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INQUEST's response to the draft Coroners Reform Bill

1. INQUEST is the only voluntary organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, MPs and wider public. In 2005 we worked on 282 cases advising over 1000 family members.

2. INQUEST has a free and detailed information pack for any bereaved family that explains the whole inquest process and where to find emotional and practical support. We work directly with the families and friends of those who die in all forms of state custody. This includes in prison, young offender institutions, immigration detention centres, police custody or while being detained by police or following pursuit and those detained under the Mental Health Act.

3. INQUEST welcomes the government's draft bill as a long overdue opportunity to reform one of the most ancient and archaic areas of the British legal system. INQUEST believes that the current inquest system is failing and in need of urgent reform. The system is especially ill equipped to deal with deaths that involve questions of state or corporate accountability. This submission summarises the concerns that have emerged from our 25 years of advising and supporting bereaved families, monitoring post-death investigations and attending inquests around the country.

4. This submission is the first of two INQUEST responses to the government's draft bill. This document deals primarily with policy issues that arise out of the draft bill, the second submission will deal with the specific legal changes we recommend be incorporated into the bill. We address the proposals in the bill responding to the generic problems experienced by bereaved families regardless of the circumstances of death and the specific issues that arise from the approach to contentious deaths and deaths in custody.

Association of London Government
● 89-93 Fonthill Road, London N4 3JH ● Tel: 020 7263 1111 ● Fax: 020 7561 0799
● Email: inquest@inquest.org.uk ● Website: www.inquest.org.uk
● Inquest Charitable Trust is a registered charity, number: 1046650 ● Company number: 03054853
Community Legal Service

5. Before outlining our responses to the government's draft bill we believe it is helpful to outline briefly the problems with the way the coroner's system is operating at present.

6 The current system

The coroner's system is one of the most neglected areas of law in the England and Wales. In contrast to the constant evolution of other legal and administrative structures and a more rights-based approach generally to public functions and services, the coroner's court has failed to evolve accordingly. This is of concern not only for the families who have lost loved ones in contentious circumstances, but also the general public. For democratic accountability, it is crucial that the inquest system works since it is the only public forum in which contentious deaths are subject to scrutiny.

7. INQUEST believes the current coroners system is failing bereaved families and the public at large. It operates as a fragmented, non-professional assortment of coroners who operate with no compulsory training and little accountability. This results in a postcode lottery of service with good practice dependent on the approach of individual coroners rather than agreed and inspected quality standards. Families' legal rights in proceedings are restricted (the rules governing inquest create a structure where the inquiry is not for them) and the administrative framework is not directed at their full inclusion in the process. There is no government funded information service for families who have to go through the inquest process and often families come to us having not been advised they can be legally represented or given any information about the inquest proceedings.

8 Deaths in state custody are not rare isolated incidents. Our research has shown that a shocking 2,120 people have died in prison and police custody between 1995 and 2005 and that a disproportionate number of these have been from black and minority ethnic groups1. An open, independent and efficient system of investigating deaths is custody is crucial in order to maintain public confidence in the care of the state and hold it democratically accountable. Recent high profile cases such as the deaths of Zahid Mubarak, killed in Feltham Young Offenders Institution

[1] INQUEST, *Families Experiences of Contentious Deaths*, (forthcoming 2006), p1

in 200l; Mikey Powell who died in police custody in 2003 and Jean Charles de Menezes shot whilst being pursued by the police in 2005, have reinvigorated public interest on how the state responds to deaths that occur in its custody.

9 Deaths in custody raise important issues of state power and accountability. When the state takes away a persons liberty it gains a responsibility for that person's welfare. In a free democratic society, deaths in state custody should be subject to the particularly close scrutiny.

10 At present the system of investigating deaths in custody continue to indicate a systemic failure to learn lessons: to review, revise and implement policies, instigate new training, to share and disseminate information and guidance across different state agencies. They also demonstrate abuses of power because no one is held accountable and as a result cultures of violence, neglect, racism or indifference continue.

11 Despite some recent reforms in light of the Human Rights Act 1998, the inquest system still has a narrow legal remit of inquiry putting an artificial and invidious limit on the scope and style of conduct of the inquiry. This often excludes from the inquest the issues of greatest concern to the family. Inquests are too often at risk of being opportunities for official and sanitised versions of deaths to be given judicial approval - rather than being an opportunity for the family to discover the truth and full circumstances surrounding the death of their loved one.

