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Briefing on Coroners and Justice Bill 2009 - House of Lords Second Reading

May 2009

INTRODUCTION

1. 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.
2. 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.
3. Of central concern are the proposals for "secret" inquests in Clause 11 and 12. We urge Members of the House of Lords to reject the government's proposals in their entirety.
4. 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.
5. 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.
6. This briefing supplements our substantial briefing prepared for the House of Commons Second Reading¹ and circulated in February 2009 in which we addressed the Bill in detail and the INQUEST, Liberty and Justice Briefing on Clauses 11 and 12². This briefing focuses a number of those matters of principle and practice that we feel warrant particular additional attention.

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http://www.inquest.org.uk/pdf/INQUEST_briefing_on_coroners_and_justice_bill_feb_2009.pdf

² http://www.inquest.org.uk/pdf/INQUEST_Liberty_Justice_Briefing_Clauses_11-12_CJB_2nd_reading_lords.pdf

Clauses 2 and 3: Investigations by other coroners – will this solve the problems of delay and complexity?

7. 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.
8. 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 restriction 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).
9. 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.
10. INQUEST and others have raised bereaved families' complaints about the impact of delay and the issue has been raised in parliament and by a wide range of organisations and individuals. Concerns have been expressed by the Independent Monitoring Boards in relation to deaths in prison – for example in their most recent report on HMP Belmarsh the Board noted that "the delay between deaths in custody and inquests is an absolute disgrace. Belmarsh is still waiting for four inquests relating to deaths over 18 months ago including one which took place in January 2005. The effect of waiting for these lengthy periods is devastating for bereaved families and also for the staff who were involved at the time".³
11. The parliamentary Joint Committee on Human Rights has made repeated comments, beginning in 2004: "Where the inquest is the means by which the Article 2 duty of investigation is satisfied following a death in custody, then significant delays may breach Article 2, which requires that an investigation into a death be prompt. We are concerned that current delays may in some instances lead to breaches of Article 2,"⁴ and "We emphasise the need for the reviews of the coronial system... to address delays in the system".⁵

³ *Annual Report of The Independent Monitoring Board July 2007 – June 2008.*

⁴ Joint Committee on Human Rights *Deaths in Custody: Third Report of Session 2004-05 Vol I,, 2004*, para 304, p87

⁵ *Ibid.*

12. More recently they commented,⁶ "As long ago as 2004, our predecessor Committee pressed the Government to move swiftly to reform the coroners system, highlighting delays, problems and lack of resources in the existing system and criticising the impact of these difficulties on the families of those bereaved by deaths in custody and the ability of the UK to comply with the right to life (Article 2 ECHR)."
13. "We do not comment on the issue of resources in this report, other than to reiterate the conclusions of our predecessor Committee that if there are inordinate delays in the system or administrative or other failings arise due to lack of resources, this creates an increased likelihood that the procedural requirements of Article 2 ECHR will be breached when the right to life is engaged and the UK relies on an inquest to provide a prompt and effective investigation of the death."⁷
14. The government response in 2005 to the Committee's initial concerns was encouraging: "The Government shares the concern expressed here about the delays in the holding of some inquests. ...There have been some cases where delay is unacceptable; work is underway to ensure these backlogs are tackled and reduced."⁸
15. However the Committee commented in March 2009 that they had recently received evidence that many of these issues and delays remain outstanding and are getting worse.⁹
16. INQUEST welcomes the provisions in the Bill that would enable 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.

The impact of delay on bereaved families

17. INQUEST's evidence-based research on families' experiences of the inquest system has highlighted the detrimental effects that delays in finding out how a relative has died has placed on the physical and mental health of family members.¹⁰ Finding out how someone has died an essential part of the bereavement process and yet for many families this is profoundly hampered by bureaucratic delay.¹¹ Families describe their

⁶ Joint Committee on Human Rights *Legislative Scrutiny: Coroners and Justice Bill Eighth Report of Session 2008-09*, para 1.68

⁷ *Ibid.*, para 1.73

⁸ *Government Response to the Third Report from the Committee: Deaths in Custody: Eleventh Report of Session 2004-05*, 2005, para 304, p.49

⁹ Joint Committee on Human Rights *2008 -09, op cit*

¹⁰ INQUEST *Submission to the Constitutional Affairs Committee into Reform of the Coroner System and Deaths Certification in England and Wales 2006*

¹¹ Home Office Research Study 241 - *Experiencing inquests*, 2002

lives as being on hold until they have been through the inquest process. Many families bereaved by deaths in custody are isolated and feel stigmatised by the nature of the death, finding it hard to discuss their concerns with those around them and living with the delay in finding out how a relative died is often detrimental to their physical and mental health.¹²

18. As we reported to the Joint Committee on Human Rights, the problems are getting worse as evidenced by these case examples:

Sam Elphick

Sam was 15 years old when he was found hanging at HMYOI Hindley in September 2005. His inquest is due to take place in July 2009 – nearly four years after his death. Reasons for the delay include the time taken to complete investigations by the police and the Prisons and Probation Ombudsman, followed by difficulties in finding a date at the coroners court. A date for the inquest was first fixed for July 2008, but cancelled indefinitely with a month's notice.

