Response to Judicial Review: proposals for reform

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Introduction

1. INQUEST is the only organisation in England and Wales that provides a free, specialist, comprehensive advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. INQUEST is an independent charity and we receive no funding from the state or the Legal Services Commission. Our casework service provides both a general telephone advice, support and information service to any bereaved person facing an inquest and a free, in-depth complex casework service on deaths in state detention or involving state agents and works on other cases that also engage Article 2 of the ECHR and/or raise wider issues of state and corporate accountability. The complex casework service supports approximately 150 bereaved families in any given year (which equates to roughly 45% of INQUEST's total caseload).

2. Our casework service gives INQUEST a unique perspective on how the whole coronial system operates. It enables us to identify systemic and policy issues arising from avoidable deaths and the way they are investigated. Drawing on this, INQUEST undertakes research and publishes reports such as How the Inquest System Fails Bereaved People (2002) and Unlocking the Truth – Families’ Experience of the Investigation of Deaths in Custody (2007) and both included in-depth surveys which sought bereaved families' views and experiences of the legal processes involved in inquests. Other INQUEST publications include: Learning from Death in Custody Inquests: A New Framework for Action and Accountability (2012); The Inquest Handbook: a guide for bereaved families, friends and their advisors; briefings on individual cases and on thematic issues arising; Inquest Law, the journal of the INQUEST Lawyers Group; and a regular e-newsletter. INQUEST is represented on the Ministerial Council on Deaths in Custody.

3. INQUEST also works in partnership with members of the INQUEST Lawyers' Group, a national network of nearly 200 solicitors and barristers who provide preparation and legal representation for bereaved people and which promotes and develops knowledge and expertise in the law and practice of inquests. This response draws on INQUEST and the INQUEST Lawyers' Group collective experiences over the last thirty years. Our answers to a number of relevant questions in the consultation paper reflect the core concerns of many

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1 Our response also benefits from the pro bono legal analysis and note provided by Bindmans LLP who are members of the INQUEST Lawyers’ Group
bereaved families: to have meaningful involvement in the legal processes following their relative’s death, to have access to justice and to ensure that the coroner is assisted to make best use of the inquest as a mechanism to prevent similar deaths occurring in the future.

4. It is important that the rules on judicial review operate effectively to challenge some of the failures in an inquest system which is acknowledged as having wide variations in the quality of coroners’ decision making. Tom Luce, the government-appointed independent reviewer concluded in 2003 that the system was “not fit for purpose”.2 Partly in response to such reports, Parliament passed the Coroners and Justice Act 2009 to improve and standardise the system. INQUEST’s evidence based research reports (see paragraph 2 above) and briefings have previously demonstrated how bereaved families face significant delays and a ‘postcode lottery’ of service.

5. Following the government’s decision to abolish s.40 of the Coroners and Justice Act 2009 (which would have allowed for a system of appeals against coroners’ decisions to be established by the Chief Coroner for England and Wales), judicial review remains bereaved families’ only route for challenging poor decision-making in coroners’ courts.

INQUEST’s concerns about the proposals in the consultation paper

6. INQUEST is troubled by the lack of an evidence base for the proposals. There is much reliance in the consultation paper on anecdotal evidence rather than any meaningful data on the impact the proposals will have if implemented. This paucity of proper evidence is worrying when wide reaching changes to fundamental legal processes and rights are being proposed.

7. The consultation describes the measures proposed as “simple and proportionate”. More disturbingly, there is talk of ‘striking a balance’ between what the rule of law requires and the ‘needs’ of public authorities, the ‘inhibiting’ effects accountability through judicial review has on them and the ‘pyrrhic’ nature of victories when unlawful decisions are struck down requiring public authorities to retake them lawfully. These assumptions reveal a deep misunderstanding of the importance of judicial review for ordinary people seeking a remedy when the state exceeds or misuses its powers. Judicial reviews relating to inquest law and coroners’ decisions have important repercussions – for the bereaved families personally

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2 Para 1, the independent review of Coroner Services commissioned by the Home Office and chaired by Tom Luce, Death Certification and Investigation in England, Wales and Northern Ireland, 2003.
affected, for the improvement of practice and procedure in coroners’ courts more broadly and for society as a whole.

