INQUEST's Submission to the Constitutional Affairs Committee Inquiry into Reform of the Coroners System and Death Certification in England and Wales

1. INQUEST is the only voluntary organisation in England and Wales that works directly with the families and friends of those who die in all forms of state custody - in prison, young offender institutions, immigration detention centres, police custody or while being detained by police or following pursuit, and those detained under the Mental Health Act - to provide an independent free legal and advice service to bereaved people on inquest procedures and their rights in the Coroner's Court. It was set up in 1981. It provides specialist advice to lawyers, the bereaved, advice agencies, policy makers, the media and the general public on contentious deaths and their investigation. It also monitors deaths in custody where such information is publicly available and identify trends and patterns arising.

2. INQUEST also provides generic advice on the inquest system to bereaved families and publishes free for any bereaved family – *Inquests – An Information Pack for Families, Friends and Advisors*[1] - that explains the whole process and where to find emotional and practical support. We have provided this service in the absence of a similar service from the current inquest system. Since we have published our pack in August 2004 we have distributed more than 350 hard copies and it has been downloaded over 5,200 times from our website. Since 1996 the organisation has worked directly to support over 2,000 families facing inquests.

3. This submission is made on behalf of INQUEST by Deborah Coles and Helen Shaw. They have been the co-directors of INQUEST since 1990 and 1994 respectively and are joint editors of *Inquest Law*, the quarterly journal of the INQUEST Lawyers Group. Deborah is a trustee of the charities Women In Prison and the Centre For Corporate Accountability and is a member of the BBC Charitable Appeals Committee. Helen was appointed as a non-executive member of the Human Tissue Authority in April 2005 and was previously (April 2001 – March 2004) a non-executive member of the Retained Organs Commission. She is also a trustee of the charity National Bereavement Partnership. They are joint members of the Independent Police Complaints Commission Advisory Group and the Ministerial Group on Suicides in Prison. They are co-authors of the forthcoming INQUEST publication *Families' Experiences of the Investigation of Contentious Deaths* and Deborah is co-author with Barry Goldson of *In the Care Of the State, Child Deaths in Penal Custody* (INQUEST 2005).

[1] INQUEST 2004, also available from www.inquest.org.uk

4. INQUEST published its submission to the Fundamental Review of Coroner Services in 2003[2] which outlined concerns about the operation of the inquest system at that time regardless of circumstance of death. We also gave oral and written evidence to the Joint Committee on Human Rights Inquiry into Deaths in Custody 2004[3] which addressed the problems with the inquest system alongside other matters. INQUEST will be publishing a new report on *Families' Experiences of the Investigation of Contentious Deaths* in April 2006 and hope this will contribute to the reform process.

5. INQUEST believes that the current inquest system is failing and that this is heightened in deaths that involve questions of state or corporate accountability.

6. The coroner's system is one of the most neglected areas of law. In contrast to the constant evolution of other legal and administrative structures and a more rights-based approach generally to public functions and services the coroner's court has failed to evolve. This means that its standards fail to reflect modern concerns about the rights of those participating in legal proceedings. The resources and structure of the current system militate against the delivery of a service that addresses the needs of post-death investigation in the 21st century.

7. INQUEST has always argued that the right to an inquest is fundamental after a sudden and unnatural death. Any new system needs to operate within a framework that ensures openness, accountability, compatibility with the Human Rights Act and sensitivity to bereaved people and the public.

8. To establish such a framework there need to be clear national protocols for all aspects of post-death investigation. Those protocols need to enshrine clearly defined mechanisms of accountability, minimum levels of service delivery and a system of sanctions where practice falls below acceptable standards. Above all it needs to be a system that balances the needs of the state with those of bereaved people and ensures that all participants have an equality of resources and information. Whilst the process will be painful for bereaved people, it will be more bearable if the system is seen to have legitimacy and meaningful outcomes.

9. This submission summarises the concerns that have emerged based on 25 years of advising and supporting bereaved families, monitoring post-death investigations and attending inquests around the country.

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[2] *How The Inquest System Fails Bereaved People* (INQUEST 2003)

