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Briefing and suggested amendments to Coroners and Justice Bill 2009 -

House of Lords Committee Stage

June 2009

INTRODUCTION

INQUEST is a charity that provides a specialist, comprehensive, free advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. In the last ten years it has worked on 2,300 cases advising over 7,000 family members.

INQUEST is proud to be associated with the process of coroner reform and we broadly welcome and support the proposals relating to that process in the Coroners and Justice Bill. However, there are a number of defects of principle and practice which, if not eliminated or amended, cause significant concern.

The government's stated objective was to put the bereaved at the heart of the process. We believe that the Bill makes progress in remedying what has historically been an unnecessarily distressing situation for the families of the deceased and urge Members of Parliament to **vote for the Bill as a whole**.

We believe it will be a proud achievement if society has a coronial service that makes an important contribution to death prevention as the majority of bereaved families we work with are motivated by the hope that there will be accountable learning. A recurring theme common to virtually every family with whom we journeyed through the coronial system is simple: an unswerving desire that other families should not have to suffer the often preventable ordeal which they have had to endure.

Our briefing prepared for the Second Reading[1] provides more background:

1 http://www.inquest.org.uk/pdf/INQUEST_briefing_on_coroners_and_justice_bill_Lords_second_reading_15_May_2009.pdf

Clauses 2 and 3: Investigations by other coroners

Will this solve the problems of delay and complexity?

Delay in holding inquests into complex cases is a feature of the current failing system. Delays not only hamper the extent to which remedial action might be applied; they are also incompatible with the provisions of the Human Rights Act. They obscure the search for truth and, perhaps most significantly, they are utterly inhumane as they serve to prolong and intensify the pain for families.

We understand that these provisions, and other relevant parts of Part 1 of the Bill, will make it possible for a coroner's geographical area boundary restrictions to be relaxed, and for the Chief Coroner to "reallocate work between coroners in the event of backlogs of work building up in a particular area" (see paragraphs 68 to 74 of the Explanatory Notes).

This is a welcome change, as inquests are often substantially delayed due to the inability of coroners to find suitable venues within their geographical jurisdiction, or because of their own backlog of cases. Additional costs can also be incurred if a coroner is compelled to hire private facilities for the conduct of an inquest due to a lack of available court rooms within his or her geographical jurisdiction.

INQUEST welcomes the provisions enabling inquests to be more easily transferred to different coroners or venues but we are concerned that there will not be sufficient resources within the reformed system to enable these powers to make a real difference.

Suggestions:

- Setting a timeframe in secondary legislation: either provision for timetabling inquests or setting deadlines.
- Development of specialist areas of knowledge and excellence that could be a national resource.

Clause 5: Matters to be ascertained

We recommend:
Page 4, line 4 [Clause 5], at end insert –

> *'(2A) The senior coroner may determine that the purpose of any investigation shall include ascertaining the circumstances the deceased came by his or her death where –*
> *(a) the senior coroner is satisfied that there are reasonable grounds to determine that the continued or repeat occurrence of those circumstances would be prejudicial to the health and safety of members of the public or any section of it; or*
> *(b) the senior coroner is satisfied that there are reasonable grounds to consider such circumstances in the public interest.'*

One of the purposes of any investigations into contentious deaths – in particular deaths in state detention and those raising questions of public health and safety - must be to learn any lessons that may arise out of a death so as to prevent similar cases occurring in the future. We think that clause 5(1) defines the scope of all inquests too narrowly. There are clearly important cases involving questions of public health and safety where the Human Rights Act does not apply and where there is a need for a broader inquiry. For example: deaths raising concerns about transport and workplace safety; the death of a vulnerable older person in a private nursing home; or a death in a private workplace.

Clause 7: Whether jury required

We recommend:
Page 4, line 31 [Clause 7], at end insert `or'

> *'(d) that the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public.'*

We consider that juries are fundamental to a democracy 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 note that clause 7, while being modelled on the current s.8(3) of the Coroners Act 1988, widens the circumstances in which a jury must be summonsed; gives coroners a wide residual discretion as to when they may summons a jury (if they consider that there is "*sufficient reason*" for doing so); and that there will be a right of appeal to the Chief Coroner against a coroner's decision with respect to the summonsing of a jury.