8. The questions that are raised by judicial reviews of coroners’ decisions frequently involve fundamental rights such as ECHR Article 2 (the right to life) and 3 (the prohibition on torture, inhuman or degrading treatment or punishment). For example, at the original inquest into the death of 14 year old Adam Rickwood, the coroner refused to rule on both the legality of the use of force on Adam by staff shortly before he died and whether the restraint used on him was causative of his death. His mother, Carol Pounder, brought a judicial review challenging these decisions and asking for a new inquest into Adam’s death. In allowing the claim, the administrative court quashed the original verdict and ordered the coroner to conduct a fresh inquest\(^3\). This was more than a “pyrrhic victory”. The second inquest was held in January 2011 and resulted in a narrative verdict from the jury which condemned the conduct of bodies such as the Youth Justice Board and the private contractor Serco who ran the facility where Adam Rickwood died\(^4\). Adam was the youngest person to die in custody and the evidence heard at the inquest into his death revealed that thousands of other children had also been systematically subjected to unlawful restraint in privatised secure training centres and that regulatory and inspection bodies had failed to stop these practices. Since that evidence was heard there has been significant public and parliamentary debate about the use of force on children in custody – resulting in the government introducing a new policy and practice framework in July 2012.

Questions 5 and 6 - proposed changes to time limits

9. In relation to identifying the starting point for the current three month time frame the consultation proposes a rule change which would require:

"any challenge to a continuing breach or cases involving multiple decisions [to] be brought within three months of the first instance of the grounds and not from the end or latest incidence of the grounds. The review should ensure that the wording of this rule reflects the current legal position that the time limit to be applied in Judicial Review

\(^3\) R (Pounder) v HM Coroner for the North and South Districts of Durham and Darlington [2009] EWHC 76 (Admin). Carol Pounder also had to judicially review the coroner when he subsequently refused to recuse himself from hearing the second inquest: R (Pounder) v HM Coroner for the North and South Districts of Durham and Darlington [2010] EWHC 328 (Admin). The administrative court also granted that application and ordered the coroner to appoint a colleague to hear the second inquest.

proceedings starts to run from the point at which the grounds for the claim first arose, taking into account when the claimant first knew or ought to have known of the grounds arising."

10. In response to Question 5 of the consultation we would urge the government not to change the current wording of Part 54.5 of the Civil Procedure Rules. How any change will operate is far from clear from the few details offered in the consultation, but INQUEST is concerned that it could have profound effects on the scope to challenge ongoing failures by the state – even in relation to its discharge of Article 2 and other investigatory duties. At worst, it could allow public authorities to rely on their own unlawful delays and failures to immunise themselves against challenge.

11. Question 6 asks if there are any risks in taking forward the proposal. INQUEST believes the proposals would present particular problems in some of the most serious types of case. The current rules allow some flexibility on the starting points for time limits which gives the court discretion to examine and make decisions on individual cases based on specific facts and circumstances. The consultation proposals could be interpreted to mean that claims must be brought within three months of the date when a claimant - such as a grieving family member - knew or somehow ‘ought to have known’ a failure of the state to comprehensively investigate was unlawful. Our concern is that a stricter, less flexible formulation runs the risk of limiting families’ access to judicial review in important cases. It could also lead to time-consuming (and expensive) satellite litigation about the new Rules which would make the process even more drawn out and painful for bereaved families.

12. For example, 15 year old Arsema Dawit was killed by a young man who had developed a friendship with her and became increasingly obsessed and violent towards her in the period before her death. On 3 June 2009, after a court had concluded the criminal proceedings against her attacker, a coroner refused to resume the inquest into Arsema Dawit’s death. This was in spite of the fact that, five weeks before she died, Arsema and her mother had reported to the police that the young man had threatened to kill her. Arsema’s family were concerned by the failure of the police to respond to these reports and take adequate steps to help prevent her death and asked the Independent Police Complaints Commission to investigate. The IPCC produced a report on 20 November 2009 which criticised “collective and organisational failings” by the police. In light of this the family’s lawyers asked the coroner to reconsider her original decision not to resume the inquest. On 13 July 2010 she
refused to do so. Arsema Dawit’s family then brought a judicial review challenging this latest refusal. In April 2012 the case was heard by the administrative court who considered the right to life issues raised by her claim, allowed the application for judicial review, quashed the coroner’s decision not to resume the inquest and ordered a full inquest to be heard as soon as possible at a different coroner’s court.5

13. If the proposals on stricter time limits contained in the consultation paper were implemented a claim like Medihani might not have been heard by the court as it could be argued that the three month time limit would have run from the coroner’s original decision on 3 June 2009 and not the refusal she subsequently made on 13 July 2010. It is important that cases involving such fundamental Article 2 rights can be considered fully by the courts and are not barred by strict, inflexible time limits.

