The Coroner Service: follow-up

Justice Committee Inquiry

Written Evidence

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Introduction

1. JUSTICE is a cross-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. Our vision is of a UK justice system that is fair, accessible, and respects the rights of all, and which reflects the country's international reputation for upholding and promoting the rule of law.

2. This is a response to the Justice Committee's call for evidence regarding the Coroner Service. It addresses the questions posed by the Committee concerning changes made to the Coroner Service since 2021, when the Committee published a series of recommendations aimed at improving the effectiveness of the service, and the experiences of bereaved people.

3. In answering these questions, we have primarily drawn on our 2020 Working Party *When Things Go Wrong: the response of the justice system.* The Working Party, chaired by Sir Robert Owen, and comprised of experts in inquests and inquiries, also made recommendations aimed at, amongst other things, remedying short comings in the coronial system. We were pleased to see substantial overlap between the recommendations of the Working Party and the recommendations of the Justice Committee in 2021.

4. This submission sets out areas where progress has been made, highlighting where more could be done to improve the experiences of bereaved families. It also identifies changes that could be made to improve consistency in the coroner service; ensure lessons are learnt and future deaths prevented; and to reduce delays and duplication in the inquest process.

Q1: What progress has been made towards the goal of placing bereaved families at the heart of the Coroner Service.

5. JUSTICE considers that whilst some progress has been made towards improving the experiences of bereaved families in the Coroner Service, the steps taken do not go far enough.

6. First, there have been some positive changes to legal aid. From January 2022, bereaved families have been able to apply for legal representation through exceptional case funding ("**ECF**") without means testing. As of September 2023, bereaved families have additionally been able to apply for non-means tested legal help, through the ECF team. Removing means testing for ECF is a significant step to improving the experiences of bereaved families at inquests and levelling the playing field between bereaved families and the state. Evidence, taken during our Working Party, found that the extensive financial disclosure necessitated by the means assessment was experienced by bereaved families as intrusive and demeaning.[1]

7. However, the circumstances under which families are entitled to ECF are limited. ECF may be granted only where it is required by Article 2 of the European Convention on Human Rights ("**ECHR**") or where representation is in the "wider public interest" such that it "is likely to produce significant benefits for a class of person, other than the applicant and members of the applicant's family."[2]

8. This means that despite the changes, the many families are still left to navigate complex legal processes alone and in the midst of grief, whilst state and corporate interested persons are typically able to deploy ranks of solicitors, junior barristers and KCs.[3] Examples of these circumstances include self-inflicted deaths of voluntary patients in mental health settings or under the care of a mental health trust in the community, deaths in supported accommodation or in care settings where the person has been placed by a public body or local authority.[4]

9. In this context, the claim that families' effective participation can be guaranteed by the coroner and the "inquisitorial" nature of the process is to ignore reality.[5] To truly level the playing field for bereaved families, JUSTICE considers that public funding should be available for cases that would or may sit outside ECF criteria, where the State has agreed to provide separate representation for one or more interested persons. This

[1] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para 5.19.

[2] Legal Aid Agency, 'Inquests – Exceptional Cases Funding – Provider Pack', 15 May 2020, p. 3.

[3] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para 5.18.

[4] JUSTICE and INQUEST, Judicial Review and Courts Bill: Joint Briefing for House of Lords Committee Stage (2022), paras. 7-12.

[5] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para 5.2, 5.18.

recommendation was reflected in the Justice Committee's 2021 report on the Coroner Service.

10. There has since been some recognition from government on this point. In 2023 the Home Office, responding to Bishop Jones' report on difficulties faced by Hillsborough families, committed to consulting on expanding legal aid for inquests following public disaster. It will also "seek to further understand the experiences of bereaved families at other inquests where the state is represented."[6] Whilst we are glad that the government has finally recognised that the inquest process is often experienced as adversarial by bereaved families,[7] placing bereaved people at the heart of the inquest process requires concerted change in line with the above recommendation.

