroner Service leaflet is available online and in hard copy where needed, the government said it accepted the recommendation that more needs to be done to make families aware of this information, and said it would provide hard copies of the Guide to coroners courts "*where there is sound reason for doing so*."[29] INQUEST caseworkers understand that many families receive the Guide by email. However, they are still aware of instances in which coroners fail to provide families timely information. By way of an example, families who's relative has died following contact with the police rarely receive a leaflet developed jointly with INQUEST, the NPCC, Chief Coroner and the IOPC.[30]

33. In addition, our casework has revealed that access to literature on the Coroner Service is only part of the problem for bereaved families. A continuing challenge for families is that there is not always a focal point within coroners' courts to help explain the information provided and overwhelmingly most of the families who seek INQUEST's help still feel completely lost on the process.

34. For example, families described communication with coroners' courts as "*poor*" or even "*terrible […] I often didn't know what was going on*". Families also told us they had a different point of contact each time they spoke with the coroner's office, with

[27] Manchester Metropolitan University and INQUEST, Exploring Inquests, Learning disability, autism, mental health and the coronial process: Research Summary, 2023
[28] Justice Committee, The Coroner Service, https://committees.parliament.uk/publications/6079/documents/75085/default/, May 2021, pg 18-9
[29] The Coroner Service: Government Response to the Committee's First Report, https://committees.parliament.uk/publications/7221/documents/77640/default/, September 2021
[30] HM Government, Deaths in police custody: a leaflet for family members, https://assets.publishing.service.gov.uk/media/5c0feb4940f0b60bacefd1ee/CPFG_Leaflet_plain_HM_Gov_colours_FINAL.pdf

one family noting the vast contrast in conduct between two different coroner's officers they spoke to. Another family told us: "*The Coroners service did not provide us with any information as to what to expect from the inquest or how we should be prepared. […] Not aware at first that we would need the support of a solicitor and a barrister, felt as though we were on trial*." A lawyer in the Inquest Lawyers' Group told us about the experience of one family who's relative died in the summer of 2023. The family have not yet received a post-mortem report and their numerous emails and calls to the coroner's office have gone unanswered: "*they [the bereaved family] are completely unclear as to the nature and progress of the investigation […] they've been given literally no information*."

35. The way in which bereaved families are told what to expect in the early stages of the inquest process requires care and consideration, particularly given the fact many families will be in the early stages of grief. Regular updates and clear information from coroners' courts is also vital given the delays many families experience. The poor and inconsistent levels of communication evidences the need for much better investment in coroners' courts to enable adequate and sensitive communication with families on the process and their legal rights. INQUEST echoes the Chief Coroner's concerns, expressed in his most recent annual report from 2021/22, over the current level of funding some local authorities are providing to coroners' courts. He states that he "*encountered some regrettable examples of authorities failing to provide an acceptable level of funding*" resulting in issues with capacity and staff retention.[31]

Conduct of coroners

36. The conduct of a coroner is another important factor in determining a families' experience of the inquest hearing. INQUEST is aware of extremely good practice, where coroners have facilitated full and fearless inquest hearings. We heard from families who had positive experiences of coroner conduct, with some describing the coroner in their case as "*amazing*", "*exemplary*" and "*excellent*". Such practice is often linked to families feeling respected, listened to, and ultimately understood or having a coroner who they felt was thorough during the hearing.

37. In contrast, some families report experiences of patronising or "*cold*" coroners. One family described how the coroner presiding over the inquest into their relative rushed proceedings through because they seemingly wanted to "*get home early*". Two respondents to our survey even said they believed the coroner in their relative's inquest to be biased.

38. INQUEST is aware of a concerning case involving an individual who died shortly after discharge from mental health detention. The assistant coroner limited the questions from the family barrister and routinely interrupted them while allowing witnesses from the NHS Trust to 'correct' their evidence.

Conduct of lawyers representing public bodies

[31] Chief Coroner, Report of the Chief Coroner to the Lord Chancellor Combined Annual Reports for 2021 and 2022, https://assets.publishing.service.gov.uk/media/657af8cd095987001295e0dd/chief-coroner-report-2021-2022.pdf, December 2023

39. As discussed in INQUEST's previous submission, the conduct of lawyers representing public bodies at inquests can also have a considerable impact on families' experience of the hearing.[32] In response to this committee's previous concerns regarding steps taken to avoid the inquest process from becoming adversarial, the MoJ have published a revised Guide to the Coroner Services for Bereaved People[33] and a protocol on the approach government lawyers should take.[34] The MoJ also held a conference for lawyers on the importance of the inquisitorial approach to which INQUEST and families contributed.

