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**Briefing and suggested  
amendments to  
Coroners and Justice  
Bill 2009 -  
House of Lords  
Report Stage**

October 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. A reformed inquest system that is capable of properly identifying where responsibility lies, as distinct from liability, would make a significant contribution to the protection of public health and safety.

Part 1 of this briefing takes the form of suggested amendments, presented here in numerical order of existing clauses, with key supporting arguments.

Part 2 consists of issues which remain unresolved after debate to date and where we feel government assurances should be sought.

Our briefing prepared for the Second Reading<sup>1</sup> provides more background.

We have also produced a joint briefing with Liberty and JUSTICE - *Joint suggested amendments to the Coroners and Justice Bill 2009 on the admissibility of intercept evidence and the relationship between inquests and public inquiries*.

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[http://www.inquest.org.uk/pdf/INQUEST\\_briefing\\_on\\_coroners\\_and\\_justice\\_bill\\_Lords\\_second\\_reading\\_15\\_May\\_2009.pdf](http://www.inquest.org.uk/pdf/INQUEST_briefing_on_coroners_and_justice_bill_Lords_second_reading_15_May_2009.pdf)

## Part 1

### Proposed Amendments

#### **Clause 1: Duty to investigate certain deaths and Clause 32: Reports and advice to the Lord Chancellor from the Chief Coroner**

#### **The problem of delay**

##### **Clause 1**

##### **Amendment:**

*Page 2, line 20, at end insert-*

*"() A senior coroner shall inform the Chief Coroner if completion of an investigation is likely to take more than 12 months from the time that the coroner was notified of the death*

*() The Chief Coroner shall maintain a register of prolonged investigations"*

##### **Clause 32**

##### **Amendment:**

*Page 15, line 33 insert*

*"() The report must also contain details of prolonged investigations where the deceased died while in custody or otherwise in state detention*

*() The Lord Chancellor shall make a six monthly statement to each House of Parliament on reasons for delay and action to be taken"*

Delay in holding inquests, particularly into complex cases, is a feature of the current failing system. Delays hamper the speed with which remedial action is applied and they are also incompatible with the provisions of the Human Rights Act 1998. 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.

These amendments would ensure a monitoring system was in place to highlight problems within the coronial service. If particular jurisdictions were struggling with workload or resources and therefore not completing inquests in a timely manner the Chief Coroner would then be able to take action. In particular it focuses on ensuring that delay is addressed in relation to deaths in custody or otherwise in state detention many of which engage article 2 of the European Convention on Human Rights by virtue of the Human Rights Act 1998.

The amendments do not set targets. They ensure that the Chief Coroner, the Lord Chancellor and parliament have the information necessary to be responsive to the needs of the service and of the bereaved, making the service more accountable and uniformly as speedy as is practicable.

Since 5 June 2006 Written Ministerial Statements have been made on a regular basis with information about inquests into the deaths of military personnel. These statements and related documents have included reports on *progress with inquests, open inquests, and liaison with the next of kin*. These detailed statements provide a template for the kind of reporting to parliament that would ensure that there is proper attention paid to the problem of delay within the inquest system.

In response to Baroness Finlay, who moved similar amendments in Committee, Lord Bach stated for the government that it was "the intention that the Chief Coroner will carry out the functions" referred to in this amendment (09/06/09: Column 572). If this is the case, we would ask that it be set down in the legislation.

## **Clause 5: Matters to be ascertained**

### **The problem of scope**

#### **Amendment**

*Page 4, line 6, 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.

As it stands, Clause 5(1) defines the scope of all inquests too narrowly and Clause 5(2) limits the wider consideration of the circumstances surrounding the death to those cases raising European Convention on Human Rights by virtue of the Human Rights Act 1998 considerations.

There are clearly important cases involving questions of public health and safety where the Convention does not apply but there is a manifest 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.

This amendment facilitates this.

## Clause 7: Whether jury required

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 coronial and judicial systems. 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.