The emotional and practical impact on the family has been at times overwhelming. Sam's parents have had to cope with long periods when there is no apparent progress or explanation for the delay. Often they have felt that the needs of the professionals, such as their availability for the inquest, have taken precedence over their needs. Sam's parents are on a very limited budget. The listing and then cancellation of the inquest last summer prevented them from planning a summer holiday, and the same is happening this year. Neither of his parents will be given time off work to attend the whole inquest and they cannot afford to take unpaid leave. They are becoming increasingly disillusioned and angry with a system which does not meet their needs.

Michael Bailey

Michael Bailey died in the segregation unit at HMP Rye Hill in March 2005 having suffered a massive mental breakdown. The family's distress and desperate need to know what had happened were particularly acute as Michael's rapid deterioration was completely unexpected and his mother had desperately tried to get the prison to take his condition seriously. An initial inquest date was set for May 2008, but ultimately did not take place until February 2009, nearly four years after his death.

Martin Green

Martin Green died from dehydration in HMP Blakenhurst in July 2002, but his inquest did not take place until November 2007, more than five years after his death. The family's distress during these years was

¹² INQUEST, *How the inquest system fails bereaved people*, 2002, chapter 5

compounded by their belief, ultimately supported by the inquest verdict, that significant failings by medical staff at the prison had contributed to his death.

Petra Blanksby

Petra Blanksby was 19 when she died in November 2003 after she was found in her cell having tied a ligature around her neck. Petra had an alarmingly long history of serious attempts at self-harm and had been under the care of the mental health services for many years. During the 130 days Petra spent in New Hall prison she was involved in at least 90 incidents of serious self harm, some resulting in hospital admission.

The inquest into her death did not take place until nearly five years later in January 2008 and during that period another five women died in New Hall prison. The delay in the inquest taking place was a source of great distress to the family as well as frustrating the opportunity to identify what went wrong and help prevent further deaths.

Simon Allen

Simon died in HMP Brixton in April 2006 and the inquest took place in February 2009. Simon's elderly parents found it increasingly difficult to cope with the delay and by the time of the inquest they were unable to attend to hear the evidence. During the course of the inquest new information led to serious consideration of a further adjournment, probably of a further 12 months. Simon's family were in the invidious position of deciding whether to agree to an adjournment, which might lead to a fuller investigation, or to proceed risking the possibility that one of his parents might not be alive in a year's time to know the outcome.

Other examples include:

- (a) Moyra Stockhill died in Middlesbrough Police Station in December 2003; tentative date set for inquest October 2009 – delay nearly six years
- (b) Mark Camm died following detention by Wakefield police in June 2004; inquest held October 2008 - delay over four years
- (c) Stephen Brown died HMP Doncaster, March 2003; inquest held July 2008 - delay over four years
- (d) Godfrey Moyo, died HMP Belmarsh January 2005; inquest pending – delay over four years.

19. As families themselves comment, delay in holding an inquest has an extremely damaging effect on their wellbeing:

After fighting for two and a half years to get a thorough inquest we are all totally drained. Our health is still suffering, I feel constantly exhausted, my eldest daughter has had many minor illnesses. My youngest daughter has had glandular fever for eight months – all because we are all at a low. It is a long hard battle and not finished yet. The inquest seemed to be the biggest hurdle for all of us; a lot of time and dedication and heartache went into that courtroom. [Family of a man who died in police custody]

I have been told the inquest may take three weeks and that I will have to give evidence in front of a jury in London. I am very stressed. There is no certainty about the date which is already extremely delayed. [Family of a man shot dead by police]

I think the time they take to sort out deaths in an institution is a disgrace, a part of you dies with your child, the emptiness goes on for a long time deep down without having the added depression so many unanswered questions. What they need is to cut the red tape and let not just me but some of these families move on - as every family has got other siblings and relatives who are watching a lot of pain and suffering. [Family of a young woman who died in prison]

20. The Royal British Legion points out in its memorandum to the Joint Committee on Human Rights that the government has recognised and understood the problem in relation to deaths of military personnel: "One of the main issues in early 2007 was the lengthy delays some families were experiencing before an inquest was held... Additional resources have been placed at both the Oxfordshire and Wiltshire and Swindon Coroners to help speed the inquest process and avoid backlogs. In the recently released Command Paper "The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans", the Government reported: *'Over the last two years, the Government has made significant changes to the support we provide to families which have to go through the painful experience of an inquest. These include making extra resources available to the coroners who are faced with a considerable extra workload, in order to minimise backlogs, and encouraging the transfer of cases to a coroner nearer to where the families live.'*"¹³

21. This clear recognition by government of the pain associated with the experience of an inquest and the problems caused by delay in the context of the deaths of military personnel is laudable and should result in action being taken to address delays in inquests in other circumstances. Some of the families of the victims of the terrorist attack

¹³ Joint Committee on Human Rights, *op cit*

on the London transport system on 7 July 2005 have recently spoken about the impact delay in holding the inquests is having on them.

