INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

INQUEST and INQUEST Lawyers Steering Group
Judicial Review and Courts Bill
Briefing for Committee Stage: Part 2, Chapter 4, Clauses 37, 38 and 39

Contents

I. Introduction

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. The INQUEST Lawyers' Group is a national network of several hundred lawyers who provide legal advice and representation to bereaved families – often acting pro bono where funding is unavailable – as well as promoting and developing knowledge and expertise in the law and practice of inquests.

2. In the last 10 years alone, INQUEST has actively worked on over 2,000 cases as they pass through inquest and investigation processes. Currently we are supporting families on 483 cases. This briefing is informed by the experiences of these families and others we have supported over our 40 years of work. We recently gathered the views and experiences of the inquest system from over 50 bereaved families to inform our recommendations for change.[1]

3. **Part 2, Chapter 4 of the Judicial Review and Courts Bill deals with coroners** and attempts to improve the efficiency of the service in light of backlogs in coroner's courts due to the COVID-19 pandemic. INQUEST has concerns about clauses 37 to 39 of this Bill, which will:

    - Broaden the circumstances in which coroners can discontinue investigations (clause 37);
    - Give coroners power to hold inquests in writing in non-contentious cases (clause 38); and
    - Enable wider use of remote hearings, including powers to hold remote juries (clause 39).

4. We are also calling for this Bill to be amended to include a provision on public funding for bereaved families at inquests where state bodies are involved and have published a separate briefing for the Bill Committee on this issue.

5. In its current form, this Bill risks increasing the coroner's discretion to discontinue inquests and investigations which could result in important evidence

[1] INQUEST Family Evidence Submission to the Justice Committee Inquiry on the Coroner Service https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=41a24ded-3add-4099-979a-ad8adf080789 September 2020

not being tested and complex cases not being publicly scrutinised. We note there is little supporting evidence for the introduction of clauses 37 to 39, yet INQUEST's evidence from our casework, examples of which are included in this briefing, clearly outlines the need for careful safeguards. It is essential that safeguards be added to ensure proper investigation and scrutiny is permitted where necessary. Crucially, these safeguards must ensure that the wishes of families are given weight.

II. Clause 37: Discontinuance of investigation where cause of death becomes clear

6. Clause 37 of the Bill broadens the circumstances in which a coroner might discontinue an investigation into a death. Current law – the Coroners and Justice Act 2009 (CJA) – holds that, where a coroner has commenced an investigation, they must proceed to an inquest unless the cause of death becomes clear in a post-mortem examination. The Government claims this is a costly and unnecessary step where the cause of death may become clear through other means, such as through medical records.[2] As such, clause 37 will amend section 4 of the CJA 2009 to allow for an investigation to be discontinued if the coroner is satisfied the cause of death is clear (thus removing reference to a post-mortem as a necessary requirement for discontinuing an investigation). If the investigation is discontinued the coroner cannot then hold an inquest into the death unless fresh evidence later comes to light or a successful challenge brought to the decision.

7. INQUEST has three key concerns relating to clause 37 and its implications for inquests and bereaved families, which relate to:

   - The need to test evidence
   - Article 2 cases
   - The need to safeguard family's wishes

The need to test evidence

8. INQUEST is concerned that clause 37 would allow a coroner to discontinue an inquest based on evidence which could change if tested. The current wording of clause 37 states that a coroner must discontinue an investigation into an individual's death if they are "*satisfied that the cause of death has become clear in the course of the investigation*". While the Chief Coroner states in his 2020

[2] Judicial Review & Courts Bill, Explanatory Notes, §61, https://publications.parliament.uk/pa/bills/cbill/58-02/0152/en/210152en.pd, July 2021

annual report that such a provision *could* include evidence such as medical records[3], the Bill itself does not clarify the types of evidence which could be used and effectively allows any evidence obtained during the investigation to be used to justify discontinuance without the opportunity for it to be challenged at a later stage.