### Public health & safety

#### Amendment

*Page 4, line 32, 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.'*

In addition to the general discretion provided for under the new clause 7(3), this amendment inserts the current wording of section **8(3)(d) of the Coroners Act 1988 and ensures that the law should continue to require an inquest jury in those cases which would currently fall within this section.**

The government raised two concerns during the Committee stage (10/06/09; column 693/4) about this amendment: firstly that it could be said to apply to road traffic accidents thus requiring jury inquests for any fatalities on the road; and secondly that it would require additional resources.

Lord Thomas of Gresford correctly stated that this amendment would only reinstate the current position and therefore not change the position in respect to road traffic accidents.

We accept the current provision in the Bill widens the circumstances in which a jury must be summoned and gives coroners a wide residual discretion as to when they may summon a jury. However, we do not agree with the government view that this will increase jury inquests by 50%.<sup>2</sup>

The number of inquests that have a jury is on a downward trend that has halved in the last ten years from over 4% to under 2%.<sup>3</sup> Thus, this restoration of existing provisions will not place any extra strain on resources.

### The problem of disputed causes of deaths in detention

#### Amendment:

*Page 4, leave out lines 25 to 27*

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<sup>2</sup> From under 2% to as much as 3% of all inquests.

<sup>3</sup> Ministry of Justice, *Statistics on deaths reported to coroners England and Wales, 2008 Statistics bulletin*; p11.

As it stands, Clause 7 means that the default position would be juryless inquests for deaths that occur in state detention that are initially classified as natural causes. This differs from the current Coroners Act 1988 clause 8(3) which specifies that an inquest must be held with a jury if the death occurred in prison, in police custody or following police contact, regardless of initial classification of the cause of death. Whilst we understand that the coroner will retain the discretion to empanel a jury, in certain cases the coroner's discretion within the current legislation has frequently been a matter of contention and has contributed to inconsistency of practice.

We would argue that the purpose of a jury inquest is to ensure that incidences of possible negligence are properly investigated. This is particularly so in cases which initially appear uncontentious but reveal concerns about the standard of care available to people who have lost their autonomy by virtue of being in custody.

Concerns have been raised, which we share, by many families of people who have died in psychiatric detention. Whilst it is welcome that the new legislation now includes deaths in psychiatric detention within the category of deaths that require a particular approach, this clause undermines that progressive step. Many deaths in psychiatric detention which have demonstrated serious concerns and systemic failings regarding medication regimes have initially been categorised as being due to "natural causes."

## **Clause 8: Assembling a jury**

### **The problem of numbers**

We fully support the government amendment proposed by Lord Bach that restores the minimum and maximum number of jurors provided for in the 1988 Act.

## **Clause 9: Determinations and findings of a jury**

We fully support the government amendment proposed by Lord Bach that clarifies that where there is not a unanimous finding or determination the majority finding can be returned only if one or two of the jury do not agree.

## **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 legislation 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.<sup>4</sup> Thus, an unlawful killing or a neglect verdict could be 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 verdict 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 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 or Welsh inquest.<sup>5</sup>

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

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<sup>4</sup> *R v HM Coroner for North Humberside ex parte Jamieson* [1995] QB 1 at 24 (5).

<sup>5</sup> *Fatal Accidents and Sudden Death Inquiry (Scotland) Act 1976*, section 4(7).

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.

## **Clause 32: Reports and advice to the Lord Chancellor from the Chief Coroner**

### **Follow up action after an inquest**

#### **Amendment**

*Page 15, line 34,*

*Insert 4 c) 'the report to include an analysis of jury findings, reports made by a senior coroner under Schedule 5, 6 (1) and responses.'*

*Page 16, line 2,*

*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 prompting improvements in public health and safety by ensuring that lessons are learned.

This welcome new clause was introduced by the government at report stage in the House of Commons. It requires the Chief Coroner to report to the Lord Chancellor annually on matters relating to the coroner service. The amendment above strengthens it.