22. Graham Foulkes, whose 22-year-old son David was killed in the Edgware Road bombing, said the years of waiting for answers had taken their toll. "I don't know how to describe the distress, the upset, the pain while the whole issue is prolonged. We were promised the inquest would be held very quickly. Then we got letter after letter putting it further and further back...It's all been really quite distressful and really quite upsetting. There are a number of us who quite firmly believe that they do not want an inquest to be held in public...It's never going to be complete closure but by deliberately, for their own purposes, delaying and delaying and delaying, that prolongs the agony and pain for us. The callousness of it is hard to believe."¹⁴

The impact on public confidence in the coroner service

23. 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 and play a monitoring role in looking at standards of custodial care.
24. After such delay it is not unusual for witnesses at the inquest to have difficulty in recalling the detail of events and the policies to which they were working at the time. Witnesses may have left the institution and not be traceable. Institutions then respond to concerns arising at the inquest by asserting that changes have subsequently been made but this cannot be tested in evidence at the inquest. Coroners are thus effectively discouraged from using their powers to report matters of concern and where they do so both their report and any media coverage of the inquest can be dismissed by the detaining institutions as out of date.
25. Delays also 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 lessons and preventing other deaths is seriously delayed.

Disproportionate burden

26. The current legal framework means that some coroners are also burdened disproportionately with complex cases by virtue of the number of prisons or other institutions of detention in their geographical area. INQUEST has long suggested that the Ministry of Justice needs to research this issue to enable consideration to be given to the impact of

¹⁴ *Evening Standard* "Bomb victim's father speaks out about inquest delays", 28 April 2009

the proposed legislative changes and the resource implications. In 2007 we argued that: "The current situation requires urgent action to ensure adequate interim resources are available to investigators and coroners to rectify the problem. An urgent audit of the caseload of each coroner's jurisdiction should be carried out by the Department for Constitutional Affairs as this information is currently unavailable centrally. Consideration should be given to allocating additional resources in the form of full time deputies to jurisdictions with the most prisons and other places of detention."¹⁵

27. For example, consider the Durham and West Yorkshire (Eastern District): The Durham Coroner has HMP Durham, HMP Frankland, HMP Low Newton, HMYOI Deerbolt and Hassockfield Secure Training Centre in his jurisdiction. The West Yorkshire (Eastern District) Coroner has HMP Leeds, HMP New Hall, HMP Wakefield, HMP Wealstun and HMYOI Wetherby in his jurisdiction along with the largest teaching hospital in Europe and Newton Lodge Secure Unit.
28. The total number of deaths from all causes in prison or secure training centres per jurisdiction during 2004-2008 was 39 (Durham) and 65 (W. Yorks). These break down as follows:¹⁶

Jurisdiction	Self-inflicted	Non-self-inflicted	Homicide	Total
Durham	11	25	0	36
W. Yorks	28	30	1	59

29. The inquests into these deaths have to meet the requirements of the *Middleton* judgment¹⁷ which means that such inquests take longer than before. In some areas these cases need to be held in other courts or public buildings because of the inadequacy of the coroners court available, with coroners having to negotiate with the other users of those spaces. This adds further pressure to the coroners' limited resources.
30. However the proposals made in the Bill and discussion of the proposals in the Public Bill Committee raised the problematic issue of resources. The Minister said: "I am confident that coroners will act reasonably, accommodate requests from their colleagues and help where they are able; they do that at the moment. However, the fact that the Chief Coroner must be informed that a request has been made will ensure that such requests are monitored, and he will be able to see whether anyone is—or appears to be—misusing the system. Therefore, the chief coroner will be able to intervene, as under clause 3, at an early stage if there are disputes; that will be part of his leadership role. I turn

¹⁵ Shaw, H. and Coles, D. *Unlocking the Truth: Families' Experiences of the Investigation of Deaths in Custody*, INQUEST 2007, para 5.2.3 b p.89

¹⁶ Source: INQUEST casework and monitoring

¹⁷ *R v. HM Coroner for the Western District of Somerset ex parte Middleton* [2004] UKHL 10

to the issue of cost. Who will pay will depend on the circumstances; generally it will be the transferring area."¹⁸

Setting a timeframe

31. Consideration should also be given to adopting a casework management approach in inquests into deaths in custody with clear timetables set out at the initial opening of the inquest, subject to regular review.
32. There is no statutory provision for timetabling inquests or for setting deadlines to reduce inordinate delays. The coroner does not have the authority to insist that an investigation is completed within a specific timeframe. The current situation means there are no clear lines of responsibility if there are delays. Some coroners have adopted a procedure whereby they timetable all inquests but they are not able to compel completion of the investigation bodies' reports within that timetable as they have no powers to do so. INQUEST has argued that setting a timeframe for inquests should be addressed in secondary legislation. See, for example, the *Prosecution of Offences (Custody Time Limits) Regulations 1987 (SI 1987/299)* as amended. We hope that consideration will be given to this during the process for establishing the rules and regulations related to the Bill.