We would, however, argue that in addition to the general discretion provided for under the new clause 7(3), **the law should continue to require an inquest jury in those cases which would currently fall within section 8(3)(d).**

We also raise a note of caution in that new clause 7(2) differs from the current Coroners Act 1988 clause 8(3) in that it does not specify that an inquest must be held with a jury if the death occurred in prison and was neither violent nor unnatural, or where the cause of death was unknown, or does not fall within the other criteria set out in 7(2) a – c. The intention here is to allow coroners discretion not to have a jury in cases of deaths of detainees where there is clearly no reason to do so. **However the new system must ensure that in those deaths that occur in prison or otherwise in state detention that are initially classified as by natural causes this does not become the default position.**

Clause 8: Assembling a jury

We recommend:
Page 4, line 39 [Clause 8],

> *leave out `six, seven, eight or nine' and insert `not less than seven nor more than eleven'.*

Clause 8 proposes reducing the number of jury members from between 7 and 11 to between 6 and 9. Explanatory Notes claim that "the nature of the inquisitorial task [inquest juries] are required to undertake means that they do not need to be of the same sizes as juries in the criminal courts."

On the contrary, inquest juries have enhanced responsibilities and therefore there is an even greater need to ensure that the quality of their decision-making remains of a high standard. We believe that it would be wholly wrong for issues as crucial to the public interest as, for example, the deliberate killing of a civilian by an agent of the state, to be determined by a jury consisting of as few as 6 members.

Clause 10: Outcome of investigation

We suggest the following amendments:
Page five, line 35 leave out clause 2 and insert new clause,

> *`(2) A determination under subsection 1(a)*
>
> > *(a) shall not affect the criminal or civil liability of any party and shall not be admissible as evidence of proof of criminal or civil liability in any subsequent legal proceedings;*
> > *(b) But an inquest is not inhibited in the discharge of its functions by any likelihood of liability being inferred from the facts that it determines in accordance with subsection 1(a) or any recommendations that it makes.'*

Page six, line 1,

> *Insert `10(4): Subsection (2) shall not prevent a determination which describes how and/or in what circumstances the deceased came by his or her death, including the reasonable precautions, if any, whereby the death might have been avoided or prevented.'*

Clause 10 is linked to clause 5 in that it governs the outcome of investigations. Clause 10(2) enshrines in primary legalisation rule 42 of the Coroners Rules 1984.

When these words were in the secondary legislation (Coroners Rules 1984) it was held on a number of occasions that they could not defeat the purpose to ascertain how the deceased came by their death, which is contained in section 11 of the current act.[2] Thus, an unlawful killing or a neglect verdict could be

[2] *R v HM Coroner for North Humberside ex parte Jamieson* [1995] QB 1 at 24 (5)

returned, both of which would by definition "appear to determine" a question of civil liability (which does not carry the similar imprimatur against naming a person). As presently drafted those verdicts would be prevented by clause 10(3). Moreover, there continues to be a debate in the courts as to whether the wording of an article 2-compliant inquest can contain judgmental words such as "serious" or "unreasonable". INQUEST regards these types of debate as arid. They speak to a period of public life where judicial review, regulatory law and professional accountability were not as developed as they are today.

An inquest, separate to civil proceedings, should discharge a duty upon the state to learn about how deaths occurred and how they might be prevented in the future. In Scotland, where there is a Fatal Accident Inquiry, deaths are investigated in this way, allowing the investigating Sheriff to determine, amongst other things, (a) where and when the death and any accident resulting in the death took place, (b) the cause or causes of the death and any such accident, (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided, (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death and (e) any other facts which are relevant to the circumstances of the death. It is unjustifiable that Scotland should have the facility to make more meaningful determinations than an English inquest.[3]

INQUEST has long argued that the prohibition on verdicts appearing to determine an issue should be removed from coronial law altogether. The issue in an inquest is responsibility, not liability. Thus, it would be far better to maintain the prohibition on naming persons publicly (in all circumstances), but otherwise free a coroner (or a jury) to describe the acts or omissions which are responsible for the death. In order to protect parties to an inquest who might be criticised, the Act should contain a clause which underscores that (a) any determination of an inquest shall not affect the criminal or civil liability of any party and (b) a determination of an inquest shall not be admissible as evidence in any subsequent legal proceedings.