40. Our recent casework shows these efforts have not been sufficient to mitigate against adversarial conduct from state lawyers and the harm this can cause for families. Some families said lawyers acting for the state were "*manipulative, risk averse, unwilling to admit any responsibility*", "*overly defensive"* with "*no care or compassion for our loss*". One family described state lawyers as "*trying to deflect blame*" while another said they "*were playing video games and surfing the net during evidence*."

41. INQUEST is aware of cases in which state bodies have instructed Kings Counsel who have strenuously cross-examined friends and family members of the deceased in a highly adversarial fashion. In one case a member of the Inquest Lawyers' Group worked on, a close friend of the bereaved was subjected to cross-examination on behalf of an NHS Trust and accused of 'making up' inappropriate advice that had been given by NHS staff. The coroner found that she was telling the truth, and that the NHS Trust's failings had contributed to the death of her friend. Without legal representation, the bereaved would be unable to challenge state bodies in cases like these, and would also have to endure an extremely traumatic, adversarial process alone.

42. Another member of the Inquest Lawyers' Group told INQUEST that a lawyer representing an NHS Trust

    "asked snide questions to get my client to confirm that whilst she was a doctor, it was via an arts PhD rather than as a medical doctor […] the coroner publicly berated my client and demanded she 'apologise' to the lawyer for the Trust whilst on the stand […] This was humiliating and upsetting for the family. The behaviour of the lawyer and coroner compounded their existing sense of injustice and not being taken seriously."

Appeals and complaints

[32] INQUEST submission to the Justice Select Committee Inquiry into the Coroner Service, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e404f863-cdfb-47b6-8e34-a65118520331, September 2020
[33] Ministry of Justice, Guide to the Coroner Service for Bereaved People, https://assets.publishing.service.gov.uk/media/5e258ec240f0b62c52248094/guide-to-coroner-services-bereaved-people-jan-2020.pdf
[34] Solicitors Regulation Authority, Competences for lawyers practising in inquests in the Coroners' Courts, https://www.sra.org.uk/solicitors/resources/practising-coroners-court/competences-lawyers-practising-inquests-coroners-courts/, September 2021

43. Families' problems with coroners or the inquest process more broadly is exacerbated by both the lack of a functioning appeals system and the difficult complaints process.

44. The government rejected the committee's 2021 recommendation that an appeals system be established to challenge coroners' decisions, although they accepted that there is merit in considering additional mechanisms for an appeal and stated that it would need to assess the proportionality of this. We would welcome an update on the decision of its analysis and whether the government is any closer to establishing a system of appeals.

45. Families and lawyers continue to raise the need for an appeals system.[35] A member of the Inquest Lawyers' Group alerted INQUEST to a case involving the self-inflicted death of someone under the care of a community mental health team. There were several concerning aspects with how the inquest was run, including the fact the coroner refused to disclose medical records seen by the NHS Trust to the family for months and also refused to allow counsel for the family to make oral submissions on the inquest's conclusion. This meant the family were expressly prevented from presenting their view on the type of conclusion and arguments on the engagement of Article 2. Despite this unsatisfactory situation, the family involved were not eligible for funding for a Judicial Review of the inquest outcome and, in the absence of an appeals process, had no way to challenge the conduct of the inquest.

46. Both INQUEST and this committee have previously raised the lengthy and difficult process of complaining about a coroner to the Judicial Conduct Investigations Office, which continues to be a problem for some of the families we work with.

Pen portraits

47. Pen portraits – which allow the coroner and, if applicable, the jury to learn more about the life of the person who has died – are an important way of commemorating a loved one. The Chief Coroner's 2021 guidance confirms this and welcomes the approach of pen portraits. The guidance notes that there will be cases in which pen portraits are not appropriate but that these are "*rare exceptions*" and otherwise a coroner should inform families in advance to confirm they are allowed to show a pen portrait.[36]

48. Positively, ten of the 15 respondents to INQUEST's survey were allowed to provide a pen portrait. However, we are extremely disappointed that some families still report instances whereby a coroner has refused to allow the family to provide a pen portrait of their loved one. We still hear from families who were unaware they were able to

[35] Family Consultation Day on deaths of people with mental ill health, a learning disability or autism, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=6f8b416f-adce-4c5e-9a9b-3c435f71d767, April 2023, page 31

[36] Chief Coroner, Guidance No. 41 Use of 'Pen Portrait' Material, https://www.judiciary.uk/wp-content/uploads/2021/07/Chief-Coroners-Guidance-No-41-Use-of-Pen-Portrait-material.pdf, July 2021

have a pen portrait or received confusing information regarding this part of the process.[37]

49. We welcome the Chief Coroner's proactive response and continuous encouragement of pen portraits, most recently in his annual report and response to the Bishop's Review in which he states "*the practice of admitting pen portrait material is one I personally encourage*."[38] It is vital this practice, which is a practical way in which families can feel at the centre of the inquest hearing, continues to be actively promoted and clearly communicated to families by coroners.