Dealing with complexity

33. In addition the current jurisdictional regime prevents the hearing of complex cases before specialist coroners: there is then a wide variation in approach depending on geographical area. We welcome these provisions that, coupled with the ability for the Chief Coroner to appoint Deputy Chief Coroners, could allow for specialisms to be developed. The Royal British Legion and others have expressed concerns that the expertise accumulated by the Oxfordshire and Wiltshire coroners in the investigation of overseas military deaths might be dissipated by arrangements to move hearings. We would urge an approach by the Chief Coroner to facilitate and encourage the development of specialist areas of knowledge and excellence that could serve in future as a nationwide resource which could be applied to a range of circumstances of death.

Clause 5: Matters to be ascertained

34. The current system is still insufficiently resourced and is failing to perform its preventative function, which is to ensure a decline in preventable deaths. One of the purposes of any investigation into contentious deaths – in particular deaths in state detention and those raising questions of public health and safety - must be to learn any

¹⁸ Hansard, *Public Bill Committee, Coroners and Justice Bill, 10 February 2009*, column 162

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 from preventable deaths. INQUEST urges the government to apply a similar ethos to the coroners system in England and Wales and to enshrine a positive duty on death prevention in any new legislation. We propose the Bill be amended to include a clause that provides that the purposes of an inquest are:

- (a) *to conduct a public investigation into a death which occurs in contentious circumstances in order to provide public accountability for the death;*
- (b) *to provide an effective mechanism for eliciting and challenging evidence; and*
- (c) *to provide a forum for interested persons to contribute to the development of coronial recommendations for the prevention of similar deaths.*

35. One of the purposes of any investigation 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 1998 does not apply and where there is a need for a broader inquiry. The existing clause 5 creates a risk that limits will be placed on the nature of the inquiry that will frustrate both the opportunity for the bereaved to get adequate answers as well as the opportunity to seek to prevent future deaths. For example:

- i. deaths raising concerns about rail, aviation and workplace safety,
- ii. multiple fatalities such as the Marchioness, Kings Cross or Hillsborough disasters;
- iii. the death of a vulnerable older person in a private nursing home; a death in a private workplace.

36. We think the Bill should be amended as suggested by the Joint Committee on Human Rights as follows:

*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.'*

37. One of the primary purposes of an inquest is preventing similar fatalities as recognised in schedule 4, para 6 (Action to prevent other deaths) of the Bill; this is consistent with the recommendations of the *Report of a Fundamental Review 2003*, Cm 5831, Chapter 8, p89; long established by the Courts¹⁹; consistent with other jurisdictions; and an essential aspect of any credible inquest system that serves the public interest. It should be explicitly recognised in the Act to prevent inconsistent standards and legal uncertainty.

38. To the extent that clause 5(2) seeks to place the ratio of *Middleton* on a statutory footing it is to be welcomed and in particular we welcome the fact that clause 5 does not seek to limit the matters that can be explored in an inquest, only those that must be ascertained: this reflects case law which has long recognised that the scope of an inquest can be wider than is strictly necessary to determine those matters that have to be ascertained²⁰; and also recent good practice, such as the inquests into the deaths of Diana, Princess of Wales and Dodi Al Fayed, where Scott Baker LJ (who presided over the inquests) recognised that the particular public interest in that case justified a far wider investigation than the law would have required²¹. It is likely that by conducting such a wide enquiry, Scott Baker LJ did in fact ensure that the inquest performed the important public functions of allaying rumour and suspicion.

Clause 7: Whether jury required

39. 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

¹⁹ For example: *R (on the application of Amin) v. Secretary of State for the Home Department* [2004] 1 AC 653 at para 31; *R (on the application of Takoushis) v. HM Coroner for Inner North London* [2006] 1 WLR 461, paras 39, 43 to 47; *Inner West London Coroner v Channel 4 Television Corp* [2008] 1 WLR 945, paras 7 and 8.

²⁰ See *Coroners Rules 1984*, r43; *R v HM Coroner for Western District of East Sussex, ex p. Homberg* [1994] 158 JP 357 at 380-1; *R v Inner West London Coroner, ex p. Dallaglio* [1994] 4 All ER 139 at 155b; and *R (Takoushis) v M Coroner for Inner North London* [2006] 1 WLR 461 at 473F-476E, paras 39-51

²¹ The *Middleton* obligation did not apply, the deaths having occurred prior to the coming into force of the Human Rights Act 1998; and on one view the investigation was even wider than *Middleton* would have required if it did apply.

are often seen by families as the key safeguard in terms of public accountability.

