# The Coroner Service

# Justice Committee Inquiry

# Written evidence of JUSTICE

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**For further information contact**

Jodie Blackstock, Legal Director
email: jblackstock@justice.org.uk direct line: 020 7762 6436

JUSTICE, 59 Carter Lane, London EC4V 5AQ tel: 020 7329 5100
fax: 020 7329 5055 email: admin@justice.org.uk website: www.justice.org.uk

## Introduction

1. JUSTICE is an all-party law reform and human rights organisation working to strengthen the justice system – administrative, civil and criminal – in the United Kingdom. It is the UK section of the International Commission of Jurists.

2. This briefing responds to the Justice Committee's call for evidence into the effectiveness of the Coroner Service and whether changes introduced under the Coroners and justice Act 2009 has helped improve the experiences of bereaved people and survivors who come into contact with the Coroner Service.

3. When a catastrophic event or systemic failure results in death or injury, the justice system must provide a framework to understand what happened and to prevent recurrence. Unfortunately, these systems are too often beset with delay and duplication, with insufficient concern for the needs of those affected by disasters. Instead of finding answers through the legal process, bereaved people and survivors are often left feeling confused, betrayed and re-traumatised. The lack of formal implementation and oversight following the end of an inquest or inquiry makes the likelihood of future prevention limited.

4. In 2019 JUSTICE established a working party, chaired by Sir Robert Owen with a membership of experts across the field of inquests and inquiries (the "**Working Party**"),[1] to address these failures. The Working Party subsequently published a report titled '***When Things Go Wrong: The response of the justice system***'[2], on 24th August 2020 (the "**Report**"). This report seeks to address the erosion of public trust in the response of the justice system to deaths giving rise to public concern. These include major incidents causing multiple fatalities, which may also arise from a pattern of systemic failure. If it is to enjoy the confidence of the public, the justice system must provide a response that is consistent, open, timely, coherent and readily understandable.

5. The Report records 54 recommendations directed at remedying such shortcomings by building on the strengths of the present system of inquests and public inquiries. This briefing focuses on our report's findings and recommendations regarding the Coroner Service:

    - *The framework* – Inconsistency is a problem for inquests. In the coronial jurisdiction, local authority control with little centralisation means that standards and practices can vary greatly. Duplication of process can cause anguish, delay and expense. We propose a full-time Chief Coroner role to provide greater oversight and a *special procedure inquest* for investigating mass fatalities as well as single deaths linked by systemic failure, able to consider closed material and make specific recommendations to prevent recurrence.[3] In order to

[1] See full list of Working Party members at the beginning of the Report, and Acknowledgements at pp.113-115

[2] *When Things Go Wrong: The response of the justice system*. A report by JUSTICE

[3] See para 2.40-2.85 and Annexe

increase coherence, we propose new State and independent bodies to provide oversight and facilitate information-sharing.

- *Opening investigations* – The opening of an investigation can be a disorienting experience for bereaved people and survivors. A lack of coordination between relevant agencies can mean that they can face multiple, repetitious interviews at the evidence-gathering stage. Greater collaboration between agencies, building a cross-process dossier, would reduce the multiple occasions that bereaved people and survivors have to recount traumatic events and ensure that they are fully informed throughout the process.

- *Procedure* – Bereaved people and survivors are not provided with adequate information, support and empathy during inquest and inquiry hearings Drawing on previous JUSTICE working parties on accessibility within the justice system, we recommend that bereaved people and survivors are placed at the heart of the inquest process. We suggest that professionals should undertake training on appropriate communication techniques and support services be signposted before and after the hearing. We also suggest ways that inquests could better provide therapeutic spaces for bereaved and survivor testimony, without the pressure of legal formalities.

- *Accountability and systemic change* – Effecting systemic change is a complex process. We conclude that an independent body should lead oversight and monitoring of the implementation of inquest recommendations, whose review could aid scrutiny by parliamentary committees.

6. A system cannot provide justice if its processes exacerbate the grief and trauma of its participants. Our recommendations seek to ensure that inquests (and inquiries) are responsive to the needs of bereaved people and survivors, while minimising the delay and duplication that impede effectiveness and erode public confidence. JUSTICE's below responses draw heavily on our findings and recommendations from our report.