12 Delays of one or two years to the inquest process are not uncommon. This causes difficulty for all concerned but particularly so for bereaved people who have described how their lives have been put on hold until they have been through the inquest process. As there is no public scrutiny of the death for such a long period, the opportunity for identifying what went wrong and to seek to prevent recurrences in the future and preventing other deaths is set back.

13 Most crucially the current system has no mechanism to monitor inquest findings or to take any follow up action with the relevant public bodies based on any issues that arise out of inquests. Unless the findings of inquests proceedings are recorded, analysed and acted upon issues of

systematic failure will never be addressed and more unnecessary deaths could occur.

14 Our casework over the last 25 years has indicated that the most pressing reforms that are needed are:

1. A extension of the remit of the inquest system
2. Changing the structure to create a national coroner service to improve service delivery and ensure high standards and accountability
3. Improvement to the support and information available to bereaved people
4. The introduction of a system of monitoring inquest verdicts and a statutory obligations on public bodies to respond to the findings of an inquest
5. Non-means tested legal aid for bereaved people
6. Specific action to be taken to counter lengthy delays

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The draft Coroner's Reform Bill 2006

15 INQUEST welcomes the bill as a long overdue piece of legislation that goes some way towards reforming an inquest system that has been inadequate and failing bereaved families for a long time.

16 There are however serious omissions in the draft Bill and many of the proposed changes simply do not go far enough. There is a risk that unless the government amends the Bill they will simply be tinkering at the edges of the system and will fail to deliver an improved service.

17 Much to our disappointment, INQUEST's main concerns as listed above are not sufficiently dealt with in the draft legislation. INQUEST echoes the sentiments expressed by the Constitutional Affairs Committee (CAC) who branded the draft bill 'a wasted opportunity' for reform in their initial report scrutinising the Bill in August 2006. We urge the government to amend the draft bill and ensure that it produces a modern efficient coroner's system fit for the 21st century.

18 Below we outline our specific responses to sections of the Bill and where we think there are additions needed or issues of concern. We are

particularly concerned that there is no concurrent public consultation on new draft Coroner's Rules as many of the concerns of bereaved families relate to issues that need to be addressed by amending the Coroner's Rules.

19 A) The purpose of the investigation

INQUEST believes that cases of deaths in custody warrant specific attention not only for those bereaved by a death but also for the public at large. This does not mean that every death in custody warrants a public inquiry (although increasingly, due to the inadequate nature of inquest investigations, families feel this is the only form of investigation in which they can get full and proper answers on a contentious deaths), but rather there must be a recognition, enshrined in law, that when a death occurs in state custody, the state it has a specific responsibility to ensure that a thorough, impartial and effective investigation is carried out. One of the purposes of any investigation into a death in custody must also be to learn any lessons that may arise out of a death so as to prevent similar cases occurring in the future. For example in Victoria, Australia the emphasis of the coroners' system is on death and injury prevention. It has been recognised in Victoria that there is an important public interest in learning lessons from preventable deaths. INQUEST urges the government to apply a similar ethos to the coroner's system in the England and Wales and to enshrine a positive duty on death prevention in any new legislation.

B) Provision of Information to Bereaved Families

There is inadequate provision of information and support to bereaved families facing inquests at all stages. This impacts on families' capacity to effectively participate in the inquest process. This has been recognised by government and addressed partially in the draft Charter for bereaved people. But the Charter alone without accompanying reform to ensure funding for legal representation, mandatory disclosure of information and a fully accountable Coroner Service will make it difficult for families to enforce the rights outlined in the Charter.

C) Coroner's system and the Human Rights Act 1998

INQUEST welcomes the government's acknowledgement that the impact of the Human Rights Act 1998 is that that the scope of any investigation into a death needs to be widened. We also welcome the proposal to extend the purpose of the investigation to include ascertaining "in what circumstances" the deceased came by his/her death.

However we are concerned that the Bill contains no direction as to the application of article 2 of the Human Rights Act with regards to investigations into contentious deaths. Although reference is made to issuing guidance before the Bill is implemented, we believe that this is an issue of such significance that it warrants specific instructions in primary legislation.

INQUEST believes that any guidelines drawn up on the application of Article 2 must state that an investigation must focus upon not only those who were allegedly directly responsible for the death but also on the planning and organisation of the state agency or operation that provided the context in which the death took place.