40. 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.
41. 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).
42. We believe the Bill should be amended as follows:

*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.'*

Clause 8: Assembling a jury

43. Clause 8 proposes reducing the number of jury members from between 7 and 11 to between 6 and 9. The 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."
44. On the contrary, since *Middleton*, inquest juries have enhanced responsibilities for providing narrative verdicts and therefore there is an even greater need to ensure that the quality of their decision-making remains of a high standard. It is also our experience that inquest juries take their responsibilities seriously and are perfectly capable of absorbing large amounts of evidence, asking incisive questions and producing highly informative narrative verdicts and factual findings that can form the basis of a coroner's rule 43 report. 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 six members as compared to lower level cases of dishonesty and public order regularly dealt with by Crown Court juries.
45. We note that there has been no costs justification advanced for these proposals (nor indeed any other justification). However, to the

extent that cost is an issue, we do not believe that there would be any substantial saving by reducing the numbers of inquest jurors.

46. We are therefore firmly of the view that the law in this respect should remain as it is. The arguments to the contrary are weak, unconvincing and motivated by short-sighted administrative convenience and cost-cutting which will be of limited effectiveness and which have disproportionate consequences to the overall quality of justice produced. 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 10: Outcome of investigation

47. 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.
48. 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.²² 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 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.
49. 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

²² *R v HM Coroner for North Humberside ex parte Jamieson* [1995] QB 1 at 24 (5)

the death. It is unjustifiable that Scotland should have the facility to make more meaningful determinations than an English inquest.²³

50. 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.

51. In order to comply with article 2 ECHR, we suggest a new clause.

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 11 – 12: ‘Secret’ inquests

52. INQUEST has produced a joint briefing with Liberty and Justice on these clauses.²⁴

53. The arguments against these proposals have been well rehearsed and are detailed in the standalone briefing. They have generated significant anxiety amongst some of the families of those who have died in contentious circumstances, in particular following deaths in detention and of military personnel. Most recently some of the families bereaved by the 7 July 2005 bombings have expressed fears that their inquests may be subject to the new provisions.

54. Despite the amendments proposed by the Justice Secretary we remain unconvinced that such broad-ranging measures are necessary. Although the amendments are welcome and an indication that the government is listening to widespread criticism, they do not go far enough.

55. The question still remains: why do we need these measures at all? The new clause still specifies a broad swathe of criteria that would

²³ *Fatal Accidents and Sudden Death Inquiry (Scotland) Act 1976*, section 4(7)

²⁴ http://www.inquest.org.uk/pdf/INQUEST_Liberty_Justice_Briefing_Clauses_11-12_CJB_2nd_reading_lords.pdf

possibly lead to an inquest being held partly in secret. Certifying an inquest on the basis of "preventing or detecting crime" could be used in the any case where there is police surveillance or other covert operations, issues that can normally be addressed by other measures such as anonymity or protective screens as occurred in the inquest into the death of Jean Charles de Menezes.

56. Similarly, given the ability to use alternative measures under the current law, there should be no need to certify the inquest simply because of the need "to protect the safety of a witness or other person." We question what lies behind the phrase "relations with another country" and whether this intended to ensure that inquests into the deaths of military personnel in cases that have raised tensions with the USA would in future be heard in secret? There is clearly some other dimension of political sensitivity or embarrassment that is not addressed by concerns about national security and that cannot be a reason for a secret hearing in a democratic society.

57. Although the High Court judge appointed as a coroner to sit in these certified cases would determine whether or not to summons a jury and what other measures would deal with the sensitive material, the Bill remains silent on many important matters. Questions remain about who would be excluded from the inquest and for how long. Despite verbal assurances that these inquests would only be "partially secret", there is nothing in the legislation that specifies that to be the case. Described by officials as an enabling piece of legislation, we do not want the law to enable those with an interest in secrecy to be able in the future to lobby for inquests that currently take place without these measures.

We recommend

Page 6, line 2, leave out Clause 11

Page 7, line 30, leave out Clause 12

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

58. 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*. Given the importance 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.²⁵ Given the powers he or she will have and the critical role that the Chief Coroner

²⁵ 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.

will play in the overall system, it is clear that the same principle should apply here.

59. 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 recommend

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

60. 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

61. 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 paras 63 – 66 below)
62. A new clause 29 was introduced by the government at report stage in the House of Commons 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 below.

*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."*

Schedule 4 para 6: Action to prevent other deaths

63. 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.*²⁶
64. 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 r43 reports and publication/circulation of the same).
65. We welcome the changes to rule 43 and the indications from the Ministry of Justice in its guidance on the new rule²⁷ that it proposes to introduce a regular bulletin of r43 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 be backed up by effective enforcement mechanisms.
66. 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.
67. 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.

²⁶ *R v. Secretary of State for the Home Department ex parte Amin* [2003] UKHL 51 para 31

²⁷ See <http://www.justice.gov.uk/guidance/coroners-guidance.htm>

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.*

Clause 32: Appeals to the Chief Coroner

68. 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.

We recommend

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

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

69. It is a matter of huge concern that the secondary legislation that underpins the operation of the reformed system has not been published and is thus not available for scrutiny. We had hoped that draft new coroners rules and the regulations would have been published alongside the Bill.