**<u>The extent of unevenness of coroner services, including local failures, and the case for a National Coroners Service</u>**

7. In coroners' courts, which are funded and administered by local authorities, standards and practices vary greatly.[4] Our findings echo previous reports that pointed to significant variation in the standard of coroners' decision making and a lack of uniformity in the ways that coroners are resources and supported. Some concerns were practical: we were told that the Gwent Coroner Service does not have an email system for the receipt of documents. Other concerns related to a lack of sufficient expertise, with particular anxiety in relation to local coroners

[4] HHJ Mark Lucraft QC, *Report of the Chief Coroner to the Lord Chancellor, Fifth Annual Report: 2017-2018* (2018), see paras 15-16.

without requisite experience presiding over complex Article 2 ECHR inquests involving issues of systemic failure.

8. There are advantages associated with the local authority-administered structure. One practical benefit is that unlike public inquiries, coroners' investigations and inquests are not seen as "an expensive anachronism in the eyes of a cost-conscious central government".[5] Adherence to tight local authority budgets and sharing of facilities with police forces has meant that local coroner services have evolved organically, without recourse to central funds. Coroners may also acquire considerable local knowledge and understanding.[6] Our consultees confirmed our experience of local coroners bringing to bear their knowledge of previous, similar cases from within the local area.

9. However, a recommendation to create a national service capable of accommodating all deaths reported to coroners and all inquests (in 2018, 210,900 and 30,000 respectively)[7] lay beyond the scope of our Working Party.[8] We suggest that the issue of centralisation should be kept on the agenda and note that Government is yet to publish its response to post-legislative consultation, which was due in "early 2016".[9]

**The Coroner Service's capacity to deal properly with multiple deaths in public disaster**

*A full-time Chief Coroner*

10. The Working Party recommends that the position of Chief Coroner be made a full-time appointment. Given the decision-making, oversight and advisory role we envisage for the Chief Coroner in the *special procedure inquest*, which is yet to be introduced, we consider that a full-time appointment is highly desirable so that the Chief Coroner's duties are not compromised. The role has been universally recognised by our consultees as valuable in giving leadership to the jurisdiction, driving up standards and providing public information through annual reporting

[5] Stephen Sedley QC, 'Public Inquiries: a Cure or a Disease?' (1989) 52 MLR 469, 472.
[6] See *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* chaired by Tom Luce (Cm 5831, 2003), p. 180, para 15.
[7] Ministry of Justice, 'Coroners Statistics Annual 2019 England and Wales' (14 May 2020).
[8] Paras 1.19-1.24
[9] Ministry of Justice, 'Post-implementation review of the coroner reforms in the Coroners and Justice Act 2009', 2015.

*Duplication of process*[10]

11. There is currently a duplication of process across inquests and inquiries. Many of our consultees felt that there is no practical benefit in opening two "inquisitorial" investigations both directed at establishing the facts of a fatal incident.

12. The Chair of the Grenfell Inquiry acknowledged these concerns and expressed the hope that he could "minimise as far as possible the need for [the coroner] to re-open any of the inquests and thereby to spare the relatives of those who died the need to endure further proceedings in relation to the deaths of their family members".[11]

13. However, the four statutory questions (who the deceased was, and how, when and where the deceased came by his or her death), which must be answered in every inquest, are not expressly set out in the Inquiry's Terms of Reference.[12] Further, the Chair noted that he could "foresee some potential difficulty in making extensive and detailed findings about the movements of each of the deceased in the period leading up to his or her death".

*Investigating deaths linked systemically*[13]

14. The is currently an inability of inquests to investigate multiple asynchronous deaths, causatively linked by systemic failure. This is worsened when such cases of systemic failure do not lead to the establishment of a public inquiry.[14] It is unsatisfactory that in the absence of sufficient political pressure, such deaths are not investigated in context, and without scrutiny of underlying systemic causes

15. A further issue arises in relation to cases where the coroner decides that they are unable to discharge their investigative obligations because of a claim for public interest immunity (PII), and the coroner asks the relevant Minister to convert the inquest into a public inquiry. There is no statutory process for such a request and it can lead to considerable delays.