The Human Rights Act also impacts on the remit of an inquiry, which should not be limited to the cause of death, but where appropriate, should indicate those responsible. At present rule 42 of the Coroners Rules 1984 prohibits a jury from returning a verdict that determines an issue of criminal or civil liability on the part a named person. However this is likely to contravene the requirements of the Human Rights Act, especially in light of the Middleton ruling in Court of Appeal which upheld the view that an inquiry needs to look at 'by what means and in what circumstances' a person came to die.

INQUEST believes that an extension of the remit of inquiry is for the inquest system to have any meaning. In cases of deaths in custody, the bereaved and the public must be satisfied that a state agency has not waived its duties and checks and balances must be in place in order to apportion blame if and when it is due.

D) Statutory obligations on public bodies to act on inquest findings

The draft Bill mentions little about the need to monitor and analyse inquest findings. We are concerned that the only reference to this

potentially important role in the current draft Bill is essentially a repetition of the existing Rule 43 CR 1984.

Any new system must produce a system of learning from the investigations and inquests into custodial deaths. There should be central collation, publication and analysis of both coroner reports and jury findings.

We welcome the office of the Chief Coroner and would recommend it take on a statutory role of monitoring the service. Individual coroners should inform the office of the Chief Coroner on an ongoing basis of the content of any reports they make. We also welcome the collation of an annual report by the proposed Chief Coroner to Parliament and believe it should specifically setting out coroner reports and suggestions for change under department specific headings. Parliament should then ask the relevant department to report on what action has been taken. There should be an obligation on government departments to respond within agreed time limits and set out what they have done or present an action plan.

The Chief Coroner should notify the relevant investigation and inspection bodies of public agencies of coroners' reports. There should be an obligation for those who receive reports to respond to the Coroner, to the investigation bodies and the family concerned. Consideration should be given to a mechanism whereby such reports must be acted upon or explanations published for why reasonable action has not been taken.

The investigation bodies should be required to incorporate any coroner's reports and jury findings into their final report on each individual case. With regards to the police service and the prison service, both the Independent Police Complaints Commission (IPPC) and Prison and Probation Ombudsman (PPO) should collate relevant reports and jury findings, publish and circulate them and use them to monitor outcomes and improve practice.

It is essential that a system of monitoring and analysing inquest findings be introduced. This should be incorporated into Clause 12 of the draft Bill.

E) Legal Aid

At present there is no 'equity of arms' in terms of legal funding at inquests. This leads to imbalance in legal representation and reduces the chances of having an independent, fair and balanced investigation.

For families or other interested parties of the deceased to participate effectively in the investigation process they need legal representation. At present there is no automatic right to legal aid for families who are thrown into an inquest process through no choice of their own. A lot of work is still undertaken on behalf of bereaved people on a pro bono basis and yet unlimited public funding is available for experienced, good quality lawyers to represent the police, prison service and other public bodies. Those representing families have to make lengthy, complicated and time-consuming representations to the Legal Services Commission for the little funding they receive.

Like so many other issues arising from the inquest system, issues of lack of legal aid exacerbate the distress of families in cases of deaths in custody. Our research has shown that it can to the view that the inquest is simply about offering a sanitised versions of deaths to be given judicial approval.

INQUEST welcomes the government's introduction of recognising the rights of bereaved persons into the investigation process but without adequate legal funding, the role will remain defunct.

INQUEST recommends that measures are introduced to provide full, non means tested legal aid for families bought into the investigation process.

F) Delays

As mentioned above, delay in completing the inquiries after deaths in custody is one of the most serious issues that needs to be addressed – not only because of the impact it has on bereaved families but because of the effect on all involved in the aftermath of a death and on public confidence in the credibility of the whole system. Delays of one or two years between the death and inquest are not uncommon and recent inquests of Anne Marie Bates (a death and Roger Sylvester (a death in police custody) were not concluded for 5 and 4 years respectively.

The lack of timely public scrutiny of the circumstances of the death undermines the preventative potential of the coronial process and the ability of the coroner to report matters of concern to the relevant authorities. We have argued above that the investigation and inquest should play a monitoring role and learn the lessons of deaths but this becomes obsolete if an investigation does not take places until many years after a death. Delays frustrate the learning process where individual or systemic issues remain unaddressed pending the inquest. As there is no public scrutiny of the death for such a long period, the opportunity for identifying what went wrong and to seek to prevent recurrences in the future, learning the lessons and preventing other deaths is seriously delayed.

We hope that the boundary changes and moves towards a more professionalised coroner's service will go some way towards reducing delays in the system and we acknowledge the need for thorough investigations however the current situation of delays is unacceptable for all concerned.