70. 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 person

71. This clause expands slightly the list of interested persons in rule 20(2) of the Coroners Rules 1984 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 is their interests are unrepresented at the inquest. It is our experience that where there is no interested person to safeguard the interests of the deceased there is a danger of the inquest becoming a mere rubber stamping of the official version of events.
72. 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 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.²⁸
73. INQUEST therefore welcomes this proposed change and suggests that an additional category should be added, by way of this amendment.

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."

Schedule 1, part 1, paragraph 2: Adjournments

74. 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.

Page 115, line 11

6(c) replace "exceptional" with "good"

²⁸ Shaw H. and Coles D., *op cit*

Schedule 4 (1): Disclosure of documentary evidence

75. 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."
76. 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.
77. Recent attention on the lack of disclosure to the families of the 96 people who died in the Hillsborough disaster has demonstrated the need for this to be properly addressed in the Bill. If such a tragedy were to occur today bereaved families would still have no right to disclosure of documentary evidence. Families bereaved after contentious deaths involving the police or prison service have to depend on voluntary protocols to obtain disclosure and in other circumstances the good will of the public authority involved. Given that disclosure of evidence has been one of the most problematic and controversial issues in the current inquest system, it is imperative that this Bill makes explicit that full and appropriate disclosure and inspection be provided to all. The Hillsborough families have suffered so much and their experience must not be allowed to be repeated.

New Clause: Funding for families' legal representation

78. The Bill is silent on the question of funding for legal representation for bereaved people at inquests. INQUEST welcomes the government's recognition of the rights of bereaved persons in the inquest process, but without adequate legal funding they remain paper rights that families cannot enforce. Currently the only funding available is through means-tested legal aid.
79. 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.

We therefore 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"

80. Without such representation, the bereaved cannot properly protect their article 2 rights. The state's obligations following a death that engages article 2 were recognised in *Jordan v UK* – the investigation must be independent, effective, prompt, open to public scrutiny and enable the participation of the next of kin. For families or other interested parties of the deceased to participate effectively in the investigation process they need legal representation.
81. The Bar Council shares our concerns and adds to them by pointing out the inadequacies in the government's arguments that funding is not needed as the system is inquisitorial rather than adversarial and "It is argued that, in the case of bereaved families, the Coroner can represent the position and look after their interests. However, the Coroner has a duty to maintain the independence of the tribunal which could give rise to a conflict of interest if he (or she) was obliged to 'descend into the arena'. In addition, the Coroner has duties regarding disclosures, which may involve deciding whether to give disclosure to bereaved families. Clearly if the Coroner is expected to represent the interests of bereaved families, an unacceptable conflict of interest will arise."²⁹
82. To date the debate on the Bill has focussed on legal aid for family legal representation. INQUEST argues that the approach to funding families' legal representation needs to be different. Families bereaved by a death involving a public authority should be automatically entitled to non means-tested public funding. They are involved in the investigation and inquest process through no choice of their own. The inquest takes place irrespective of family participation but it is the only hearing for them to find out how the death of their relative was caused and whether any public authority was in any way responsible.

Why legal representation is important

83. Some coroners have supported family applications for funding as they recognise the important contribution family lawyers bring. However, no such support from a coroner is needed by detaining authorities for them to be represented. As Tom Luce pointed out, "if a police authority or a health authority is involved in an inquest, its legal costs will be met by its budget, which is a publicly tax-financed budget"³⁰.

²⁹ 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

³⁰ Select Committee on Constitutional Affairs *Reform of the coroners' system and death certification Eighth Report of Session 2005–06 Volume II*, 2006, Ev20.

84. INQUEST Lawyers Group members have been at the forefront of developing legal practice in relation to representing families at inquests with a particular focus on deaths in detention. In pushing at the boundaries of the inquest system lawyers instructed by families have helped to expose systemic and practice problems that have contributed to deaths. Many of the changes to training and guidance, changes to the law in relation to inquests, increases in information entering the public domain about deaths in custody and other contentious deaths, and increased public awareness of the issues, have been a direct consequence of the deceased's family's participation in the inquest proceedings and lobbying work thereafter for change.
85. Indeed many coroners have welcomed the contribution and assistance that families' lawyers bring to these inquests. It has been lawyers representing families that have helped to expose systemic and practice problems contributing to deaths. Our experience is that good quality, experienced legal representation can have a significant positive impact on the quality and outcome of the inquest. A legally qualified representative can develop a constructive relationship with the coroner more easily than a family that may be struggling with the law and its arcane vocabulary.
86. An awareness of the procedures, such as which witnesses to call, what documentation to obtain, the reasons and effect of adjournments, etc, both speed the process and ensure that the family's interests are properly considered during the investigation and other pre-inquest hearings, thus assisting the hearing itself.