These provisions were proposed as two separate amendments (117 and 118) during the Lords Committee stage and the government stated that they covered policy that they expected to occur in practice (HoL, 23/06/09, column 1563-4). Lord Bach argued that it was "inevitable that the Chief Coroner will provide some analysis of the data he or she receives from coroners" and that "any Lord Chancellor would wish to take whatever action is possible to support the Chief Coroner's analysis of particular problems".

Bearing this in mind we expect government support for these amendments which put into primary legislation the specific requirement to publish the full reports of senior coroners and the powers that the Chief Coroner has.

In July 2009 the Ministry of Justice published its first bulletin *Summary of Reports Under Rule 43 of the Coroners Rules, and Responses* as it is required to do following the introduction this time last year of the Coroners (Amendment) Rules 2008 which give coroners a wider remit to make reports to prevent future deaths and impose a duty on relevant persons or organisations to respond to the report.

The report presents interesting statistical information and it also exposes the inconsistency of practice across the country. However, the report falls short of the kind of transparent and robust reporting that is necessary as it summarises 143 reports and responses rather than making them available and we hope it is not the model for the reports envisaged by this legislation.

In an online society there should be a publicly accessible database of all reports in full as well as the responses to them. This would enable cross-sector learning and all concerned to benefit from the detailed consideration given to preventing further deaths by the coroners who have made them.

## **Clause 42: "Interested person"**

### **Amendment**

*Page 23, line 15, insert,*

*(n) 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 as an interested party for the purposes of judicial review proceedings.'*

We have sought at earlier stages to introduce a further category of person or organisation that would be specified as an interested person.

Our experience is that where an interested person willing to represent the interests of the deceased does not exist, a coroner should be specifically empowered to recognise an organisation or person to do this. We suggested someone who would be otherwise recognised as an interested party for the purposes of judicial review proceedings.

The government has made no such change to the Bill and given no undertakings in debate. We would like to see the regulation and rule-making processes give instructions to coroners to exercise the discretion they have under Clause 42(2)(m) positively with regard to these bodies in these circumstances.

## **Schedule 1, part 1, paragraph 2: Adjournments**

### **Amendment**

*Page 120, 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 5, para 6: Action to prevent other deaths**

We fully support the government amendment moved by Lord Bach that puts coroners under a duty to make a report where he or she is of the opinion that action should be taken to prevent further deaths. The amendment strengthens the powers available to coroners to protect public health and safety.

### **New Clause: Funding for families' legal representation**

We propose a new clause be included in the Bill:

*'The Secretary of State shall provide non means-tested funds to ensure that the family of the deceased is legally represented at inquests that engage article 2 of the European Convention on Human Rights by virtue of the Human Rights Act 1998.'*

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 of the European Convention on Human Rights 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 public purse and professional associations. 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. The bereaved family are usually the only interested party to an inquest without access to public or professional association funds and thus most acutely affected by the lack of equality of arms.

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 by the presence of barristers representing officials and agencies but with 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 on every occasion. This encourages perceptions of imbalance and inequality that affect 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. Indeed our own analysis of the use of current powers under rule 43 (Coroners Rules 1984) indicates that it is in those cases where the family has been legally represented that the power is used most extensively, demonstrating the important contribution family legal representation makes to the preventive function 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 obtain 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 defined too narrowly and limits families' rights to effective representation.

The government indicated at an earlier stage its rough calculations that approximately 800 inquests a year involve public authorities. They estimate an average cost for family legal representation of £8,000 per inquest making a total cost of £6.4 million a year. Government figures<sup>6</sup> indicate that in 2008 there were 526 deaths in and following state custody (England and Wales) excluding fatal shootings, fatal road traffic incidents and the deaths that occur during or following other types of police contact. Not all of these 526 deaths will engage article 2 ECHR. If for example 400 such inquests engaged article 2, then based on the government formula the cost to the public purse would be £3.2 million a year.