11. Another step taken by the government aimed at improving the experiences of some bereaved families, is the proposed introduction of advocates for victims of major incidents. These advocates would be introduced by the Victims and Prisoners Bill.[8] The Bill would amend the Coroners and Justice Act 2009 to make an advocate an Interested Person at an inquest into a death following a major incident, meaning that they would be able to ask questions of witnesses and receive copies of evidence relevant to the inquest.[9] In addition, advocates would help victims of major incidents understand the actions of public authorities, direct victims to sources of support, communicate with public authorities on behalf of victims, and assist victims in accessing documents.[10]

12. As highlighted in our briefing ahead of the Bill's Second Reading in the House of Commons, it is unclear what added value an advocate would bring to inquests as an Interested Person. This is because legal representatives already have powers to facilitate engagement with the legal process by, for example, requesting documentation.[11] We are concerned that without further clarification on the role of the advocate in this context, their position as another Interested Person at an inquest could create duplication and confusion. Additionally, whilst we support provisions to increase support for bereaved people at inquests and during other post death investigations, the support provided by advocates

[6] Home Office, *A Hillsborough legacy: the government's response to Bishop James Jones' report* (2023).

[7] Ibid.

[8] Victims and Prisoners Bill 2023, clauses 28-39.

[9] ibid, clause 34.

[10] ibid, clause 33.

[11] JUSTICE, Victims and Prisoners Bill House of Commons Second Reading Briefing (2023), para 19.

would only apply to a comparatively small subset of bereaved people – namely those bereaved through a major incident.[12]

13. Moreover, the steps taken by government and other public bodies to date do little to address the institutional defensiveness that mars many bereaved families' experiences of inquests and other post death investigations. In 2023, the government signed the charter for families bereaved through public tragedy, following other public bodies,[13] such as the police and fire services. The charter commits its signatories to, amongst other things, approach inquests "with candour in an open, honest, and transparent way, making full disclosure of relevant documents, material and facts."[14] In our 2020 report we highlighted that the voluntary nature of this Charter means that its impact is limited. For instance, whilst all police forces signed up to the Charter in 2021, reports like the Casey Review show that this has done little to counter the culture of secrecy and institutional protectionism within the Metropolitan Police.[15]

14. To ensure truth and accountability for bereaved families at inquests, and investigations, there needs to be a statutory duty of candour: a codified requirement on all public bodies, and other adjacent corporations to assist with investigations, including inquests proactively and truthfully, at the earliest possible opportunity. As our 2020 report highlighted, a statutory duty of candour would significantly enhance the participation of bereaved people in inquests, by guarding against institutional defensiveness and fostering a 'cards on the table' approach.

15. Furthermore, JUSTICE is concerned that their remains a significant lacuna between the entitlements afforded to bereaved people at inquests, and those afforded to victims of crimes. Bereaved people in inquests will have suffered serious harm, often at the hands of the State or corporate bodies. However, families do not receive the same level of practical support as those recognised as 'victims' in the criminal justice system.

16. To rectify this, JUSTICE considers that the relevant provisions of the Code of Practice for Victims of Crime should be extended to apply to bereaved interested persons at inquests,

[12] For definition see clause 28 of Victims and Prisoners Bill.

[13] For instance, National Police Chiefs Council on behalf of all police forces in England and Wales; College of Policing; Crown Prosecution Service; various fire services; various local authorities.

[14] See, Charter for Families Bereaved through Public Tragedy.

[15] Baroness Casey, *An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service* (2023).

through the introduction of a statutory code.[16] This code should reflect the principles, set out under clause 2 of the Victim and Prisoners Bill, applicable to victims of crime, namely that they should:

a. Be provided with information;
b. Be able to access support services;
c. Have the opportunity to make their views heard; and
d. Be able to challenge decision which have a direct impact on them.

17. From a practical perspective, the introduction of a statutory code guided by the above principles would require coroners to reconsider their protocols in line with certain minimum entitlements. This could include making provisions to conduct needs assessments 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.[17]

18. Beyond these substantive benefits, extending the Victims' Code to the inquest context would also raise the status of victims within these processes. Affording bereaved interested persons entitlements in line with the Victims' Code would represent a recognition of their status as victims of significant, and often wrongful, harm who should be treated in a manner that is dignified and promotes participation.

19. In When Things Go Wrong, we made a range of recommendations which addressed bereaved peoples experience of the inquest process itself.[18] These provide examples of the kinds of things that could be included in statutory code for bereaved people. In the absence of a statutory code, steps should in any case be taken to implement these recommendations across the coroner service.

20. Finally, little progress has been made to ensuring that the findings of inquests in relation the prevention of future deaths are acted on by government bodies. Our research found that the ability of inquests to effect meaningful change and prevent future deaths is a key

[16] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para 3.5.

[17] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para 3.5.