50. Overall, the continuance of many of these issues facing families – from difficulties in accessing information, to adversarial conduct at hearings – shows that families are not always placed at the heart of the inquest process. We repeat the recommendation made previously to this inquiry that the Chief Coroner establish a regular advisory group or forum to consult directly with bereaved people and the organisations which support them to enable feedback on the inquest process and help encourage improvements to the system for families based on their experiences.

What progress has been made by the Government in implementing those of the Committee's earlier recommendations which it accepted in September 2021?

Legal Aid

51. This committee's 2021 report made the following recommendation on legal aid for families at inquests:

    The Ministry of Justice should by 1 October 2021, for all inquests where public authorities are legally represented, make sure that non-means tested legal aid or other public funding for legal representation is also available for the people that have been bereaved.[39]

52. In response, the government agreed that access to legal aid for families should be simplified and have since introduced two significant reforms. Firstly, in January 2022 the rules for Exceptional Case Funding (ECF) for inquests were changed to remove the means test.[40] Following this, in May 2023 the government announced it would also remove the means test for legal help for inquests involving a potential breach of rights under the ECHR (within the meaning of the Human Rights Act 1998) or where

[37] INQUEST, Family Listening Day, Families' experiences of the coronial process following deaths in police custody or prison, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=aad6f0dd-8b4c-46d2-a84b-20c64fb7a197, September 2023, pg 19-20
[38] Chief Coroner, Response to the Right Reverend James Jones KBE Report on the Experiences of the Hillsborough Families, https://www.judiciary.uk/wp-content/uploads/2023/06/Chief-Coroner_Response-to-the-Bishop-James-Jones-report_final_061223_2311-1.pdf, December 2023
[39] Justice Committee, The Coroner Service, https://committees.parliament.uk/publications/6079/documents/75085/default/, May 2021
[40] Legal Aid Agency, Civil news: exceptional case funding for families inquests, https://www.gov.uk/government/news/civil-news-exceptional-case-funding-for-families-at-inquests, December 2021

there is likely to be a significant wider public interest in the individual being represented at the inquest.[41]

53. These two reforms are considerable steps forward to ensure bereaved families involved in inquests where Article 2 (the right to life) is engaged are funded without having to go through a complex and intrusive application process.

54. However, these reforms do not go far enough. Importantly, they do not satisfy the requirements set out in the recommendation made by this committee that bereaved families at *all* inquests where the state is represented are publicly funded for their legal representation.[42] In their response to the Bishop's Review recommendation that there should be equality of arms for bereaved people, the government said they will consult on expanding legal aid to victims of public disasters or terrorist incidents, further ignoring the recommendation being made.[43]

55. Many key findings on the conduct of state bodies arise from cases in which Article 2 may not be arguable, such as in the following cases:

    - healthcare-related deaths in detention;
    - self-inflicted deaths of voluntary patients in mental health settings or under the direct care of a mental health trust in the community;
    - deaths in supported accommodation or in care settings where the person has been placed by a public body or local authority;
    - armed forces veteran suicides involving both mental health trusts and the Ministry of Defence.

56. Many of the families involved in these cases would still have to pay out of pocket for their legal representation, crowd-fund, or go unrepresented.

57. A recent example of the unfairness of the current legal aid system is the inquest into the death of Ruth Perry, a headteacher who took her own life following an inspection by Ofsted. Ruth's family were forced to crowdfund to be legally represented at the inquest, while three public bodies had top legal teams at public expense. At the inquest into Ruth's death, the coroner made clear the significant disadvantage the family of Ruth Perry would have been in without their legal team. The coroner made a PFD which has resulted in the suspension of Ofsted inspections until the roll out of mental health training for inspectors. See Annex I which includes additional cases that illustrate why the government's reforms to legal aid for inquests do not go far enough.

[41] Written Ministerial Statement, Government Response to Legal Aid Means Test Review, https://questions-statements.parliament.uk/written-statements/detail/2023-05-25/hcws809, May 2023
[42] Justice Committee, The Coroner Service, https://committees.parliament.uk/publications/6079/documents/75085/default/, May 2021
[43] Home Office, A Hillsborough legacy: the government's response to Bishop James Jones' report, https://www.gov.uk/government/publications/hillsborough-disaster-report-government-response/a-hillsborough-legacy-the-governments-response-to-bishop-james-jones-report-accessible, December 2023

58. Further, we heard from members of the Inquest Lawyers' Group about instances in which coroners defer making a decision on whether an inquest engages Article 2 until the end of the inquest. This can cause uncertainty and anxiety for families on whether they are entitled to Legal Aid Agency funding.

59. We recommend that legal aid entitlements are widened so that bereaved families at *all* inquests where the state is represented or involved are publicly funded for their legal representation.