This needs to be considered in the context of current costs of state legal representation. A letter dated 8 May 2009 from the Ministry of Justice explained that Prison Service policy recommends that all prisons have legal representation for staff at an inquest. The costs are paid for by the Prison Service and include the costs of Treasury Solicitor, counsel's fees where applicable and other disbursements but excluding any adverse costs. The letter set out the following:

<i>Financial Year</i>	<i>Total</i>
2004 – 2005	£900,725.68
2005 – 2006	£1,546,917.81
2006 – 2007	£1,670,470.23
2007 – 2008	£1,961,640.24
<b>Total</b>	<b>£6,079,753.96</b>

We are not aware if figures about the costs of similar representation where deaths occur in other forms of state detention are available.

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<sup>6</sup> Paper prepared for the Ministerial Board on Deaths in Custody meeting on 15 October 2009.

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 in the investigation. ECHR rights have to be effective, not illusory, and effective participation is only possible at an inquest if the family has legal representation. 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.<sup>7</sup>

The proposed new clause would make non-means-tested funds available to families for legal representation during investigations and at inquests into deaths that engage article 2 ECHR. 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<sup>8</sup> and by Baroness Corston's report on women in the criminal justice system<sup>9</sup>.

*For further information on this issue see Inquest's Briefing for the House of Lords Second Reading of the Bill, 15 May 2009<sup>10</sup>.*

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<sup>7</sup> 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.

<sup>8</sup> JCHR *Deaths in Custody Third Report of Session 2004–5*.

<sup>9</sup> 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.

<sup>10</sup>

[http://www.inquest.org.uk/pdf/INQUEST\\_briefing\\_on\\_coroners\\_and\\_justice\\_bill\\_Lords\\_second\\_reading\\_15\\_May\\_2009.pdf](http://www.inquest.org.uk/pdf/INQUEST_briefing_on_coroners_and_justice_bill_Lords_second_reading_15_May_2009.pdf)

## **Part 2**

### **Further Issues**

#### **Clause 21: Provision of staff and accommodation**

In our opening briefing on this Bill in February this year we set out in full our concerns at the overall level of resources and funding available to the coronial system and at the potential for conflict between nationally-determined requirements and locally-determined funding decisions.

Both Lords and MPs have raised the problems posed by the proposed arrangements. So far the government has made no changes to the Bill or given substantive undertakings in debate to make arrangements to meet these concerns.

The government's decision to leave responsibility of appointing and funding coroners with local authorities is problematic. All local authorities are under tremendous financial pressures with competing budgetary demands and many have to cut or reallocate their budgets.

There is an important issue regarding the perceived independence of the coroners system from local government, which is also responsible for facilities where deaths may occur – for example those of people in local authority care homes, of a child under the care of children's services, or on the roads. Clearly it is desirable and in the public interest that the coroners system should be a nationally-funded service so that there can be no perception of any possible conflict of interest.

We remain concerned that without measures to ensure appropriate resources and administrative support for the coronial system, the lofty intentions of the Bill will not be translated into realistic and effective change.

#### **Clause 35: Appeals to the Chief Coroner**

The consequence of the appeals system introduced under clauses 35 will be to remove ordinary judicial review from coronial law, with appeals to the Court of Appeal limited to points of law.

We welcome the proposals for a simpler appeals procedure which affords the opportunity to bereaved people to raise concerns in a more informal manner. Currently the only options are judicial review on law and the Office of Judicial Complaints on the conduct of a coroner.

However we are concerned that in complex cases, as this is now the route that families have to take, there is no provision for funding their lawyers to make those appeals. This is particularly important in relation to directions given to juries on their determinations and findings, and the clause is silent on this.

As the only further appeal is to the 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 will no longer exist.

If that is to be the case, then it becomes imperative that the Chief Coroner should be a High Court Judge (rather than a Circuit Judge<sup>11</sup>) in order to ensure that the standard of review provided by the Chief Coroner is equivalent to that available from an experienced judge who has held high judicial office.

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<sup>11</sup> Schedule 8 para 2 (2) (a).