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[10] Paras 2.43-2.47

[11] Sir Martin Moore-Bick, 'Chairman's Response to Submissions made on 21 March 2018' (Grenfell Tower Inquiry, 28 March 2018), para 4. In the previous paragraph, the Chair noted submissions made by bereaved and survivor core participants stressing "the importance…of making findings of fact sufficient to meet the requirements of an inquest which satisfies the state's obligation under article 2 of the European Convention on Human Rights, thereby making it unnecessary for the coroner to continue the inquests which she has suspended" – submissions contested at the hearing by Counsel to the Inquiry.

[12] Coroners and Justice Act 2009, s. 5. In an Article 2 ECHR inquest, the question of "how, when and where" is to be read as including the purpose of ascertaining *in what circumstances* the deceased came by his or her death. The Grenfell Tower Inquiry terms of reference do commit to examine the "circumstances" surrounding the fire at Grenfell Tower on 14 June 2017, but the 72 deaths are not referenced explicitly.

[13] Paras 2.48-2.50

[14] See para 2.49 for examples of cases where a single inquest focused on systemic failures would have been beneficial, and where a public inquiry was never established.

16. We have designed our proposed Special Procedure Inquest ("SPI") such that it could consider closed evidence,[15] therefore avoiding conversion altogether.[16] However, in cases where – in any event – a public inquiry is established to investigate one or more deaths, the Working Party recommends that the inquiry, where possible, should be required to answer the four statutory questions.[17]

**Ways to strengthen coroners' role in the prevention of avoidable future deaths**

17. The inability of the Coroner Service to effect long-lasting change is of great concern to bereaved people and survivors. The hope that others will not have to endure near-death experiences, or the deaths of loved ones in similar circumstances, is consistently dashed when coroners issue a series of Prevention of Future Death (PFD) reports, each making identical findings aimed at preventing recurrence, yet without reasonable prospect of implementation.

*The Special Procedure Inquest[18]*

18. Our recommendations for a Central Inquiries Unit and the expansion of the Office of the Chief Coroner will contribute to improving the establishment and management of inquests and inquiries. However, neither will address issues with duplication and an inquest's inability to consider systemic failings.

19. As such, the Working Party recommends the establishment of a new *SPI,* in order to investigate both mass fatalities and single deaths causatively linked through systemic failure. This represents a "fused" model, combining what we consider to be the most successful features for effective participation of inquests and public inquiries. The Working Party considers that the introduction of the SPI would serve to reduce duplication and delay, foster certainty, ensure inclusion of bereaved people and survivors and ultimately promote public trust in the system.

20. The Working Party recommend that the SPI is adopted for "specified deaths". The specified deaths to be investigated are:

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[15] Paras 2.69 and 2.74
[16] See Ministry of Justice, *Justice and Security Green Paper* (Cm 8194, 2011), pp. 15-16.
[17] Para 2.69. We accept that this is already the case for inquiries suspended under Coroners and Justice Act, sch 1 para 3. However, this accommodates only the narrow subset of cases where the Lord Chancellor requests the coroner to suspend the inquest on the ground that the cause of death is likely to be adequately investigated by a *statutory* inquiry and a "senior judge" has been appointed as chair.
[18] Paras 2.40-2.85 and Annexe

i. multiple fatalities, i.e. two or more deaths occurring in circumstances giving rise to serious public concern or for other good reason ("type I");[19] and
ii. any death which a coroner has reason to suspect requires investigation and which, by reference to another death or deaths, may give rise to issues of systemic failure ("type II"). The issues may arise either:
    a. from an inquest or inquests already held or;
    b. from a death or deaths (including deaths in other coroner jurisdictions) in which no inquest has yet been held.[20]

21. The possibility of the SPI should not prejudice the Government's ability to establish a public inquiry under Section 1 of Inquiries Act 2005. The Chief Coroner would maintain an oversight and advisory role throughout the process, including during the preliminary hearings in order to monitor the timetable and to ensure family participation