60. INQUEST believes short term investment in greater legal aid or public funding capacity for families at inquests will contribute to long term savings: deaths are expensive, and investigations and inquests are often retraumatising for bereaved people. Any efforts to strengthen the preventative qualities of inquests – which funding will do – is crucial and would help to facilitate learning and avert future deaths and risks to health and safety more generally.

61. Further, INQUEST and the Inquest Lawyers' Group are concerned about the possible implications of changes made by the MoJ to the Fixed Recoverable Costs (FRC) regime with regard to families' access to legal representation and justice. The government has extended the Fixed Recoverable Cost (FRC) regime to more areas of law, including inquests. FRCs set the amount the winning party can claim back in civil litigation. We do not consider the MoJ has fully engaged with the consequences of FRC and how the proposals impact on the state's procedural obligations under Article 2 ECHR.[44]

Duty of candour on public officials

62. In its 2021 report, this committee recommended the government consider whether a duty of candour should be extended to all public authorities at inquests.[45] The government said it would defer responding to this recommendation until it published its response to the Bishop's Review, which also recommended the government establish a duty of candour for the police and called for the government to consider Hillsborough Law (the Public Authority Accountability Bill) which would introduce a duty of candour on all public bodies.

63. The government have now proposed a duty of candour on the police as part of the Criminal Justice Bill 2023. While a step forward, we believe a duty of candour needs to apply to all public authorities to ensure an effective end to evasive and obstructive practices following contentious deaths. State-related deaths, and major incidents such as the Hillsborough disaster or Grenfell Tower Fire, commonly involve many different public agencies from local authorities to health services. Without ensuring a duty of candour that applies to all involved in relevant investigations, the culture of

[44] INQUEST and Inquest Lawyers' Group, Fixed Recoverable Costs (FRC): Consultation on issues relating to the new regime, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e89793c2-6004-49d3-b18b-a20fbb615b1a, July 2023
[45] Justice Committee, The Coroner Service, https://committees.parliament.uk/publications/6079/documents/75085/default/, May 2021

institutional defensiveness, denial and delays will continue, and the fundamental purpose of such investigations – to prevent future deaths – will continue to be undermined.[46]

64. We detail below the recent experience of an INQUEST caseworker attending an inquest with a family we are supporting, which emphasises the need for a stronger duty of candour on all public authorities. This example involves Essex Partnership University NHS Foundation Trust, (EPUT) who are now being investigated as part of a statutory public inquiry. This inquiry was put on a statutory footing after the previous Chair wrote in an open letter that a non-statutory inquiry would not allow the inquiry to meet its aims and that, despite duty of candour regulations on health and social care providers, only 11 out of 14,000 members of current or previous EPUT staff had agreed to provide oral evidence to the inquiry.[45]

    Lawyers for the EPUT NHS Trust provided very late disclosure of key evidence which almost derailed the inquest three weeks before it was due to start. Witnesses during the inquest behaved so appallingly the jury complained to the coroner that members of staff were intimidating them by staring at them all day. Two witnesses were seen by the jury high fiving after their evidence in the back of court. The coroner then ruled that witnesses would not be allowed to sit in court during each other's evidence. Despite a ruling that staff were not to speak to each other during evidence one member of staff waited outside the courtroom door for his colleague who was mid-evidence and started running towards her when she left the court room. The coroner issued a reporting restriction due to concerns that witnesses would collude, corroborate, or seek to interfere with each other's evidence. One member of staff admitted in evidence that a union rep […] wrote her statement for her. She also admitted to falsifying observations records.

65. The behaviour of EPUT witnesses demonstrated a culture of dishonesty and unwillingness to engage openly, honestly and transparently with the post-death process and inquest. The lack of candour hindered the family and coroner getting to the truth of 'how' the young person died, thereby avoiding the opportunity to learn lessons from individual, systemic and operational failures.

66. We welcome the government's announcement to conduct a review into the effectiveness of the duty of candour for health and social care providers, as we have worked on many cases, such as the one cited above, where this duty has arguably not been complied with.[47]

[46] For more information, see INQUEST, JUSTICE and Hillsborough Law Now Campaign's briefing for second reading of the Criminal Justice Bill 2023, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=bacb2d3f-643c-45d2-80e0-ec2b54accc72, November 2023

[47] Home Office, A Hillsborough legacy: the government's response to Bishop James Jones' report, https://www.gov.uk/government/publications/hillsborough-disaster-report-government-response/a-hillsborough-legacy-the-governments-response-to-bishop-james-jones-report-accessible, December 2023

67. The government deferred their response to this committee's recommendation that there be a charter of rights for bereaved people modelled on the victims' code to their response to Bishop's Review. In December 2023, the government said they "*strongly agree*" with the principles of a charter and have signed up to the Hillsborough Charter to learn lessons from the Hillsborough disaster.[48]

68. It is worth noting that the Bishop's Review only recommended a charter for people bereaved through public tragedy, whereas this committee recommended a broader charter of rights for all bereaved people going through the coronial system. Therefore, we believe the government should provide an updated response to the committee on whether the charter will outline the rights for bereaved people.