[18] See ibid, recommendations 27, 28, 29, 31, 32, 33, 40, 41, 42, 43.

factor motivating families' participation in the process.[19] This is dashed when findings are not implemented, and the grief and trauma of families is exacerbated when deaths continue to occur in similar circumstances.[20] The introduction of a National Oversight Mechanism, charged with overseeing the implementation of findings and recommendations arising from post death investigations is crucial to placing bereaved families at the heart of these processes. This proposal is set out in greater detail in our response to question 5 below.

Q4: Given that the Government has rejected the Committee's recommendation to unite local coroner services into a single service, what more can be done to reduce regional variation and ensure that a consistent service operates across England and Wales.

21. In our 2020 report JUSTICE, recognised that the introduction of a national coroner service may have significant benefits for allocation of resourcing and consistency of standards. However, a recommendation to unite a local coroner service into a national service was ultimately beyond the scope of our Working Party. Moreover, we recognise that there are also a number of advantages associated with the local authority administered structure.[21]

22. Nevertheless, as recognised by our research, the current structure is liable to produce significant variation in the standard of coroners' decision making and a lack of uniformity in the ways that coroners are resourced and supported. Some of the variation went to practical concerns: we were told that the Gwent Coroner Service did 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 without requisite experience presiding over complex Article 2 ECHR inquests involving issues of systemic failure.

[19] ibid.

[20] ibid, para 1.17.

[21] 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". 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. Our consultees confirmed our experience of local coroners bringing to bear their knowledge of previous, similar cases from within the local area. See Stephen Sedley KC, Public Inquiries: A Cure or a Disease? (1989) 52 MLR 469, 472; Tom Luce, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* (Cm 5831, 2003), p. 180, para 15.

23. We consider that there are several steps that could be taken to reduce regional variation and ensure that a consistent service operates across England and Wales. First, greater consistency could be achieved through the establishment of a small Coroner Service Inspectorate, which would monitor the timeliness or process, standard and suitability of the physical environment and the provision of prompt clear information to families across the coroner system.[22] The inspectorate could also examine complaints made by members of the public and address complaints which cannot be resolved by the area coroner.[23]

24. The need for a Coroner Service Inspectorate was recognised in the Justice Committee's 2021 report.[24] However, the government was unable to accept its recommendation at that stage, stating that it needed to consider the affordability of establishing a new public body and ongoing running costs.[25] There is no indication that steps have been taken in relation to this recommendation.

25. Whilst we recognise that this would necessitate some expenditure of central funds, it is worth noting that such an inspectorate function was originally set to be discharged by HM Inspectorate of Court Administration ("**HMICA**"). When the HMICA was abolished in 2011, the Government stated its commitment to "joint inspection of the criminal justice system."[26] That no such commitment was, or has since, been made in relation to the coronial system, reflects a lacuna in quality control that sorely needs addressing.[27]

26. Moreover, given the envisaged role of the inspectorate with respect to ensuring early communication with bereaved families, their ability to make complaints and the suitability of hearing venues, the introduction of the inspectorate would also further the Government's stated aim of putting bereaved families at the heart of the justice systems response to tragedies.

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[22] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), paras. 2.36-2.39; Tom Luce, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* (Cm 5831, 2003), p.176.

[23] ibid.

[24] Justice Committee, First Report of Session 2021-22, The Coroner Service, HC 68, pp. 41-44.

[25] Justice Committee, Third Special Report of Session 2021-22, The Coroner Service: Government Response to the Committee's First Report, HC 675, p. 13.

[26] Ministry of Justice, 'Impact Assessment: Abolition of HM Inspectorate of Court Administration, IA No: MoJ 118', 2011, p. 4, para 7.

[27] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para. 2.38.

27. In addition to the establishment of a Coroner Service Inspectorate, we consider that consistency of the coroner's service would be improved by making the Chief Coroner a full-time appointment.[28] This would reflect the role as envisaged by in Luce's 2023 Fundamental Review.[29] We recognise that the current system, which allows the role to be combined with sitting duties may make the appointed more attractive. However, given the vital importance of the role in giving leadership to the jurisdiction and driving up standards, a full-time appointment is highly desirable so that these functions are not compromised.

28. There are also a number of steps that could be taken to ensure consistent treatment of bereaved people during inquests. For instance, we have been told that families are not uniformly given reasons where a coroner decides not to investigate, and so are left uncertain as to whether to challenge a decision. Where a decision to discontinue is made, 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.[30]

29. Equally, there is no consistent standard as to the regularity and volume of contact bereaved people might expect from a coroner's office once and 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.[31] 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.

30. To increase consistency, we consider 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.[32] The "victim contract" drawn up between certain police forces and victims of crime to regulate contact in accordance with the victim's wishes may serve as an appropriate model.[33]

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[28] Ibid, para 2.35.