New clauses after clause 12: proposed amendments

Insert the following new Clause—
Information for inquests

> *'In section 15 of the Regulation of Investigatory Powers Act 2000 (c. 23) (general safeguards), after subsection (4)(c) insert—*
>
> > *"(ca) it is necessary to ensure that an inquest has the information it needs to enable the matters required to be ascertained by the investigation to be ascertained;" '*

Insert the following new Clause—
Amendment to the Regulation of Investigatory Powers Act 2000

> *'(1) Section 18 of the Regulation of Investigatory Powers Act 2000 (c.23) (exceptions to section 17) is amended as follows.'*

[3] *Fatal Accidents and Sudden Death Inquiry (Scotland) Act 1976*, section 4(7)

(2) In subsection (7), after paragraph (c) insert—
'(d) a disclosure to a coronial judge or to a person appointed as counsel to an inquest or to members of a jury at an inquest or to an interested person in which the coronial judge has ordered the disclosure.'

(3) After subsection (8A) there is inserted—
'(8B) A coronial judge shall not order a disclosure under subsection (7)(d) except where the judge is satisfied that the circumstances of the case make the disclosure necessary to enable the matters required to be ascertained by the investigation to be ascertained.
(8C) An order for disclosure made under subsection (7)(d) may include directions enabling the redaction of any material relating to the method or means by which the information was obtained.'

(4) After subsection (13) there is inserted—
'(14) In this section "interested person" has the same meaning as in section 38 of the Coroners and Justice Act 2009.
(15) In this section "coronial judge" means a judge nominated by the Lord Chief Justice under the Coroners and Justice Act 2009 to conduct an investigation into a person's death and who has agreed to do so.".'

The first amendment alters section 15 of RIPA to require that a copy made of any of the intercepted material or data is not destroyed before an inquest if it may be necessary in the investigation (without this amendment, current law and practice means that intercept material that may be relevant to an inquest is likely to be destroyed as soon as an investigation is complete). The second new clause amends RIPA to remove the prohibition on intercept material to a judge, counsel, jury members and other interested persons in an inquest when the judge considers it necessary to do so in the circumstances of the case.

While we welcome the government's decision to withdraw clauses 11-12 from the Bill, we believe that a change in the law is required so that inquests involving intercept material are not unnecessarily stalled. The inquest of Azelle Rodney is one such case which has been delayed for over four years as a result of the general bar on the admissibility of intercept evidence.[4] Susan Alexander, the mother of Azelle Rodney, has repeatedly been put off by the government and told to wait for the next piece of legislation before an inquest could go ahead. She was given assurances that this Bill would lay down provisions so that she could finally get answers pertaining to the circumstances surrounding

[4] Azelle Rodney,[4] a 24 year old black man, died in April 2005 after a police operation in north London in which he was shot seven times by a Metropolitan Police officer. The shooting took place after the car he was in was brought to a halt in a 'hard stop' in Edgware, after being under police surveillance for several hours. In July 2006 the Crown Prosecution Service (CPS) announced that there was insufficient evidence for a successful prosecution. After the CPS decision, the family was told by the coroner that the full inquest could not be held because large portions of the police officers' statements had been crossed out, probably pursuant to RIPA, which excludes information obtained from covert surveillance devices such as telephone taps or bugs from being used as evidence or even being seen by coroners.

her son death at the hands of police officers in 2004. The government has yet again reneged on their promise and are now stating that any decisions on the use of intercept evidence should follow the completion of the Chilcot review. Susan Alexander has endured over four years of uncertainty and we feel it is totally unacceptable that she is being asked to wait a further indeterminate period before gaining some closure on her son's death.