Problems of applying for funding

87. Although funding for representation is available in "exceptional" cases those representing families have to make lengthy, complicated, intrusive and time consuming applications to the Legal Services Commission. Many families are excluded from such support simply by virtue of the fact that they own their own home, even if this does not mean in real terms that they have substantial disposable income to be spent on legal fees.
88. The complexity of applying for funding adds to the procedural burden. Families who are denied representation by simple cost are crucially disadvantaged, not only with regard to their own interests but also with regard to the preventive role of the inquest. Skilled advocacy for the family aids the inquisitorial process and can contribute to the making of coroner reports for the prevention of future deaths.
89. The intrusive funding system causes some families to withdraw from the process altogether while others report family conflict because of intrusive questioning of their financial circumstances irrespective of

whether individual family members had any relationship with the deceased. Even where families get funding this does not cover their travel and subsistence, the costs of which can be significant.

90. While Legal Aid may be provided in "exceptional" circumstances, experience would suggest that the exception is too narrowly drawn, that decisions are subject to demoralising delay, and that bereaved families resent being means-tested for what in all conscience should be their right to effective representation.
91. In the case of deaths in custody, some funding has been generally forthcoming so far to meet article 2 obligations at inquests. However, the means-testing of the funding means complex and intrusive investigations into family circumstances and has given rise to inconsistent decisions as demonstrated below.
- (a) The Legal Services Commission denied exceptional funding for the family of a man who died in hospital a few days after a struggle with a police officer on the grounds that the death fell outside their definition of "in custody" and raised no matters of wider public interest.
 - (b) The Legal Services Commission required earnings details of the family of a man found dead in prison. They were subsistence farmers living in Ghana.
 - (c) The inquest into the death of a woman in prison was adjourned in November 2006 to permit the representation of the family. Her retired parents were initially asked for a contribution of £8,500 by the LSC in February 2007. After an appeal the LSC announced in March 2008 a reduction of the requirement to £3,000.
 - (d) A man died in prison in 2007 and his inquest took place in April 2009. He had a number of siblings, but only one of them, his sister, wanted to be an interested person at the inquest. His sister had continued working until shortly before the inquest, but when she received the report from the Prison and Probation Ombudsman and read the extent of the apparent failings, she became ill and was signed off work by her doctor. As she was in employment she was required to make a monthly contribution to her legal funding as well as a contribution to representation at the inquest itself. As a single parent with two small children, she found the financial burden extremely difficult to manage. After six months sick leave her employer reduced her pay by half, but she had to continue to pay the legal contributions. She has since left her former employment and is now working part time. Whilst given her recent change in

circumstances, she could be reassessed in relation to her legal contributions, she is now so distressed by the inquest process and the impact it has had on her career that she feels unable to deal with the necessary form filling which would be required.

92. INQUEST has worked with a number of families who have not been eligible for legal aid who have had to make a decision as to whether they are willing to use their savings or other capital to pay to be represented at the inquest. Examples include:

- (a) The retired parents of man who died in prison were required to use the money set aside for their retirement to contribute to representation.
- (b) The high-earning family of man who died in custody is funding all of their legal representation, anticipated to cost tens of thousands of pounds. The sympathetic solicitor offered his service at a reduced cost and the family is undertaking many of the tasks usually undertaken by a solicitor themselves in order to save money.
- (c) The daughter of a woman who died in police custody was required to contribute from the inheritance she received from her mother who is the subject of the inquest. The Legal Services Commission initially questioned whether there was significant wider public interest, which is unnecessary given that the death engages articles 2 as it occurred in custody and refused funding, twice. Some funding was granted on appeal but a contribution of £4,000 was required. The family member concerned is a single mother of a three year old.

93. INQUEST Lawyers Group members are increasingly reporting situations where wide representation of state bodies and their employees who may all be seeking to avoid imputations of blame or wrongdoing (such as the Chief Constable/Metropolitan Police Commissioner, Prison Service, trades unions and professional associations, Primary Care Trusts,) is secured at inquests. This can often have the effect of creating a substantial appearance of - and actual - inequality between the family's representation and that of the other interested persons. For example at the inquest in 2008 into the death of Mark Camm who died following police contact "there were some 13 legal representatives at the inquest, looking after the interests of the Chief Constable, specific police officers and detention officers, Force Medical Examiners (FME), the NHS Trust, and individual Accident and Emergency doctors."³¹

³¹ Ruth Bunday – "Series of failings by police and health authorities contributed to the death of Mark Camm", *Inquest Law* Issue 16, April 2009, INQUEST