INQUEST urge the government to include measures in its secondary legislation to address the issue of delays and, if necessary, for cases of contentious deaths, put in place a statutory maximum timeframe within which issues must be heard. This could form part of the Bereaved Person's Charter.

G) DISCLOSURE

At present there is no mandatory right to pre inquest disclosure of documentary evidence and this is a serious omission in the government's draft Bill. Whilst some voluntary protocols were introduced in 1999 in relation to deaths in custody, it remains the case that there is no automatic right to advance disclosure. In many controversial cases we have worked with disclosure has been difficult to obtain and furthermore sometimes even when it has been provided, the delay in its provision has not allowed sufficient time for adequate preparation by families legal teams. We remain concerned about the pace at which documents are disclosed, the lateness of disclosure and the withholding of critical documents until the day of the hearing. Documents should be disclosed to the family as soon as they become available.

By giving an automatic right to disclosure in deaths in custody cases, all parties would be assisted and it would remove some conflict from the hearing itself. It also reduces unnecessary pain for bereaved people in that they do not have the shock and distress of hearing information about how someone died for the first time in public.

INQUEST recommends that at all inquests there should be full mandatory disclosure of all information (irrespective of whether the coroner intends to call the witnesses) and clear rules about when and how it will be made.

H) Juries

The draft Bill contains a proposal to reduce the number of jury inquests and the number of jurors. INQUEST opposes this proposal and believes it is of serious detriment to the service if it were to go ahead. Juries are fundamental to a democratic system as they are the only opportunity where ordinary people, independent of the state can participate in the judicial system. They have the effect of diffusing power into the community and in cases of contentious deaths are often seen by families as the key safeguard in terms of public accountability.

We are strongly opposed to the proposal in the Bill to scrap the automatic right to a jury inquest in cases of deaths at work. We find it surprising that whilst the government is in the process on introducing legislation on corporate manslaughter with one hand, it is removing one of the key planks in working towards corporate accountability with the other. We urge the government to reconsider this and its other plans to restrict the use of juries in inquests. INQUEST believes that there should be an automatic right to a jury inquest in cases of deaths at work and the government should remove this clause in its draft Bill.

I) Prohibiting publication of information

The draft bill contains some very worrying clauses regarding directions prohibiting the publication of information. The clause is drafted so loosely it gives very wide discretion to coroners and could restrict information of public interest being disclosed.

INQUEST joins the National Union of Journalists in being critical of the proposed changes which we believe will of detriment to the public interest cases. We urge the government to review this clause.

J) Resources and Administrative Issues

INQUEST joins the CAC, and British Medical Association and Coroners in criticising the lack of resources that will be made available for these reforms – the amount of funding that has been set aside by the Department for Constitutional Affairs is thoroughly inadequate. Justice and accountability do not come on the cheap.

Whilst there is an office of Chief Coroner is being introduced, Coroners will still not be part of a national organisation therefore the fragmented localised system will continue. Funding arrangements on a local level will remain the same resulting in the system depending on local authorities for the appointment and funding of coroners in some cases this will include funding from police forces which will not help cede families concerns that the coroners system works in favour of particular state agencies. Furthermore this continuation of funding from local sources will inevitably lead to a differentiation of funding between courts continuing the post-code lottery of service.

INQUEST urges the government to review the amount of money being allocated to the proposed reforms and to introduce a national system of funding and running the service.

K) Primary & Secondary legislation

Many of the proposals mentioned in the Bill are hard to evaluate due to the lack of detail with which they are addressed. It seems apparent that a considerable amount of secondary legislation will therefore be needed to accompany the Bill and make the proposals in it workable or in some cases even valid. INQUEST is concerned that the over use of secondary legislation for the accompanying sections of the Bill will mean that there will not be the necessary public and parliamentary scrutiny and therefore urge the government to stipulate more of the Bill's details particularly with regards to some of the issues raised in this submission in primary legislation.

INQUEST proposes that the government indicates the proposed additions to the Bill as soon as possible and as far as practical include them in the primary legislation.

20 In conclusion, a nationally funded and organised coroner service would ensure greater accountability and higher standards in the service. A structure that ensured better monitoring and follow-up of the outcomes of inquests would potentially have the impact of saving lives and ensuring the process is meaningful for bereaved families. It is imperative that the government acts on these recommendations to ensure that a democratic and accountable system for investigating contentious deaths in put in place.