22. Some of the pertinent features of the SPI include:

- A pool of judges and Senior Coroners trained in advance and ticketed to conduct SPI hearings.
- Jurisdiction to hear and, if appropriate, rely upon "closed" evidence, i.e. evidence heard in the absence of the public.[21]
- The judge or Senior Coroner would have the option to request agencies to conduct specific inquiries.
- Interested persons should be able to ask questions of witnesses.
- The SPI should determine answers to the four statutory questions,[22] the medical cause of death and a conclusion as to the death. In a type II SPI, scope may well include evidence on other deaths, and on episodes of near-death.[23]
- In a departure from the current position,[24] findings would be admissible (although not binding) in civil proceedings.[25]
- The SPI should formulate recommendations to prevent future deaths,[26] hearing further evidence if necessary. Recommendations could be wider than permitted under the current regime, extending to specific actions to be taken by addressees.[27]

[19] Obvious examples of type I multiple fatality cases include deaths from an aircraft, helicopter or train crash, deaths of children in a school bus incident, and multiple deaths from a single terrorism incident.
[20] One or more transfers would take place under existing provisions in Coroners and Justice Act 2009 ss. 2-3 so that the inquests may be held together.
[21] See Coroners (Inquests) Rules 2013, r. 11.
[22] Coroners and Justice Act 2009, s. 5.
[23] See *R (L) v Secretary of State for Justice* [2009] 1 A.C. 588.
[24] i.e. an exception to the rule in *Hollington v Hewthorn* (1943) K.B. 587.
[25] The Working Party agrees that the findings of all inquests should be admissible in civil proceedings. This proposal, however, lies beyond our terms of reference.
[26] Coroners and Justice Act 2009, sch 5 para 7.
[27] See 'Chief Coroner's Guidance No. 5: Reports to Prevent Future Deaths', 2016, para 24.

- The Chief Coroner, or following the decision to establish an SPI, the judge or Senior Coroner appointed to conduct it, could draw upon the advice of the Central Inquiries Unit as to its management.

23. Our recommendations for the SPI include:

- The establishment and conduct of the SPI should be guided by a clear and publicly accessible *Protocol*. The *Protocol* would include standard terms of reference, to be adapted according to the circumstances of the case.[28]
- There should be a presumption that criminal proceedings, if commenced or expected, will precede the SPI. The Working Party recommends that this presumption should also apply in the establishment of public inquiries.[29]
- The judge or Senior Coroner should retain discretion as to whether the investigation should be opened notwithstanding any ongoing prosecution, where delay is likely to be inordinate and/or where the fair trial rights of potential suspects are unlikely to be prejudiced by concurrent investigations.[30]
- Non-means tested publicly funded legal representation of families should be provided where State bodies are represented[31]

24. The Working Party considers that introduction of the SPI would be a considerable advance on the current framework for inquests and public inquiries:

- Points of overlap between inquests and public inquiries or other independent inquiries would be avoided, as the SPI would obviate the need for two processes
- The scope of the inquest could be expanded beyond present limitations to include (proportionately) consideration of issues of wider importance relating to obvious aspects of “serious public concern” or “systemic failure”. This should reduce the number of calls for public inquiries, whilst leaving open the possibility that Government might establish one where appropriate.
- There should be a special and recognised focus on the needs of families throughout the process, and from a very early stage.
- Bereaved people and survivors with interested person status should be entitled to full disclosure of relevant (but not closed) material.
- The procedure would be published and available at all times. It would be expressed in clear and simple language.
- The use of juries in the majority of cases would promote public trust and confidence.
- The process of investigation would become more structured, particularly in coordinating different investigations and avoiding delay.
- The process would also lead to a more significant exploration (than at present) of factors which could save future lives and to more specific recommendations.

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[28] Para 2.61. Recommendation 14
[29] Para 2.79. Recommendation 15
[30] Recommendation 16
[31] Paras 2.82 and 5.20-5.23

For example, the recognition that certain deaths in different prisons are linked by a specific systemic failure could lead to a marked reduction in deaths in custody.

*Prevention of Future Death ("PFD") reports*

25. Rule 43 letters were replaced by PFD reports following enactment of the Coroners and Justice Act 2009 ("the 2009 Act"). Schedule 5, paragraph 7(2) of the 2009 Act provides that a person to whom a Senior Coroner makes a PFD report must give a written response to the Senior Coroner. However, as noted by Dame Elish Angiolini, "coroners are not able to follow up or enforce recommendations in their PFD reports".[32]

26. The Working Party supports proposals that an independent body be established to monitor the implementation and effectiveness of recommendations arising from death investigations.[33] It would prepare thematic reviews regarding implementation of related recommendations across multiple inquests, so that PFD findings are not viewed in silos but rather as part of a broader project to promote public safety.