**Questions 7 and 8 - proposed abolition to the right to an oral permission hearing in many cases**

14. According to the consultation, a claimant “may have up to four opportunities to argue the case for permission”6 and proposes two reforms. The first is to:

> “remove the right to an oral hearing in cases where there has already been a prior judicial process involving a hearing considering substantially the same issue as raised in the Judicial Review claim”.

15. It is clear that the ‘judicial process’ is intended to encompass a wide range of decisions – those of coroners, magistrates and certain tribunals are all mentioned. We understand the proposals to apply where a coroner makes a decision on procedure at an inquest. For example, she refuses to adjourn an inquest when this is necessary, adjourns inappropriately, directs the jury in an objectionable way, or decides that the inquest need not be conducted in compliance with Article 2. Challenges to a coroner’s substantive decisions (for example, verdicts) would also be affected.

16. Given the well-documented issues about the variability and quality of coronial decision-making, INQUEST is concerned by these proposals. If implemented they are likely to mean many, significant decisions of judicial bodies being exposed to far less scrutiny than now. The

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5 *R (Medihani) v HM Coroner for Inner South District of Greater London* [2012] EWHC 1104 (Admin)
6 It is unclear what the four are, as there are only three mentioned (consideration on the papers, oral renewal hearing, Court of Appeal appeal on the papers).
right to an oral hearing to present arguments about unlawful action on the part of public bodies - whether magistrates, tribunals Coroners, the Police, the IPPC or central government departments - is a vital element of the judicial review process; one that has been preserved despite careful examination of the process when the CPR were established by Lord Woolf and reviewed for judicial review cases by Sir Geoffrey Bowman.

17. As the consultation paper itself acknowledges, each year hundreds of judicial reviews are granted permission to proceed at oral hearings, despite that permission having been refused on the papers. These cases will simply not proceed if the government’s reforms are implemented. As research by the Public Law Project reveals, refusal rates on paper-only permission decisions vary hugely between different judges.  

18. In relation to judicial review proceedings brought specifically in relation to coroners’ decisions, our experience is that oral hearings are important – particularly as they are sometimes the only opportunity to develop and properly test arguments for permission. Analysis of figures provided by the Ministry of Justice supports this and suggests that the opportunity for the court to hear full oral argument is important when deciding whether or not an application should proceed. In 2009-10 of the 15 applications made (both paper and oral) there were renewal hearings in 6 cases resulting in 12 substantive hearings. In 2010-11, the last year for which figures were supplied, 14 applications were made with 3 renewal hearings resulting in 3 substantive hearings.

19. Against this background, INQUEST opposes the consultation proposals to remove the right to an oral hearing in cases where there has been a prior “judicial process”.  

Concluding comments

20. During recent parliamentary debates on the implementation of the Coroners and Justice Act 2009 (as part of the proposed abolition of the Chief Coroner’s office in the Public Bodies Bill), government ministers repeatedly assured parliamentarians that bereaved families could challenge poor decision-making in coroners’ courts through judicial review. For example, the Government Briefing on the Bill circulated to MPs and Peers stated “a new appeals system...”

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8 Answer from then Parliamentary Under-Secretary of State for Justice, Jonathan Djanogly MP to a parliamentary question from Bob Ainsworth MP, [HC Deb, 18 July 2011, col 727](http://www.thelive.parliament.uk/ Hansard/2011-07-18/HCDeb/18170)
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[for coroners] will not be taken forward because of the significant costs that this would entail. However, we are retaining the existing appeal mechanisms, whereby the outcome of an inquest can be challenged by Judicial Review. Against the backdrop of those assurances that recourse through judicial review would remain available to bereaved families, the House of Lords agreed to a government amendment to the Public Bodies Bill which repealed s.40 of the Coroners and Justice Act (the appeals system provision).

21. It is concerning that little over a year later the Ministry of Justice has now put forward proposals which, if implemented, would restrict bereaved families’ ability to bring judicial review proceedings against flawed coroners’ decisions.

22. INQUEST does not believe the government has made a properly evidenced case to support their proposals for restrictions on judicial review. Given the detrimental impact the proposals are likely to have on families seeking to challenge unlawful decisions by coroners, and the potential impact on their Article 2 rights, we urge the Ministry of Justice to reconsider.

For more information on any of the issues contained in this response, please contact:

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9 Government Briefing on the Public Bodies Bill, DEP2011-1213 available from www.parliament.uk
10 See HL Deb, 23 November 2011, col 1096 onwards