69. Further, while symbolically important, we do not believe an unenforceable charter is enough to address or prevent the challenges bereaved people face during inquests and investigations into state-related deaths. Rather, we believe a duty of candour with appropriate sanctions on all public bodies, as stipulated in Hillsborough Law, is necessary.

Consistency across the Coroner Service

70. The committee asked "*[w]hat more can be done to reduce regional variation and ensure that a consistent service operates across England and Wales*". Much of INQUEST's previous evidence on inconsistencies across the coroner service remains true. This was reflected in the family testimony documented in our two recent Family Listening/Consultation Day reports.[49]

71. The committee recommended the government establish a coroner service inspectorate to improve consistency across the service. The government said this required a cost analysis, but we are not aware that one has been undertaken or that the results of one have been made public. We recommend the government respond to this inquiry with the most recent analysis on whether to establish a coroner service inspectorate.

72. INQUEST believes a coroner service inspectorate and an appeals system would go some way to reducing inconsistencies – or what this committee has previously called a "*postcode lottery*" – which exists across the inquest system. Similarly, families have

[48] Home Office, A Hillsborough legacy: the government's response to Bishop James Jones' report, https://www.gov.uk/government/publications/hillsborough-disaster-report-government-response/a-hillsborough-legacy-the-governments-response-to-bishop-james-jones-report-accessible, December 2023

[49] INQUEST Family Listening Day report with Birkbeck's Institute for Crime & Justice Policy Research in partnership with the Centre for Death and Society at the University of Bath on Families' experiences of the coronial process following deaths in police custody or prison, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=aad6f0dd-8b4c-46d2-a84b-20c64fb7a197, September 2023; INQUEST's Family Consultation Day report on deaths of people with mental ill health, a learning disability or autism, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=6f8b416f-adce-4c5e-9a9b-3c435f71d767

shared their recommendations for change with us, which include "*scrutiny from external examiners*" as well as more funding for the coroner service and stricter guidelines to ensure consistency.

73. Ultimately, however, INQUEST's view remains that a National Coroner Service would be a more adequate response to addressing the current inconsistencies across the service.

Delays

74. This committee asks "*[w]hether there is evidence that inquests are taking too long to be completed, and if so why, and what can be done in response*." Of the 15 families who responded to our survey, six had to wait over a year for the inquest into their relative to be held. Three families had to wait for over two years. Only one family said they waited under a year despite guidance stating inquests should, where possible, take place in six months.[50] Families told us how delays "*had a huge impact on their mental health*", "*delayed grief/grieving*", and "*added to the stress and agony*" of the process.

75. The number of inquests open for more than two years has risen from 378 in 2017 to 1,760 last year.[51] As the Chief Coroner notes in his latest annual report, the average time taken to complete an inquest went up from 27 weeks in 2020 to 31 weeks in 2021, but dropped down to 30 weeks in 2022.[52] Some of the areas INQUEST are aware are experiencing long delays include the Isle of Wight, Cornwall, Cheshire, Hampshire and Inner West London. Delays are also a mixed picture, with varying practice across coroners' courts which shows the fundamental inconsistency across the service.

76. Of critical concern is how inquest delays preclude learning and the possibility to prevent future deaths. Recent deaths emphasise this point, such as the deaths of women at HMP/YOI Styal. In 2006 Baroness Corston led an independent review of women in the criminal justice system, brought about by six self-inflicted deaths of women with mental health issues in HMP/YOI Styal over a 13-month period in the early 2000s. INQUEST has witnessed the continued deaths of women in this prison. Since the publication of our report 'Still Dying on the Inside' on deaths in women's prisons[53], we are aware of a further 12 deaths in HMP/YOI Styal. [54] While the inquests into some of these deaths have now been listed, the delays are noteworthy:

[50] The Coroners (Inquests) Rules 2013, rule 8, https://www.legislation.gov.uk/uksi/2013/1616/article/8/made
[51] Coroner Statistical Tool, https://coroner-stat-tool-ext.apps.alpha.mojanalytics.xyz/
[52] Chief Coroner, Report of the Chief Coroner to the Lord Chancellor Combined Annual Reports for 2021 and 2022, https://assets.publishing.service.gov.uk/media/657af8cd095987001295e0dd/chief-coroner-report-2021-2022.pdf, December 2023
[53] INQUEST, Still Dying on the Inside, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=8d39dc1d-02f7-48eb-b9ac-2c063d01656a, May 2018
[54] This figure is according to INQUEST's casework and monitoring. Since 2006, the year in which the Corston report was published, INQUEST's casework and monitoring shows 26 women have died at HMP and YOI Styal.