The government's original clause relating to certified investigations amended RIPA to allow for the use of intercept evidence in these cases; therefore tacitly accepting that intercept material could be made admissible in coronial proceedings. We would argue that it was always unreasonable to restrict the use of intercept evidence to certified investigations as the Bill already contains the necessary provisions for protecting national security by restricting access to sensitive material. Under the proposed amendments, a judge could still be appointed to conduct relevant inquests and have the power to issue Public Interest Immunity (PII) certificates if necessary. The example of Jean Charles de Menezes illustrates that there are enough safeguards in place for an inquest to be conducted in a manner that deals with sensitive material and situations.

The UK is an anomaly in regard to the bar on the admissibility of intercept evidence - it is the only country to maintain such a ban. Other countries effectively manage using intercept material in criminal proceedings without jeopardising the work of security services. The Chilcot review first recommended abolishing the absolute prohibition contained in section 17 of RIPA in February 2008[5], but there has been little progress since then. Although we still maintain that the ban on intercept evidence should be lifted in respect of all proceedings, as inquests remain stalled in the meantime, we believe that the amendments above are urgently necessary.

For a more detailed analysis of these proposed amendments, please refer to our previous joint briefing with Liberty and Justice.[6]

Clause 28 and Schedule 7: Chief Coroner and Deputy Chief Coroner

We recommend
Page 132 line 19, 1 (2) a,
Leave out 'or a Circuit judge,'

We welcome the creation of the offices of Chief Coroner and Deputy Chief Coroner and the important element of judicial oversight it introduces into the system. Under schedule 7 paragraph 1 the Chief Coroner and the Deputy Chief Coroner can be a High Court judge *or a Circuit Judge*. We do not believe that the Chief Coroner should be recruited from among Circuit Court judges who we believe would lack the experience necessary for the role. Given the importance

[5] Privy Council review of Intercept as Evidence available at: http://www.official-documents.gov.uk/document/cm73/7324/7324.asp
[6] http://www.inquest.org.uk/pdf/INQUEST_Liberty_Justice_Briefing_Intercept_Evidence_and_Inquiries_CJB_Lords_Committee_Stage.pdf

of the role, INQUEST believes that the Chief Coroner *must* be a High Court judge. This is the requirement in relation to the chairs of the Special Immigration Appeals Commission and the President of the Asylum and Immigration Appeals Tribunal.[7] Given the powers he or she will have and the critical role that the Chief Coroner will play in the overall system, it is clear that the same principle should apply here.

The consequence of the appeal system introduced under clauses 30(2) and (8) will be to remove ordinary judicial review from coronial law, with appeals to the Court of Appeal limited to points of law. Experience in the immigration setting makes it absolutely essential that the standard of review provided by the Chief Coroner must be the equivalent of an experienced judge who has held high judicial office.

We also welcome the power to appoint additional Deputy Chief Coroners to assist. We also urge parliament to consider a process whereby an existing coroner could become a Deputy Chief Coroner as the increasing expertise amongst some coroners would benefit the office of the Chief Coroner. It is important that unnecessary barriers are not created to that experience being made available.

Clause 29: Reports and advice to the Lord Chancellor from the Chief Coroner

We recommend:
Page 16, line 26

> *Insert 4 c) 'the report to include an analysis of jury findings, reports made by a senior coroner under Schedule 4, 6 (1) and responses.'*

Page 16, line 30

> *Insert 6) 'and take any other action he or she considers appropriate in response to the report.'*

One of the most important roles of the coronial service is the prevention of similar fatalities and to seek improvements in public health and safety by ensuring that lessons are learned, matters which are addressed in clause 24 and schedule 4 para 6: Power to report if risk of future death (see below)
A new clause 29 was introduced by the government at report stage in the House of Commons which requires the Chief Coroner to report to the Lord Chancellor annually on matters relating to the coroner service. We suggest that this clause could be strengthened by the amendment above.

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[7] See, respectively, schedule 1 paragraph 5(a) of the Special Immigration Appeals Commission Act 1997 and section 5 of the Nationality, Immigration and Asylum Act 2002.