27. The Working Party recommends Parliamentary oversight of such recommendations, in the form of a select committee, which provides a feasible way of ensuring that inquiry recommendations do not simply disappear for lack of political will. Further, it ensures that where recommendations are rejected, Government must explain why, and do so publicly. It also recommends that Ministers directly accountable for the implementation of inquiry and SPI recommendations should, where recommendations are accepted, be required to report back to Parliament with an Implementation Plan.[34]

*Central Inquiries Unit*

28. We encourage the Cabinet Office to be ambitious and give effect to the various calls made over the years to establish a dedicated Central Inquiries Unit, which would advise on best practice in the set-up of our recommended SPI.

29. The Working Party recommends that at the close of a SPI, members of the inquest team should be seconded to the Central Inquiries Unit for between six and twelve months in order to share recent experience. This would allow Government to learn iteratively from the successes and failures of recent inquiry processes. Secondees should be drawn from members of the inquest team who are sufficiently senior to have exercised broad oversight of the process.

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[32] The Rt Hon Dame Elish Angiolini DBE QC, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (2017), para 17.23.
[33] Recommendation 51
[34] Paras 6.27-6.32

## **Improvements in services for the bereaved**

### Opening investigations
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*30.* For those already dealing with bereavement, confrontation with the complex legal processes triggered by a fatal event can serve to prolong and intensify trauma. Multiple concurrent investigations may require grieving families to tell their stories several times, Concurrently, bereaved people often receive insufficient information as to their legal rights and only sporadic communication as to the progress of investigations. This affects participation.

*Status of bereaved people*[35]

*31.* *Interested person bereaved people and survivors in inquests will have suffered serious harm, often at the hands of State or corporate bodies. However,* families do not receive the same practical support as those recognised as 'victims' in the criminal justice system.

32. Bereaved people and survivors in investigations into contentious deaths should be afforded the relevant entitlements outlined in the Code of Practice for Victims of Crime[36], the statutory code that sets out the minimum level of service that victims should receive from the criminal justice system. These may include conducting a needs assessment to identify what support is required; interviewing without unjustified delay and limiting the number of interviews to those that are strictly necessary; arranging court familiarisation visits; providing expenses for travel to inquests, subsistence and counselling; and affording a route for administrative complaints, with a full response to any complaints made.

*Delay*

33. An unexpected death may trigger investigation by a wide range of investigators. A lack of coordination between different investigating agencies is a significant cause of delay.[37] In cases where specialist agencies are involved in investigations concurrent with an inquest, coroners should hold prompt and regular pre-inquest hearings with investigating agencies requiring them to liaise closely and account for the progress of their work and coordination.[38] Building on this recommendation, our proposed SPI incorporates a pre-hearing at which it would be open to the judge or Senior Coroner to request that agencies conduct specific lines of inquiry,[39] and

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[35] Paras 3.3-3.5
[36] Ministry of Justice, <u>*Code of Practice for Victims of Crime*</u> (2015).
[37] Paras 3.6-3.10
[38] *R*ecommendation 49
[39] As a comparator, see also Crime and Courts Act 2013 s. 5 and Sch. 3, which provide the Director of the National Crime Agency with the power to *request* or *direct* another police force to fulfil a task. We do not propose that the SPI judge or Senior Coroner is given powers of direction.

to report on whether and how they are working with one another, and how delay is being minimised.[40]

*Witness questioning*

34. Bereaved people and survivors are often required at the early investigative stage to give evidence on multiple occasions, where a number of agencies with discrete objectives require witness evidence relating to a single event. Evidence from our consultees suggests that the experience of *repeating* evidence to several agencies is in itself “distressing, exhausting and deeply inefficient”. One consultee described the process for bereaved families as a “war of attrition”.[41]