10. From our work with bereaved people we have identified the following problems within the current system:

    a. Lack of provision of clear, accessible information for bereaved people about their rights in relation to the inquest system and coroner's post mortem;
    b. Lack of understanding and sensitivity within the system to religious and cultural beliefs;
    c. No shared understanding of the function and purpose of post-mortem examination;
    d. Lack of explanation to families about their rights and funding for a second post-mortem;
    e. Lack of explanation and public understanding of the legal status of the body and problems with different standards and practice in relation to bereaved families' access to the body;
    f. Insensitivity of coroners and others in relation to post-mortem evidence;
    g. Inconsistency of quality and extent of coroner's post-mortems;
    h. The formality of the procedure frequently more than many given to expect;
    i. Variable time delays and approach to inquests into deaths in similar circumstances dependent on geographical area;
    j. Variable quality of courts and lack of private space for bereaved people;
    k. Inappropriate delays in holding the inquest;
    l. Variable treatment on a range of issues dependent on geographical area;
    m. Good practice dependent on the approach of individual coroners and coroner's officers rather than agreed and inspected quality standards;
    n. Varying levels of legal knowledge and understanding of relevant issues amongst coroners and lack of compulsory training;
    o. Insensitive treatment of families before and during the hearing - by coroner/coroner's officers and other advocates for Interested Persons;
    p. Lack of career structure and training for coroner's officers;
    q. Lack of clear accountability as no national coroner service;
    r. Lack of easily accessible and effectve complaints procedure;
    s. Rules of coroner's jurisdiction prevent the hearing of complex cases before specialist coroners;
    t. Lack of right to disclosure of documentary evidence;
    u. Narrow legal remit of the inquest;
    v. Lack of central monitoring of coroner's Rule 43 concerns and lack of duty to respond;
    w. Perception by bereaved people that the inquest does not function to prevent future deaths occurring in similar circumstances;

x. Problems with lack of non-means tested funding for legal representation
y. Negative impact of the above on physical and mental health of bereaved people;
z. Lack of referrals to legal, social and health service providers, including voluntary sector providers;
aa. Lack of follow-up communication about action being taken where the death has occurred in an institution. Bereaved families frequently describe how they know that the inquest cannot bring back their relative but that if lessons are learned to prevent similar deaths it will have some meaning for them.

11. These factors have serious consequences for families faced with an unexpected or violent death. The narrow focus of the inquiry puts artificial and invidious limits on the scope and style of conduct of the coroner's inquiry, which often exclude from the inquest the issues of greatest concern to the family. The inquest is usually the only investigation of death to which a family has access. Importantly, for the public interest and democratic accountability, it is the only public forum in which contentious deaths will be subject to scrutiny. Inquests are too often at risk, particularly in the absence of legal representation for the family, of being opportunities for official and sanitised versions of deaths to be given judicial approval - rather than being an opportunity for the family to contest the evidence presented, to discover the truth and full circumstances surrounding the death of their loved one.

12. Despite some examples of good practice, an outmoded administrative mindset means that families are marginal to the overall process, whereas they should be central. Death is far more significant for the bereaved than for the doctors, police, coroner and lawyers involved, for whom it is ultimately a professional matter.

13. There have been some developments seeking to soften the hard edges of legal procedures following death, and individual coroners do often try on an *ad hoc* basis to be sensitive to families' feelings and concerns. The position however remains that families' legal rights in proceedings are restricted: the inquiry is not for them, and the administrative framework is not directed at their full inclusion in the process. Families are not recognised properly as stakeholders with an interest in the final outcome. The Government's review is an important opportunity to change the inquest system fundamentally.

14. Bereaved families have frequently described the experience as one that adds to rather than diminishes distress, marginalises them and leaves more questions than answers. Many agencies have little or no understanding of the particular experience of the inquest system including lawyers, generic advice agencies and bereavement agencies.

Lawyers are not routinely taught about inquests during their training. Coupled with the lack of access to public funding in most inquest cases, this means that often families have sought advice from lawyers that has been inadequate, expensive and sometimes wrong.

15. Overwhelmingly our work with these families has resulted in an outpouring of anger and distress from bereaved people and raises some fundamental questions about society's collective ability to deal with the aftermath of death. It affirms what we suspected, that far from being the isolated or highly controversial cases or incidents that the system proves incapable of dealing with, it is ill equipped to deal with *most* deaths and *most* families suffer additional distress and grief as a result.

16. The significance in this context of the coroner's court - as a point of contact with public services for most "at risk" families, regardless of how and where their loved one's death occurred - is at once clear. Its potential role in guaranteeing informed and effective access to appropriate bereavement intervention options for bereaved families must therefore be a central concern in developing a new system.

INQUEST's service

17. The aim of our casework service is to advise families and empower them through the provision of information and advice about their rights. Because of the length of time from the death to the conclusion of the investigation and inquest process our support can last for a number of years.

18. We operate a telephone-based service offering free support, advice and information to all bereaved people facing an inquest and their basic rights in the coroner's court. There is no other organisation in England and Wales with such specialist knowledge about the inquest system. Our informed casework team provides this specialist advice as well as sending out written information, such as our comprehensive Information Pack[4] and leaflets concerning specific areas of death. We also provide information to bereaved people about how to access other services and in many non-custody related deaths we will provide both advice and referrals to other organisations e.g. road traffic related deaths to RoadPeace, work related deaths to the Centre for Corporate Accountability, deaths in hospital to A*v*MA. We also monitor any legal issues arising from these cases that concern the inquest system.