Clause 32: Appeals to the Chief Coroner

We recommend:
Page 18, line 45 [Clause 32]
(8) leave out 'on a question of law'

We welcome the proposals for a more simple appeals procedure which affords the opportunity to bereaved people to raise concerns in a more informal manner. However we are concerned that as the only further appeal is to the Court of Appeal on a point of law, it means that the possibility of any challenge by way of judicial review in respect of most if not all coronial decisions would no longer exist.

Clauses 35 and 36: Governance: guidance, regulations and rules

We suggest there should be a rules committee including at the minimum coroners and practitioners, similar to the rules committees operating in relation to the Civil Procedure Rules. We consider this would assist in maintaining confidence in the process as controversy may arise in relation to rules making provision for evidence, anonymity, disclosure, or exclusion of specified persons during the giving of evidence by a witness under the age of 18 or by reasons of national security.

Clause 38: Interested persons

We recommend:
Page 23, line 5
Insert (o) 'in circumstances, where an interested person willing to represent the interests of the deceased does not exist, a coroner may recognise as an interested person an organisation or person who would be otherwise recognised an interested party for the purposes of judicial review proceedings.'

This clause expands slightly the list of interested persons in rule 20(2) of the 1984 Rules and empowers the coroner to determine that any other person is an interested person. There have been a significant number of contentious deaths in detention where the deceased has no family or no interested family and as such their interests are unrepresented at the inquest. It is our experience that in these cases there is a danger of the inquest becoming a mere rubber-stamping of the official version of events.

In the absence of legal representation on behalf of the family, it is unusual for a coroner to conduct the kind of searching questioning that occurs when they are represented. There are custodial and other controversial deaths that have not been properly scrutinised because families did not have the information and the resources to be legally represented; where the deceased had no family interested in participating in the inquest; or no family at all.

Schedule 1, part 1, paragraph 2: Adjournments

We recommend:
Page 115, line 11
6(c) replace 'exceptional' with 'good'

We note that this clause largely replicates s.16 of the Coroners Act 1988, save that it dictates that a coroner can only refuse to adjourn an inquest when there are parallel criminal proceedings when there is "exceptional" reason to do so. At present the test is that there is "good" reason not to adjourn. We do not know what the rationale is for this change, and we would urge the government to leave the test as it is currently.

Schedule 1: proposed amendments

Page 115, line 28, leave out paragraph 3
Page 117, line 14, leave out paragraph 8

Page 117, line 16, leave out paragraph (a) and insert—
'(a) it must be resumed;'
Page 118, line 27, leave out paragraph (a)

The first amendment removing paragraph 3 from schedule 1 of the Bill stops the allowance of an inquest to be suspended if an inquiry is launched under the Inquiries Act 2005 that would adequately investigate the death. The second amendment removes paragraph 8 of the same schedule; which deals with the resumption of an inquest suspended if there is an inquiry. The second two amendments are alternative proposals to amend paragraph 8 to ensure that if an inquest is suspended because an inquiry is being held, the inquest must be resumed once the inquiry is finished (rather than leaving it to the discretion of the senior coroner to resume or not resume the inquest). They also remove paragraph 8(11)(a) which provides that where an inquest is resumed after an inquiry has been held a determination as to the cause of death etc. cannot be inconsistent with the outcome of the inquiry, thus effectively tying the hands of the jury or coroner.

The Secretary of State has now said that the government will consider establishing, in exceptional cases, an inquiry under the Inquiries Act 2005 to ascertain the circumstances of a death where evidence cannot be disclosed to a jury. We do not believe that a public inquiry can ever be a substitute for an inquest. Neither do we believe that this was intended by parliamentarians when the Inquiries Act was passed in 2005. Instead it seems that this option is now being promoted as an alternative to secret inquests. We believe that this option should be opposed in its entirety as it would completely undermine the integrity of the coronial system.