35. Recognising existing efforts to encourage coordination, the Working Party recommends that where possible, investigating agencies collaborate in the questioning of witnesses. A lead interviewer should aim to gather evidence that can satisfy the objectives of multiple investigations and form part of a cross-jurisdictional dossier. Investigating agencies should meet with a view to appointing interviewers and briefing them as to the issues on which information is sought. Interviewers should employ cognitive interviewing techniques to elicit the fullest possible evidence in a single session.[42]

36. In addition, where possible, interviews conducted during investigations should be video recorded so that the recordings and transcripts can form part of the dossier.[43] In addition, evidence-gathering teams should undergo training on trauma-informed practice and communication with those who have suffered catastrophic bereavement.[44]

**Early participation of bereaved people and survivors**

*Notifying next of kin*

37. Participation of bereaved people is stymied from the very start of the inquest procedure. As a result of there being no legal definition of “next of kin”, coroners' officers may simply accept that the first relative who makes contact should be registered as “next of kin” irrespective of the nature of their relationship with the deceased. Being considered next of kin is greatly beneficial, as it affords a number of rights beyond other interested persons. The Chief Coroner should issue guidance defining “next of kin”, and the term should be explained in communications from the coroner's office to bereaved people.[45]

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[40] Para 2.66

[41] See also ‘INQUEST report of the Family Listening Day held to support the Rt Rev Bishop James Jones' Review of the Hillsborough Families' Experiences', April 2017 and ‘INQUEST report of the Family Listening Days held to support the independent review into deaths and serious incidents in police custody', May 2017.

[42] Para 3.14. Recommendation 21

[43] Recommendation 22

[44] Recommendation 23

[45] Recommendation 24

38. Furthermore, we have been told that families are not uniformly given reasons where a decision is taken not to investigate, and so are left unsure as to whether to challenge a decision. The Working Party recommends that where a coroner decides that an investigation should be discontinued, the coroner's office should ensure that the next of kin or personal representative are always informed of the reasons for the decision within seven days.

*Communication about the procedure*

39. The importance of proper communication has been a constant throughout our evidence gathering. Families consistently speak to the experience of being unaware of the procedural steps ahead, their rights in the process and in particular the possibility of seeking specialist legal representation.

*Immediate provision of information*

40. It is crucial that at the earliest possible point following the initial report of a death to the coroner, bereaved people are informed of the procedural steps ahead and their rights (including the right to be properly represented). In order to make informed decisions, families need information about access to their loved one's body; the post-mortem process (including the possibility of a non-invasive post-mortem); and the possibility of the removal of body parts. It is also essential that family members are informed from the outset about what to expect at an inquest hearing: the roles of the legal professionals; the order of proceedings; the process of giving evidence; and the courtroom layout.

41. Equally importantly, families need to know how to find relevant organisations offering specialist advice and support about contentious deaths involving investigations, inquests and inquiries and how these processes impact on traumatic bereavement.

42. The Working Party recommends that in cases where a coroner has taken the decision to begin an investigation, provision of the Ministry of Justice's 'Guide to Coroner Services for Bereaved People'[46] should if possible coincide with the notification of next of kin or personal representative.[47]

43. The Working Party recommends that the 'Guide to Coroner Services for Bereaved People' point out that officials are likely to be legally represented. The Guide should also be amended to advise family members concerned about the circumstances of a loved one's death to urgently seek specialist legal advice.[48]

*Continuing communication*

[46] Ministry of Justice, 'Guide to Coroner Services for Bereaved People', 2020
[47] Recommendation 27
[48] Recommendation 28

44. There is no consistent standard as to the regularity and volume of contact bereaved people might expect from a coroner's office once an investigation is opened. Our consultees and members of the Working Party acting for bereaved families stressed that in practice, communication tends to be irregular, with long periods of silence typically followed by a sudden deluge of information and disclosure shortly before a hearing. In general, we conclude that more regular contact is desirable. However, we recognise that in some cases additional contact may serve to re-traumatise and be unwanted. Moreover, a person's need for regular contact may change as a hearing approaches. It is recommended that where an inquest is opened, progress updates should be given to family interested persons every three weeks, or by agreement at such interval as the family interested party requests.[49]

45. The Working Party that where a coroner opens an inquest, or the Chief Coroner invokes the SPI, bereaved people should be directed to an engaging, clear and professional quality video on what to expect at an inquest.[50]

**Pre-Hearing Procedure**

46. Bereaved interested persons in inquests typically report a "drip-feed" of documents in the months following the death, often with a glut of material arriving the night before or on the day of the hearing. Furthermore, despite the advances made in the questioning of vulnerable witnesses in the criminal justice system ("CJS"), families in inquests are typically "not prepared for what they [have] described as the intensity and ferocity of the approaches taken by lawyers representing public authorities".[51] This is exacerbated by the difficulty in accessing public funding for representation at inquests under the current regime, which means that families are almost invariably left to navigate this adversarial battle without specialist legal support and whilst in the midst of grief.