[29] Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review chaired by Tom Luce (Cm 5831, 2003), p.186.

[30] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para. 3.30.

[31] ibid, para. 3.39.

[32] ibid, para. 3.40.

[33] See Suffolk Police, 'Victim and Witness Information' (undated), p. 2.

31. Finally, to ensure consistency in disclosure, we recommend 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.[34] Whilst we appreciate it is difficult to be prescriptive about disclosure at inquests and that it is important that the coroner can control the investigation and makes decisions on relevance, we consider that the above step is important both to reduce inconsistency and to avoid the potential unfairness caused by late disclosure. Where exceptional circumstances mean that disclosure with the seven-day period is not possible, notice should be given to the relevant interested persons.[35]

Q5: Whether more can be done to make best use of the Coroner Service's role in learning lessons and preventing future deaths. In particular (a) are Coroners across England and Wales making consistent use of their power to issue Prevention of Future Death (PFD) reports? And (b) could the way PFD reports are being used to help prevent future deaths be improved.

32. Whilst Prevention of Future Death reports are important in ensuring that lessons can be learnt and further tragedy avoided, the capacity of such reports to achieve this depends on public bodies acting on the concerns raised in such reports. However, as recognised in our 2020 report, and as remains the case today, the lack of accountability for or oversight of the implementation of PFD reports means that they are often not properly considered or acted upon by public bodies.[36]

33. There are strong reasons to address this, and for providing a more robust framework for the implementation of recommendations arising from post death investigation processes. A lack of accountability for implementing PFD reports has significant implications for public safety, as dangerous policies and practices go unaddressed increasing the likelihood of further deaths.

34. In addition to the public safety benefits, the implementation of PFD report findings is also of central importance to bereaved families. Research conducted for JUSTICE's Working Party revealed that a key concern of bereaved people is that others will not have to endure

[34] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para. 4.30.

[35] Ibid.

[36] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), paras 6.5 -6.7; INQUEST, *No More Deaths, Learning, action and accountability: the case for a National Oversight Mechanism*. (2023).

the deaths of loved ones in similar circumstances. This is undermined when the findings of PFD reports go unaddressed.[37]

35. Moreover, the lack of accountability for action taken in response to PFD reports has implications for Article 2 ECHR. As recognised by Dame Angiolini in her 2017 review of deaths in custody, the lack of accountability and oversight for implementing recommendations arising out of post death investigations, means that the preventative function of Article 2 ECHR inquests is "not yet being achieved adequately or consistently."[38]

36. JUSTICE, alongside organisations like INQUEST as well as many others, consider that the best way to reduce this accountability gap, and ensure lessons are learnt and future deaths prevented is through the establishment of a National Oversight Mechanism.[39] The National Oversight Mechanism would be a public sector body dedicated to monitoring the take-up and implementation of PFD reports, as well as recommendations arising from other post-death investigations, such as public inquiries. It would be independent of government and would be created by and accountable to Parliament.

37. In terms of the functions of the National Oversight Mechanism, JUSTICE considers that the Equality and Human Rights Commission ("**EHRC**") may serve as an instructive analogue. Like the EHRC, whose functions are contained in the Equality Act 2006, the National Oversight Mechanism should, at a minimum, be empowered to:

    a. Monitor recommendations, including findings of PFD reports, and actions taken to implement them;
    b. Report on the performance of those tasked with implementation;
    c. Give notice of non-compliance (where, for examples, no action is taken within a specific time).
    d. Require recipients of such notices to prepare an action plan.[40]

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[37] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para 1.17.

[38] The Rt Hon Dame Elish Angiolini DBE KC, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (2017).

[39] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), paras. 6.15-20, 6.27; INQUEST, *No More Deaths, Learning, action and accountability: the case for a National Oversight Mechanism*. (2023).

[40] We do not, however, anticipate the national oversight mechanism to operate at the scale of the EHRC or to require similar resources. For instance, we do not envisage it making applications to court for injunctions, bringing its own judicial reviews, or itself providing legal assistance. See JUSTICE, *When Things Go Wrong: The response of the justice system* (2020) para. 6.23.

38. In addition, such a body could also prepare thematic reviews regarding implementation of related recommendations across multiple inquests, and other investigations.[41] This would ensure that PFD findings, and other recommendations, are not viewed in silos, but rather as part of a boarder project to promote public safety.