Particular problems following deaths in custody

19. In the context of all of the problems described above there are particular concerns about how deaths in custody are dealt with and INQUEST

[4] Also available to download from www.inquest.org.uk

outlined these in both written and oral evidence to the Joint Committee on Human Rights in 2003 and 2004.[5]

20. The key role of the public inquest in contentious deaths is that it is often the only public forum in which there is any scrutiny of the death. The importance of the investigation being in *public* cannot be underestimated.

21. With custody-related deaths the lack of support and appropriate assistance is more acute with families feeling doubly victimised – they have suffered a death and because of its nature they are treated as though they are criminals.

22. All deaths in custody involve an inquest so the potential role of the Coroner's Service in guaranteeing informed and effective access to appropriate bereavement intervention options for bereaved families must therefore be a central concern in developing a new system.

23. Finding out how someone has died is a fundamental human right and an essential part of the bereavement process and in coming to terms with the death. All of the families who have sought our assistance have been motivated by a need to establish the truth for their own peace of mind, and to prevent others going through the same experience. Above all, they want an acknowledgement of fault or responsibility where appropriate, an apology where an apology is due, for justice to be seen to be done and for lessons to be learnt.

24. Maximising the possibility for families and friends to discover the truth is the guiding principle of INQUEST's casework service. The family can have a real information deficit after a death in custody. They have a very steep learning curve to understand the various investigations that are initiated by such a death. Some professionals argue that the family should not be overloaded with information. But all families have told us how access to proper information and advice is crucial in ensuring that they are aware of their rights and it is the responsibility of the state to ensure that this happens at the earliest possible opportunity.

25. This should include information about access to the body, post-mortems, organ retention, rights regarding disclosure, the inquest process, and legal rights. These principles apply equally to deaths in other circumstances

[5] *Deaths in Custody: Third Report Of Session 2004-05. Volume II:Oral and Written Evidence. HL Paper 15-II and HC 137-II.* Joint Committee on Human Rights (The Stationery Office 2004)

26. In our experience the nature of the circumstances of many of the deaths on which we work inherently attracts prejudice and strong feelings. The majority of families we work with do not experience the system as compassionate. Families feel overwhelmingly excluded, dissatisfied and let down by it as a process for establishing the facts. The coroner's inquest has become an arena for some of the most unsatisfactory rituals that follow a death - accusations, deceit, cover-up, legal chicanery, mystification; everything but a simple and uncontroversial procedure to establish the facts.

27. The limited ambit of investigations, ineffective inquiries and the failure to prosecute those responsible have all been issues for bereaved families. They have also increasingly become an issue in law both in the ECHR and in the domestic courts.

Legal developments

28. The most significant recent development in coronial law has been the implementation of the Human Rights Act and the direct incorporation of Article 2 (the right to protect and safeguard life) into domestic law. Alongside this two significant House of Lords judgments (Amin[6] and Middleton and Sacker[7]) have impacted on procedure in coroners courts.

29. The obligation on the state to protect the right to life requires the state taking appropriate measures to protect life, to investigate deaths and ill treatment in custody thoroughly and to prosecute where there is sufficient evidence to justify proceedings.

Amin

30. The decision of the House of Lords in the case of the SSHD ex-parte Amin (October 2003), established consistent minimum standards for the state's duty to investigate deaths in custody. [8]

31. The House of Lords ruled that whichever form the investigation takes there are minimum standards, which must be met as set out in Jordan v UK[9]. The Court concluded in Jordan that there were five essential requirements of the investigatory obligation: **independence; effectiveness; promptness and reasonable expedition; public scrutiny and accessibility to the family of the deceased.** The lack of an investigation which embodies the requisite qualities will and of itself constitute a violation of Article 2.

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[6] R v. Secretary of State for the Home Department ex parte Amin [2003] UKHL 51
[7] R v. Coroner for the West Somerset and other ex parte Middleton [2004] UKHL 10 and Regina v. Coroner for West Yorkshire ex parte Sacker [2004] UKHL 11
[8] See "Amin: The Legal Significance". Paddy O'Connor QC, *Inquest Law* issue 6, January 2004.
[9] Jordan and ors v. UK (2001) 37 EHRR 52

32. The Court ruled that such requirements apply with at least equal force to a 'state neglect' or omission case (relevant to deaths in police custody) as to a state 'lethal hands' case.

33. Many of INQUEST's concerns about the inquest process were put forward for the family at the Amin hearing including: inconsistency of disclosure of evidence to the family despite the Home Office circular; inconsistency of funding; the narrow boundaries to the jury's findings; coroners' current restrictions upon system neglect. The Amin judgment recognized these concerns as legitimate.

34. There is now strong recognition of the need for more effective investigation than can be currently provided by inquests. The issues raised about individual and system neglect in the Amin judgment, although rare, are sadly not unique. Until reformed substantially there is strong judicial recognition for the need for more effective investigations than can be provided currently by inquests and provides an important incentive to accelerate the programme for inquest reform.