Under schedule 1 to the Coroners and Justice Bill a senior coroner will be required to suspend an inquest (and discharge any jury) if an inquiry is being

or will be held under the Inquiries Act 2005 which will investigate the cause of death. Once the inquiry has concluded an inquest may be resumed, but only if the senior coroner thinks there is sufficient reason for resuming it. Thus, there is no requirement for an inquest to be held if an inquiry has been held that investigates the cause of death. Even if an inquest is resumed after an inquiry is held, paragraph 8(11) of schedule 1 greatly restricts the role of the inquest by providing that a determination as to how, when and where, and in deaths that engage article 2, "in what circumstances", the deceased came by his or her death may not be inconsistent with the outcome of the relevant inquiry. This effectively ties the hands of the coroner (and any jury) meaning there can be no true independent and effective inquest.[8]

Where a death occurs in state custody or as a result of alleged negligence by state agents, the Human Rights Act[9] requires that the state must ensure that an independent, effective and prompt investigation into the death must be made which is both open to public scrutiny and support the participation of the next of kin.[10] An inquiry under the Inquiries Act 2005 will by definition focus on general matters of public concern rather than exclusively on the circumstances or cause of death of an individual. There is also no assurance that it will involve the participation of the next of kin or be open to public scrutiny. Therefore we believe an inquest should not be suspended pending such an inquiry or bound by any findings by an inquiry and these amendments seek to remove the provisions allowing this to happen. At the very least, the second amendments would ensure that an inquest must resume following an inquiry and would be independent of any findings from the inquiry. Without these amendments, any inquiry held without a corresponding inquest with a jury in cases of state involvement in a person's death is likely to breach article 2 ECHR requirements.

Schedule 4, para 1: Disclosure of documentary evidence

We welcome the provisions under schedule 4(1) which gives power to the coroner to compel a person to give evidence and produce documents. At present there is no mandatory right to pre-inquest disclosure of documentary evidence and this is a serious omission in the Bill. Paragraph 25 of the revised draft Charter for Bereaved Families says "disclosure of all relevant documents to be used in an inquest will take place, on request, free of charge and in advance of an inquest to those family members, whom the coroner has determined have an interest in the investigation."

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[8] Note, currently section 17A of the Coroners Act 1988 provides that an inquest must be adjourned if a judge is holding an inquiry into the events surrounding a death. The inquest is not required to be resumed, but if it is, it begins afresh and the findings of the inquiry are not binding.

[9] Article 2 of the European Convention on Human Rights (ECHR) as incorporated by the Human Rights Act 1998.

[10] *Jordan v UK* (2001) 33 EHRR 38 and *R v Secretary of State for the Home Department ex parte Amin* [2003] UKHL 51.

We hope that the government will ensure in the rules that the coroners will be required to ensure that there is full and timely disclosure of all evidence to all interested persons and to require the Secretary of State to make rules to implement this.

Schedule 4, para 6: Action to prevent other deaths

The Bill is currently says a coroner *"may"* report and this should be replaced by *"must"* and to:

- *(a) impose sanctions for a failure of authorities to respond to the report;*
- *(b) require disclosure of the report to all interested persons and its publication;*
- *(c) include a mechanism for the monitoring and scrutiny of such reports and responses to ensure that there is effective accountable learning and a provision requiring the central collation, publication and analysis by the Chief Coroner in respect of all jury findings, reports and responses and an annual report to Parliament so that there is proper scrutiny and action where appropriate.*

One of the ways in which bereaved families seek meaning from their experience and engagement with the inquest process is in the hope that some good or learning will come from the death of their loved one. This is recognised by LJ Bingham:

> *The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.*[11]

INQUEST welcomes this power as one of central functions of the inquest system – the prevention of other fatalities. One of the most important roles of the coronial service is the prevention of similar fatalities and to seek improvements in public health and safety by ensuring that lessons are learned. That aspect is all the more important in article 2 cases. It was no doubt in recognition of this that in 2008 the government strengthened the provisions of rule 43 of the Coroners Rules 1984 (enabling there to be greater follow-up of rule 43 reports and publication/circulation of the same).

We welcome the changes to rule 43 and the indications from the Ministry of Justice in its guidance on the new rule[12] that it proposes to introduce a regular

[11] *R v. Secretary of State for the Home Department ex parte Amin* [2003] UKHL 51 para 31
[12] *See http://www.justice.gov.uk/guidance/coroners-guidance.htm*

bulletin of rule 43 reports. However we consider that the Bill presents an opportunity to strengthen the preventative role of the inquest. The fact that secondary legislation in the form of rules and regulations has not been published alongside the Bill means there is no opportunity to scrutinise detailed government proposals about how the reporting mechanisms will work. We suggest the Bill should be amended to require monitoring and analysis of inquest findings and in order to make this a meaningful power it must been backed up by effective enforcement mechanisms.