Annelise Sanderson died in December 2020 and her inquest is taking place in January 2024, and the inquest into the death of Susan Knowles, who died in HMP Styal in May 2019, will not start until October 2024.[55]

77. Similarly, delays at West London coroners court are seriously affecting families bereaved by deaths in HMP Wormwood Scrubs. In 2023 Andy Slaughter MP raised this issue in Parliament, noting that:

"*Between April 2020 and February this year, there have been seven self-inflicted deaths at the Scrubs […] Any self-harm death in a prison is a potentially preventable one that deserves a rapid response to work out what went wrong and to implement learning for the future, but not one of those cases has yet made it to an inquest. An inquest for one of the families is scheduled for August this year, but that is over three years of waiting for answers. […] If an institution such as Wormwood Scrubs is waiting over three years for an inquest into the death of a prisoner and there is crucial learning that a coroner could uncover, how can that prison be expected to make the necessary changes?*"[56]

78. Many of the cases which have been delayed are likely to engage Article 2 of the Human Rights Act, requiring an enhanced level of investigation. There are legitimate questions over whether the ongoing delays across the coroner's service are impeding coroners' ability to discharge their Article 2 duties and ensure access to justice for families. Inquests are a crucial avenue to revealing harmful practice and working to prevent future deaths. Their ability to run in a timely manner must be viewed as a priority.

79. INQUEST acknowledges the balance needed to address and prevent delays while also ensuring there is adequate time to properly scrutinise deaths. We have previously noted that measures brought forward in the Judicial Review and Courts Act – which, *inter alia*, broaden the circumstances in which coroners can discontinue investigations, give coroners power to hold inquests in writing in non-contentious cases and enable wider use of remote hearings – could risk complex deaths not being scrutinised. Rather than imposing further restrictions on the number of inquests taking place, we believe the ongoing delays in inquests and the impact this has on families shows the need for greater investment in the coroner service.

Covid-19

80. The committee asks whether the Coroners' Service has "*recovered from the challenges of the Covid-19 pandemic*". The pandemic saw an expansion in the use of remote attendance at inquest hearings. Provisions for remote attendance were extended as part of measures in the Judicial Review and Courts Act 2022.[57]

[55] For more information, see the Cheshire Coroner Service website, https://www.warrington.gov.uk/cheshire-coroner-service/inquest-hearings?page=5
[56] Commons Debate, His Majesty's Prison and Probation Service, https://hansard.parliament.uk/Commons/2023-07-04/debates/A48BEBE3-ED93-4E2F-8254-3D1E2FCAD991/HisMajesty%E2%80%99SPrisonAndProbationService#contribution-45A5FDDB-967C-4945-A09F-E792A5C2E4F1, July 2024
[57] Judicial Review and Courts Act 2022, part 2 section 41, https://www.legislation.gov.uk/ukpga/2022/35/contents

81. INQUEST and the Inquest Lawyers' Group have previously made clear our position on remote inquest hearings.[58] We have seen remote pre-inquest reviews working well during the pandemic and understand some families welcome remote inquest hearings. Further, we are aware that there can be additional benefits of remote hearings in facilitating wider participation for public and media access. However, we have heard a much greater number of negative views on and accounts of the experiences of remote inquests from bereaved families.

82. INQUEST is aware of cases in which attending inquests remotely from home has added to, rather than diminished, their distress. We are also concerned that remote hearings make assumptions about families' access to the internet or a computer. In the case of Darrell Sharples, for example, Darrell's family were informed at a very late stage in the inquest process whether the case would be wholly or partly remote. The family informed their lawyers that this caused them great concern because the family did not want to participate remotely. In addition, they did not have the facilities in their home to do so. The inquest was ultimately conducted as a hybrid hearing, with some parts carried out online and others in-person.

83. We believe the MoJ should conduct an evaluation of remote inquest hearings to assess their possible impact on families, as well as on the principles of accessibility, transparency, participation and open justice.

Conclusion

84. INQUEST's work has consistently shown the great importance of the Coroner Service. It is a critical arm of the UK's investigative system, assists holding public bodies to account, and can help families understand the truth of how their relative died. Inquests can and should be a forum from which deficiencies in organisations and institutions can be uncovered and dangerous practices exposed to enable learning.

85. In analysing the experiences of bereaved people from the conclusion of this committee's previous inquiry to the present, it is apparent the Coroner Service still suffers from fundamental inconsistencies and inadequate resources to enable it to properly respond to families' concerns. Families can still expect some uncertainty over whether they will experience a full and fearless inquest, or a re-traumatising, highly adversarial hearing.

86. Our recommendations are drafted with a view to seeing broader improvements to the system for all bereaved families going through inquests where state bodies are involved, and facilitating the cultural changes needed to ensure a properly preventative system. This is in both families' and the public interest.