39. As noted by Dame Angiolini, there would inevitably be a cost associated with the establishment of a National Oversight Mechanism.[42] However, JUSTICE considers that the proposals would bring long-term savings in preventing future deaths and the costly, investigations and inquests that follow.[43]

40. Finally, as well as promoting public safety, reducing costs, and ensuring better compliance with Article 2 ECHR, a National Oversight Mechanism would also allow for greater transparency as to whether and how public bodies are addressing concerns identified during post death investigations, which in turn would promote trust in these processes.

41. Whilst JUSTICE considers the introduction of a National Oversight Mechanism is the best way to ensure lessons are learnt and deaths prevented, it is worth noting that only a small proportion of inquests result in Prevention of Future Death reports being issued. Given this, narrative conclusions also play an important role in highlighting systemic failures.[44] We therefore recommend that the Office of the Chief Coroner should explore how best to compile and publish narratives online where those conclusions raise systemic failings.[45]

42. We appreciate that this task will involve providing some context for each conclusion and so may be more resource-intensive than simply uploading text. However, insofar as this practice would promote open justice, and contribute to great transparency about and accountability for such failings, it warrants serious consideration.

Q7: Whether there is evidence that inquests are taking too long to be completed, and if so why, and what can be done in response.

[41] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), paras 6.23-6.26.

[42] The Rt Hon Dame Elish Angiolini DBE KC, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (2017), para 17.36.

[43] ibid; JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para 6.25.

[44] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para 2.32.

[45] ibid, para 2.39.

43. In *When Things Go Wrong*, we identified an inquest system beset with delay and duplication. Since then, little has been done to mitigate this.

44. It is worth noting that longer inquests may not always be a bad thing. For instance, our consultation with bereaved people suggested that long investigations are on occasion welcome where length is perceived to correlated with thoroughness.[46] However, unnecessary delays create significant anguish for bereaved families, impede the effectivess of inquests and erode public confidence in the process. Our report highlighted several areas where delay and duplication could be reduced, and provided recommendations aimed at achieving this.

45. Unexpected deaths often trigger a wide range of investigators and processes. We recognise that the need for separation between proceedings able to determine liability and those, such as inquests, which are prohibited from doing so, means that to an extent some of the delays and duplication caused by multiple process are intractable.[47] However, more can be done to ensure that poor coordination of investigations and evidence gathering following a death does not cause undue delay.

46. For instance, we agree with Dame Angiolini's caution that "independence does not require isolation."[48] JUSTICE considers that where multiple agencies are involved in investigations concurrent with an inquest, coroners should hold prompt and regular pre-inquest hearings with investigating agencies to require them to liaise closely and account for the progress of their work and co-ordination.[49]

47. A related issue, raised frequently over the course of our Working Party, was the experience of bereaved people giving evidence on multiple occasions. To avoid the delay and distress caused by this, the Working Party recommended that investigating agencies should collaborate in the questioning of witnesses. A lead interview 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.[50]

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[46] Ibid, para 1.8.

[47] Ibid.

[48] The Rt Hon Dame Elish Angiolini DBE KC, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (2017), para 14.9.

[49] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para 3.10.

[50] Ibid, para 3.14.

48. To ensure that the interviewer can elicit the fullest possible evidence in a single session, when interviewing witnesses who have suffered trauma, interviewers should employ cognitive interviewing techniques, such as those incorporated into the Achieving Best Evidence framework.[51] The Achieving Best Evidence framework also suggests that interviews with "significant" or "key" witnesses should be recorded, as this is likely to "increase the amount and quality of information gained from the witness."[52] Whilst not appropriate in the context of a cognitive interview, interviews with witness who have not suffered trauma, including experts and eyewitnesses, should be video recorded so that the recordings and transcripts can form part of the dossier described above.[53]

49. Finally, we recognise that there may be difficulties in evidence sharing and rationalising between investigations aimed at ascertaining blame, and other investigations aimed at purely at fact finding or preventing future recurrence. However, subject to data protection, there is nothing preventing the migration of prosecution material to inquests, or indeed other investigations, once the criminal process concludes. In *When Things Go Wrong,* we recommended that where an inquest or other form of investigation follows a concluded criminal trial, investigators should consider whether the witness statement (including the victim impact statement) of a bereaved person used at trial might be sufficient to serve as that person's evidence for the purposes of the investigation.

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[51] Ibid, para 3.16.

[52] Ministry of Justice, 'Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures', 2011.

[53] JUSTICE, *When Things Go Wrong: The response of the justice system* (2020), para. 3.18.