47. In inquests, lack of candour and institutional defensiveness on the part of State and corporate interested persons are invariably cited as a cause of further suffering and a barrier to accountability.

*Disclosure*

48. A number of consultees and Working Party members reported significant delays in receiving disclosed evidence from coroner's offices. In order to avoid the problems and potential unfairness caused by late disclosure, the Working Party recommends that where documents have been received by the coroner and there is no objection from the record-holder, a presumption should apply that disclosure will be made to bereaved family interested persons within seven days of receipt. Where in exceptional circumstances disclosure within that period is not possible, notice

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[49] Recommendation 29
[50] Para 3.42. Recommendation 30
[51] The Rt Rev Bishop James Jones KBE, 'The patronising disposition of unaccountable power': A report to ensure the pain and suffering of the Hillsborough families is not repeated (HC 511, 2017), para 2.72.

should be given to the relevant interested persons.[52] Also, in order to encourage transparency and promote participation, the Working Party recommends that SPIs and public inquiries issue regular public updates on disclosure, including the number of documents already disclosed and time estimates for the completion of any processing phase.[53]

*Duty of Candour*[54]

49. A number of reports have cited "institutional defensiveness" as a main concern for bereaved and survivors, who have expressed that a refusal to acknowledge wrongdoing or engage openly with the inquest further exacerbates feelings of injustice. In addition to the pain and suffering caused, such a stance contributes to lengthy delays as the inquiry grapples with identifying and resolving the issues in dispute.[55] The Working Party recommends that a statutory duty of candour in inquests (and inquiries) should be introduced, subject to the privilege against self-incrimination.[56]

**Hearing Procedure and Practice**

50. Evidence from bereaved family members and their representatives suggest that, ostensibly, inquisitorial procedures are often a "highly adversarial battle"[57] and can isolate and exclude lay users.

51. Recognising that legal processes can be deeply alienating for lay users, and drawing on the proposals in our *Understanding Courts* Report[58], the Working Party makes four general recommendations applicable across inquests and inquiries:

    i. All inquest and inquiry professionals should be encouraged through training, continuing professional development and reflective processes to empathise with bereaved people and survivors, involving both active and observational methods, such as sitting in the witness box, using a video link, sitting in hearings where they themselves are not acting, and shadowing members of the Coroners Courts Support Service.

    ii. Careful consideration should be given to communication in the hearing to ensure that – as far as possible – the proceedings can be fully understood by family members and members of the public.

[52] Recommendation 36
[53] See Grenfell Tower Inquiry, 'Update from the Inquiry', 9 June 2020: "Disclosure figures: as at 8 June 2020, the Inquiry has disclosed 20,752 documents in Phase 1, and 154, 333 in Phase 2, coming to a total of 175,085".
[54] Para s4.32-4.49
[55] Jones, *supra* note 50, para 2.106.
[56] Recommendation 39
[57] Jones, *supra* note 50, para 2.37 (citing David Conn).
[58] JUSTICE Working Party report, Understanding Courts (2019).

iii. Inquests and inquiries should put systems in place so that vulnerabilities of any interested persons, core participants or other witnesses are identified early, and appropriate adjustments made to enable them to effectively participate.

iv. Inquests and inquiries should ensure that bereaved people and survivors are signposted to appropriately specialist sources of support for trauma, including at the close of the legal process.[59]

*Questioning witnesses*

60. A number of accounts of inquest proceedings suggest that interested persons are on occasion subjected to aggressive and inappropriate questioning. We consider that there is much to be learnt from best practice developed for cross-examination in criminal trials. This was an impression enthusiastically greeted by consultees with practices straddling both jurisdictions. Consequently, the Working Party recommends that advocates and coroners questioning witnesses in inquest and inquiry hearings should be required to complete the ICCA *Advocacy and the Vulnerable* training programme. Further, it recommends that the Advocate's Gateway should consider providing a toolkit for questioning witnesses in inquests and inquiries.