[58] INQUEST and Inquest Lawyers Steering Group, Judicial Review and Courts Bill Briefing for Committee Stage: Part 2, Chapter 4, Clauses 37, 38 and 39, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=82aaf325-60a1-4cfc-9678-c164d299e191, October 2021

Annex I: Additional case studies showing the need for legal aid or public funding for all bereaved families during inquests where state bodies are involved.

Tina Robson was 35 years old when she was found dead in Bridge House Mission in Stockton on Tees on 26 July 2020. Tina was considered a vulnerable adult and was subject to a safeguarding enquiry and a Police Public Protection Order. The charity run housing at Bridge House Mission is funded by Stockton Borough Council as short-term accommodation for people in need of housing related support, primarily individuals with 'complex needs'. Despite Tina's engagement with public services and concerns around the housing placement, the coroner refused to engage Article 2 of the Human Rights Act. As such, Tina's family were denied legal aid for the inquest but successfully crowdfunded over £5,000 for representation. The council were represented at public expense. The inquest exposed issues around the housing-related support offered by Bridge House Mission and the decision to offer Tina accommodation there.[59]

Leo Toze was 17 years old when he died by suicide in September 2021. Leo had a childhood diagnosis of Autism and was under the care of CAMHS for depression. In the week leading up to his death Leo was twice visited by police officers after posting on social media that he planned to take his own life. The coroner in Leo's case did not engage Article 2 and public funding was not available. The family relied on pro bono representation that was arranged only days before the final inquest in January 2023. Other interested persons represented at the public expense were East London NHS Foundation Trust and Bedfordshire Police.[60]

Cristian Vallejo, 31, was a Colombian national resident in the UK. He was found unresponsive by members of the public in London's Green Park on 9 July 2019. He had died from postural asphyxia and drug intoxication and toxicity whilst on leave from a mental health hospital and subject to a Community Treatment Order. Article 2 was refused and the family were not able to access public funding and relied on pro bono representation. North west London NHS Foundation Trust were represented at the public expense.[61]

Dany Forster, 45, had a history of mental ill health and substance misuse. He was being housed by a charity in Manchester. In December 2020, Dany disclosed to staff that he was mentally unwell and needed help. Dany was later seen sitting straddling his windowsill on the third floor and staff called the police for assistance. Six officers attended but only two remained. They spoke with Dany for ten minutes before leaving. Minutes later, Dany fell to his death. Article 2 was refused by the coroner and legal funding denied by the Legal Aid Agency. The police force and NHS were represented at the inquest at the public expense and the family had to rely on a pro bono barrister who came forward the day before the inquest.

[59] INQUEST, Tina Robson: Inquest into death in supported accommodation for homeless adults finds misadventure, https://www.inquest.org.uk/tina-robson-inquest-closes, July 2022
[60] INQUEST, Leo Toze: Family of Bedfordshire teenager call for change after inquest hears evidence of missed opportunities to prevent his death, https://www.inquest.org.uk/leo-toze-inquest, January 2023
[61] INQUEST, Inquest into death of Cristian Vallejo explores home leave and care of mental health home treatment team in North London, https://www.inquest.org.uk/cristian-vallejo-opens, April 2021

Alexandra Greenway, a 23-year-old transgender woman from Bristol, died on 11 May 2019. Alexandra had long term issues with mental ill health, including depression and previous suicide attempts dating back to her teens. Just over a month before her death, on 10 April 2019 Alexandra was detained by police (under Section 136) after attempting to jump from a bridge. She was taken to the Bluebell Unit at Green Lane Hospital, who assessed that there was no imminent risk to her safety. Alexandra was discharged to the care of her GP and she was provided with the number of a crisis line in case things got worse. In October 2020, the coroner deemed that Article 2 had not been engaged in this case. Crucially, this meant Alexandra's family were not able to access legal aid for representation at the inquest, despite the fact the NHS were represented at the inquest at public expense. Through the help of INQUEST, a barrister was able to attend some of the inquest's hearings on a pro-bono basis. However, Alexandra's family felt the scope of the inquest was severely limited. Key systemic failings regarding the quality-of-care Alexandra received from her GP or mental health professionals at Avon and Wiltshire Mental Health Partnership NHS Trust were not examined. Without consistently funded representation throughout the process, the family found it extremely hard to make their wishes known to the coroner and engage meaningfully in the process.[62]

Alison Henley: Alison Henley was 53 years old when she died of an overdose at her home in Glossop, Derbyshire on 25 August 2016. She had been prescribed strong opiate pain medications due to a range of physical health conditions and was also experiencing serious mental ill health. Alison was engaged with mental health services at Pennine Care NHS Foundation Trust, and had previously seriously self-harmed and overdosed, including weeks before her death. She had been diagnosed with Emotionally Unstable Personality Disorder, anxiety and depression and had spent significant time in the mental health unit in Tameside General Hospital. The inquest into her death in October 2020 examined the monitoring of Alison's medication and physical healthcare, as well as the response to her mental ill health and previous suicide attempts by Tameside General Hospital, GPs and Community Psychiatric Nurses from Pennine Care NHS Foundation Trust and Cohen's Chemist. Alison's sister Kathryn was not entitled to legal aid for the inquest. She had to pay £36,000 in legal costs and face five other Interested Persons at the inquest who were all represented, with many at public expense.