A number of coroners have valued the important role they have in the prevention of future fatalities and have made regular use of their powers under the existing rule 43. Despite the best endeavours of these coroners and juries there is abundant evidence that their recommendations and findings have often vanished into the ether, undermining the investigation and inquest process. The Bill should be amended to impose a positive duty on the coroner to make a report if he or she believes action should be taken.

New Clause: Funding for families' legal representation

We propose a new clause be included in the Bill:

> *'The Secretary of State shall provide for non means-tested funds to ensure that the family of the deceased is properly represented at relevant inquests.'*

The Bill is silent on the question of funding for legal representation for bereaved people at inquests. While we welcome the government's recognition of the rights of bereaved people in the inquest process, exercise of these rights is cruelly hampered without adequate legal funding.

An inquest that raises article 2 ECHR issues - a death in custody or otherwise in state detention or on military service - often involves an attempt by the authorities to engage in damage limitation, restrict the public inquiry and defend the status quo. This is carried out by large teams of specialist lawyers funded by the taxpayer. In contrast, at present Legal Aid for families may be provided only in narrowly drawn "exceptional" circumstances and is means-tested. This involves intrusive investigation of the bereaved family, causes delay and inhibits effective representation.

One of the obligations imposed by article 2 is that in cases of death involving state agents, the next of kin must be able to participate with the investigation. ECHR rights have to be effective, not illusory, and effective participation is only possible at an inquest if the family is legally represented. Consequently, we believe that the current practice contravenes article 2 by offering a family the choice of either participating without professional help or disengaging from the process completely.

The Bar Council shares our concern and points out that the government's argument that funding is not necessary as the coronial system is inquisitorial

rather than adversarial is invalid. It states that if the coroner was expected to represent the interests of bereaved families, this could give rise to a conflict with their duty to maintain the independence of the tribunal.[13]

An inquest is often the only opportunity for a bereaved family to find out the circumstances of a loved one's death and without legal representation they are left to struggle to understand the proceedings and the language of the court. In cases involving state authorities the problem is compounded with the presence of barristers representing officials and agencies but little opportunity for the family's voice to be heard. Currently a family relies on a coroner's support for their application for funding but the authorities are assured of adequate legal representation every time. This encourages perceptions of imbalance and inequality that impact on public confidence in cases with state involvement.

Many coroners recognise and welcome the important contribution that a family lawyer makes at an inquest, often having a significant positive impact on the quality and outcome of the inquest.

The present problems that families report in applying for funding is that the process is lengthy, complicated and often seen as intrusive. A family can be excluded from gaining support simply by virtue of the fact that they own their own home. Even where families do get funding, this does not cover their travel and subsistence which can be significantly prohibitive. While Legal Aid is provided in "exceptional" circumstances, experience shows that this is too narrowly defined and limits families' right to effective representation.

Our proposed new clause would make non-means-tested funds available for families to be legally represented during investigations and at inquests into deaths involving public authorities. The effect would be to balance representation rights in such cases and thus to fulfil the purpose of this Bill to place families at the heart of the coronial process. INQUEST's proposals are supported by the Joint Committee on Human Rights[14] and by Baroness Corston's report on women in the criminal justice system[15].

For further information on this issue see Inquest's Briefing for the House of Lords Second Reading of the Bill, 15 May 2009[16].

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[13] The Bar Council *Coroners and Justice Bill 2009 - A Parliamentary Briefing Paper prepared for Report in the House of Commons on 23rd and 24th March 2009*, para 6.
[14] JCHR *Deaths in Custody Third Report of Session 2004–5.*
[15] Home Office, *The Corston Report - A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system*, 2006.
[16] http://inquest.gn.apc.org/pdf/INQUEST_briefing_on_coroners_and_justice_bill_Lords_second_reading_15_May_2009.pdf

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