## Fairness in the Coroner Service

52. Our concerns with the overall fairness of the Coroner Service centre on its ability to position bereaved people and survivors at the heart of proceedings and enable effective participation. Essentially, meaningful participation depends first and foremost upon an understanding of the process, which in turn depends upon proper communication as to what it is for, what is involved, what is to happen and when. People thrown into the system need to know from the outset what part they can play, whether they can be represented, and if so whether their representative will be able to ask questions, and whether they will be able to see any documentary material. The importance of effective communication cannot be overstated.

*Publicly funded legal representation*[60]

53. Public funding for legal representation in inquests is still heavily circumscribed and only available through the Exceptional Case Funding (ECF) scheme. ECF may be granted only where it is required by Article 2 ECHR or where representation is in the "wider public interest"[61] such that it "is likely to produce significant benefits for

[59] The Infected Blood Inquiry webpage has a click-through box labelled "confidential support" clearly visible on the frontpage of its website. This details the telephone counselling service run by the Red Cross, available to anyone affected by treatment with infected blood or blood products.
[60] Paras 5.16-5.23
[61] Legal Aid Agency, 'Inquests – Exceptional Cases Funding – Provider Pack', 15 May 2020, p. 3.

a class of person, other than the applicant and members of the applicant's family".[62] The current arrangements mean that legal representation at inquests is out of reach for the vast majority of bereaved people. In the class of complex cases concerning the Working Party, specialist legal representation is invariably essential.[63]

54. State and corporate interested persons are typically able to deploy ranks of solicitors, junior barristers and QCs to advise and advocate on these issues.[64] In this context, to claim that families' effective participation can be guaranteed by the coroner and the "inquisitorial" nature of the process is to ignore the reality. Further, evidence from our consultees suggested that the extensive financial disclosure necessitated by the means assessment is an intrusive and demeaning process, in circumstances where the cost of representation in an inquest is in any event beyond those of any reasonable means.

55. The Working Party recommends that the Lord Chancellor should amend the Exceptional Funding Guidance (Inquests) so as to provide non-means tested public funding for legal representation for families where the State has agreed to provide separate representation for one or more interested persons.[65]

*Survivor Testimony*

*56.* Many of our professional consultees suggested that inquests can serve a cathartic function, However, the claim that they presently do so in practice should be treated with caution. Drawing on the strengths in the models adopted by the IICSA's Truth

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[62] *Ibid.*

[63] See submissions made by the CTI to the London Bridge Inquests (26 June 2019), pp. 165-6: "…in our respectful submission, the part played by [counsel for the families] and their instructing solicitors has been of great assistance in exploring the issues and allowing the Inquests to be as rigorous as they have been". In response, the Chief Coroner "entirely endorsed" the CTI's observations.

[64] For example, in the London Bridge inquests, legal representation for public authorities comprised:
three QCs and a Junior for the Secretary of State;
one QC and one Junior for the Metropolitan Police;
one QC for the City of London Police;
one QC and one Junior for the British Transport Police;
one junior for the London Ambulance Service;
one junior for the London Fire Commissioner;
one junior for Transport for London;
one junior for the City of London Police; and
one junior for the IOPC.
All of the above were supported by full solicitor teams. The Working Party is grateful to Hogan Lovells for the provision of this information.

[65] Amendment of the Guidance would bring a collateral benefit. In our experience, the availability of public funding for advocacy in Article 2 ECHR inquests invariably leads to extensive argument as to whether Article 2 is engaged (and subsequent judicial review challenges). Adoption of our recommendation would address this source of delay and expense.

Project[66] and INQUEST's Family Listening Days,[67] the Working Party recommends that SPI teams should consider incorporating a non-evidential forum to facilitate the therapeutic giving of testimony by bereaved people and survivors.[68]

JUSTICE
2 September

[66] See IICSA website, 'The Truth Project'.
[67] See INQUEST website, 'Family Listening Days'.
[68] Recommendation 54