94. To our knowledge, lawyers representing public authorities are provided with funding which appears not to be restricted or constrained (as is the situation for bereaved families) and does not appear to be assessed and/or have its merits examined in the manner prescribed within the statutory framework. INQUEST is not aware of a single inquest into a death in custody where the state has not had lawyers in attendance.
95. An investigation that raises article 2 issues - a death in custody or otherwise in state detention, in an army training establishment, or a death on military service overseas - all too frequently is met with what appears to families to be a concerted offensive by the authorities to engage in damage limitation, restrict the scope and remit of the inquest and defend the status quo.
96. This leads to imbalance in legal representation and reduces the chances of having an independent, fair and balanced investigation. It is our experience that detaining authorities' representatives are concerned to protect their interests and this often takes the form of seeking to constrict the scope of the investigation and inquest. It requires legal skills to make the case to the coroner for context and corporate issues to be considered.
97. The result of the present position is that there is a damaging inequality of arms in representation with detaining authorities able to retain large numbers of people to assess the documentation and evidence while families' lawyers struggle to fund sufficient people to fulfil their responsibilities. This has an inevitable effect on the balance of investigations and inquests.
98. The Forum for Preventing Deaths in Custody looked at whether or not the current regime disadvantaged families in terms of their ability to explore all relevant issues in inquests and said that

...the question for the Forum was whether or not this state of affairs might inhibit learning which could prevent future deaths. Almost every Forum member who expressed a view on this issue felt that, potentially, it could. The objective of exploring all relevant issues was felt to be most easily achieved where all the interested parties have the same access to legal representation by representatives who have sufficient experience and expertise. Making the family wholly or partly financially responsible for their own legal representation risked either dissuading them from being represented at all, or else being insufficiently represented. Many Forum members felt that could have a knock-on effect on the ability of the inquest to identify learning opportunities.³²

³² The Forum for Preventing Deaths in Custody *Annual Report 2007/8*

99. The Bar Council commented that

...if the Coroners' system is to achieve the objectives of delivering justice for all interested parties should be entitled to legal aid in all cases. However, the Bar Council understands that the legal aid pot is finite and that difficult decisions have to be made vis-a-vis funding. As a matter of principle, all interested parties should be represented where the state has obtained representation funded via the taxpayer. The Bar believes that to deny representation to other parties where it is provided by the state (or indeed, inquests that do not involve the state but where one party has access to representation) is a violation of the equality of arms principle that underpins our system of justice.³³

100. INQUEST's proposals are supported by the Joint Committee on Human Rights in their *Deaths in Custody Third Report of Session 2004–5* and by recently by Baroness Corston in *The Corston Report* on women in the criminal justice system. Recommendation 6 in her report stated that

Public funding must be provided for bereaved families for proper legal representation at inquests relating to deaths in state custody that engage the state's obligations under article 2 of the European Convention on Human Rights. Funding should not be means tested and any financial eligibility test should be removed whenever article 2 is engaged. Funding should also cover reasonable travel, accommodation and subsistence costs of families' attendance at inquests.³⁴

101. It is worth reflecting on the importance of family legal representation at the inquests into the six deaths at HMP Styal. The public scrutiny that their representation ensured prompted the Corston review, which makes it all the more disgraceful that the government did not accept this recommendation. Whilst the inquest process is inquisitorial it is not simple and informal and no family bereaved by a death that engages article 2 would want to represent themselves. Rather these deaths raise complex and important questions about the state's obligation to protect life and therefore there should be no argument about the benefits of ensuring all involved have equal access to public funding for legal representation.

102. ECHR rights have to be effective, not illusory. In *Airey v Ireland* (1979) 2 EHRR 305, a case about breaches of article 8 in the context of domestic violence, the European Court of Human Rights stated that in civil proceedings, public funding will be required if the assistance of a lawyer is indispensable for effective access to court, either because legal

³³ The Bar Council, *op cit*, para 10

³⁴ 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, p5

representation is compulsory or because of the complexity of the procedure or of the case. An inquest into a death in custody is almost inevitably so complex that professional legal assistance is necessary. It is for that reason that the police and Prison Service instruct lawyers.

103. We think that current practice contradicts article 2, which calls for effective family participation. A family cannot participate without professional help but if they cannot afford either financially or emotionally to access that help they will be left to deal with the inquest alone, or disengage from the process completely. If they are lucky they will be able to rely on free representation. All of these options are unsatisfactory and none meet article 2 requirements: the investigation and inquest are only compliant with the Human Rights Act if there is effective family participation.
104. Given the public and parliamentary disquiet about many deaths that involve public authorities – in custody, in hospitals, in the military - INQUEST believes it is in the public interest that these deaths are properly scrutinised with the family's interest represented properly.
105. Parliamentary Under Secretary of State for Justice Bridget Prentice MP said at the Committee Stage of this Bill "We estimate that about 800 inquests a year involve public authorities. They cost an average of about £8,000 for legal aid, which amounts to £6.4 million a year." (Col 203 10 Feb '09)
106. INQUEST agrees that this is a fair estimate of the current outlay by the LSC on family representation. Our estimate of what would be needed initially to fund our proposal is in the region of £10 million per year.
107. INQUEST believes that the LSC is not the appropriate body to decide on funding because:
- i. it should not be legal aid and should be held separately from that budget,
 - ii. it should not be means-tested and thus should not be administered by a body whose policies and procedures assume means testing and
 - iii. it should be specific to inquests and should therefore be administered by a body more closely linked to the new coroners service.
108. 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.

109. 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.

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