35. This legally significant case has been brought about because of the courageous struggle by the family of the deceased whose campaigning will contribute to the future protection of vulnerable prisoners. Lord Bingham recognised this as one of main purposes of the investigation and thereby humanely connected the needs of the bereaved with the duties of the state.[10]

Middlton and Sacker

36. In the House of Lords cases of Middleton and Sacker (11 March 2004) their Lordships affirmed that Article 2 of the ECHR required there to be an effective official investigation into a death involving the state. Both cases concerned prisoners who had hanged themselves in prison in circumstances where prison officers and health care staff might have done more to prevent the death.

37. The critical function of a coroner's inquest is to determine how a person came by their death. The word 'how', as used in inquest law, is contained in section 11(5)(b)(ii) of the 1988 CA and rule 36(1)(b) of the 1984 Coroners Rules.

38. Before Middleton, the case of Jamieson[11] had held that 'how' in the primary legislation should be interpreted as "by what means" and not in "what circumstances"

[10] O'Connor *op cit.*
[11] R v. North Humberside Coroner ex parte Jamieson [1995] QB 1

39. The effect of that judgment was threefold:

    a. First, to narrow the circumstances in which state responsibility for failing to prevent a suicide could be reflected in the conclusion of a jury;
    b. Second, it limited the scope of the inquiry to the means and not the circumstances by which the death had come about; and
    c. Third, Jamieson required inquest juries to follow a highly restrictive concept of causation based on the requirement of a "clear and direct causal link" to the death as opposed to a requirement for them to be satisfied that an act or omission had acted as a "material contributory cause" – that is to say "a more than minimal cause" of a death – a test that we know operates in other areas of civil and criminal law every day of the week.

40. As a result of Middleton, the word 'how' is now to be interpreted as "by what means and in what circumstances".

41. Inquest juries now have more opportunity to draw attention to any failings in the circumstances surrounding the death through the use of more narrative verdicts, or in answers to questions put to them on factual matters by the coroner.

42. This recent ruling signifies a major breakthrough for inquest law. The essence of these decisions is that they require an inquest to return verdicts which properly reflect:

    a. Whether a person takes their own life in part because the dangers of their doing so were not recognised by the prison authorities;
    b. Whether appropriate precautions could have been taken to prevent the death.

43. These two judgments have positively impacted on the inquest system and we hope that the spirit and actuality of the judgments will be reflected in the proposed reforms of the system. But they have also demonstrated how under-resourced and unfit the current system is to meet the requirements of the current law.

Funding

44. For families to participate effectively in the investigation and inquest process they need legal representation. Despite welcome reforms to the funding regime, INQUEST is still dealing with ongoing problems in obtaining public funding for legal representation for families and their operation is proving an additional stress for already distressed families who find themselves enmeshed in a legal system following a death in

custody about which they have no choice. INQUEST Lawyers Group members are constantly engaged in huge amounts of work to obtain funding for legal representation with little uniformity of approach to decision making in the various Legal Services Commission (LSC) offices across England and Wales. Much work is still undertaken on behalf of bereaved people *pro bono*.

45. It has often been the lawyers instructed by the family who have pushed these boundaries to secure funding for some families. But this funding is sporadic and needs to be consistent. It still remains the case that unlimited public funding is available for experienced, good quality lawyers to represent the police, Prison Service and other bodies, while those representing families have to make lengthy and time-consuming representations to the Legal Services Commission for the little funding they receive. INQUEST is also concerned that the introduction of limited public funding has not been accompanied by a concurrent introduction of appropriate quality standards for those representing bereaved people. We have witnessed and heard of lawyers representing families sitting through weeks of inquest hearings and making little or no verbal intervention at all.

Delay in custody inquests

46. Another illustration of how the system is failing is the serious delay from the death through to the investigation and subsequent inquest. Delays of one or two years are not uncommon – in part due to the length of time such investigations take, the lack of resources available to coroners and the fact that these are jury inquests and can last up to two weeks or longer. This is often made worse by the shortage of suitably qualified forensic pathologists and other experts. The delay clearly causes all concerned great difficulty but this is particularly so for bereaved people who have described how their lives have been put on hold until they have been through the inquest process. INQUEST's evidence-based research on families' experience 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.[12]

47. As there is no public scrutiny of the death for such a long period, the opportunity for identifying what went wrong and to seek to prevent recurrences in the future, learning the lessons and preventing other deaths is seriously delayed.

[12] Chapter 5 – *How The Inquest System Fails Bereaved People* (INQUEST 2003)

Conclusion

48. In conclusion we consider the system is long overdue for reform and can provide further and more detailed evidence to illustrate INQUEST's concerns if required.

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