Matthew Copestick: Matthew died on 8 January 2019. The inquest concluded that his death was sudden, unexpected and linked to alcohol dependency. Matthew's family were keen for his inquest to be as broad as possible in scope to understand the circumstances around his death. They paid privately for legal representation to make the case for the inquest to be Article 2 during the pre-inquest review, given systemic issues around detoxification pathways from A&E. Ultimately, the coroner decided that Article 2 was not in breach in this case, and therefore Matthew's family were not eligible for legal aid under ECF. Crucial failings were identified in the care Matthew received, including the fact that Matthew should have been admitted for inpatient detoxification four days prior to his death and that there was poor communication between staff on his case. Although it was ultimately decided that Matthew's case did not engage Article 2, with help from lawyers, the inquest into his death revealed critical findings about his care at the hands of the state. Given the state's

[62] INQUEST, Family of Alexandra Greenway, a trans woman who died awaiting therapy, devastated by coroner's findings, https://www.inquest.org.uk/alexandra-greenway-closes, October 2022

involvement, Matthew's family should not have been forced to pay out of pocket for legal representation, especially when the five other interested legal parties all had legal representation mainly paid for by the state.

Harry Richford: Although not an INQUEST case, we also wish to draw your attention to the case of Harry Richford who died seven days after childbirth at the Queen Elizabeth the Queen Mother hospital in Margate, Kent. Harry's family were not able to pay for specialist legal help needed to navigate the complex inquest process (in which NHS Trust lawyers dropped 1,400 pages of new evidence on the morning of the second day of the inquest). The family worked with their local MP and the organisation Advocate to secure pro-bono legal representation. Following the inquest into Harry's death, the Care Quality Commission confirmed it would be criminally prosecuting the Trust for unsafe care and treatment of both Harry and Sarah, his mother. Without legal representation. Harry's family may never have found out what went wrong in their son's care and there would have been no accountability for his death. It is unfair that state agencies were able to be represented at taxpayers' expense while Harry's family had to struggle to find pro-bono representation.

Coco Rose Bradford, a six-year-old girl with autism, was taken to hospital in Cornwall and died unexpectedly on 31 July 2017. In January 2022 the inquest into her death concluded, finding her death to be of natural causes (a finding Coco's family disputes). Coco's mother, Rachel Bradford, told the inquest how she watched her daughter die in front of her and how the hospital dismissed the family's concerns even though Coco was in glaringly obvious pain. Rachel gave evidence that Coco's autism played a role in how she was treated by medical staff and that the professionals wrongly viewed her as being uncooperative and noncompliant. This is a concern raised by other families in similar circumstances involving the death of someone with autism and/or a learning disability. Members of the local community donated to contribute toward the family's legal costs for the inquest. Coco's mother said in a personal statement: "Without our barrister offering to act pro bono at the inquest hearing we're not sure what would have happened. It seems desperately unfair that we have had to crowdfund to cover our legal fees, and rely on our barrister waiving her charges, when the hospital's legal team are paid for by our taxes."

ILG members also told us about other recent cases they have worked on where families whose loved one died in circumstances relating to a public body were not entitled to public funding:

- *"ECF refused for the family of a man who took his own life in the community after presenting to police and mental health services on consecutive days prior to his death with suicidal ideation, but who was not admitted to hospital for assessment or treatment, and had been on a waiting list for treatment for a personality disorder for 11 months […] ([legal team] ended up acting pro bono in the three-day inquest)"*

- *"ECF granted on second day of a four-day inquest into the death of an elderly Black man who suffered a broken hip during an incident in which officers threatened to taser him and then physically restrained him on the ground – he died in hospital two days after surgery for the broken hip (which the jury ruled was suffered when he fell after an officer threatened to taser him). Due to the*

delay in granting legal aid, counsel was not able to attend the first day of the inquest (and the solicitor did the advocacy pro bono/at risk)"

- *"[…] detained under s37/41 MHA and suffered from resistant paranoid schizophrenia as well as a number of physical health issues. The coroner found Article 2 was not engaged and the tests for ECF were not met. It was found to be a natural causes death."*

- *"[…] inquest into the death of a young woman who died from a self-inflicted death in a charity run crisis house. IPs included the Mental Health Trust who had placed her there, the charity (represented by the same solicitor as the MHT), the ambulance service and the police."*