9. **Clause 37 therefore requires amendment to set out a series of safeguards to be met before an investigation into a death is discontinued. Such an amendment should ensure investigations are not terminated prematurely where there may be evidence which could change once tested.**

Case example: *Laura Booth*

Laura died on 19 October 2016 at Royal Hallamshire Hospital in Sheffield. Laura went into hospital for a routine eye procedure but in hospital became unwell and developed malnutrition due to an inadequate management of her nutritional needs. The coroner overseeing the investigation into Laura's death was initially not planning on holding an inquest because the death was seen to be from natural causes. However, Laura's family and BBC journalists fought for the coroner to hold an inquest. The inquest reached the hard-hitting conclusion that Laura's death was contributed to by neglect. A Prevention of Future Deaths report issued by the coroner to Royal Hallamshire Hospital noted serious concerns about staff's lack of knowledge and understanding of the Mental Capacity Act and recommended families are better consulted in 'best interests' meetings.

If clause 37 were applied in this case before evidence brought by Laura's family and journalists was properly scrutinised, there may never have been an inquest hearing. The serious failings in Laura's case would never have been brought to light and there would not have been a Prevention of Future Deaths report published, which serves a significant public interest in attempting to stop similar deaths occurring in the future.

Article 2 cases

10. The consequence of clause 37 outlined above could have a significant impact in cases where there has been a death of an individual in the community who was receiving state support or a so called 'natural causes' death of a detained person. While such cases are often viewed as non-contentious and believed not to require an inquest, it is common for evidence to emerge during the process to

[3] Chief Coroner, 2020, Report of the Chief Coroner to the Lord Chancellor, Sixth Annual Report 2018-2019, Seventh Annual Report 2019-2020, §143, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932518/chief-coroner_s-annual-report-1920.pdf

suggest further scrutiny is required. These cases are often borderline Article 2 cases, meaning there has been some argument over whether the case breaches the operational or systems duty to safeguard the right to life under the Human Rights Act. Where Article 2 is found to be engaged, the scope of an inquest is widened to include an investigation of the wider circumstances of the death. If clause 37 were used in such cases and an inquest hearing discontinued, there would be no hope of renewing submissions on Article 2 if evidence were to emerge – as it often does – that would engage it. **Clause 37 therefore must be amended to ensure the coroner has considered whether Article 2 is engaged and is satisfied it is not.**

Case example: *Case A*
INQUEST worked on the case of *A*, who died in hospital in 2012. *A* was admitted to hospital as a voluntary patient, had learning difficulties and a history of mental ill health. *A's* family waited several years for the inquest into *A's* death to begin. Prior to this, *A's* death was believed to be from natural causes meaning it would not have been subject to an inquest. However, *A's* family worked with lawyers who successfully argued that the case engaged Article 2 and that an inquest should be held. Consequently, the coroner found that *A's* death was not, in fact, natural but that there were major failures in treatment and a missed opportunities to provide proper care.

Had the coroner been able to discontinue this inquest prior to considering whether Article 2 is engaged, we believe it unlikely this case would have proceeded to a full inquest hearing.

Consent of the bereaved and other safeguards

11. Clause 37 includes no safeguards that would ensure the coroner has invited and considered submissions from bereaved families and asked for their consent to discontinue the investigation. The Bill does include some of these considerations in clause 38 and so it is not clear why these are not set out in clause 37. **We believe this inconsistency must be addressed and clause 37 amended to ensure the wishes of bereaved families are taken into account in the decision by the coroner, and that the family have an ultimate veto on the decision to discontinue an inquest.**

III. Clause 38: Power to conduct non-contentious inquests in writing

12. Clause 38 gives coroners the power to hold inquests in writing where they decide that a hearing is unnecessary (i.e. in non-contentious cases). Currently, Rule 23 of

the Coroners Rules allows for documentary inquests to take place, where no witnesses are required to give evidence but a hearing must still take place.[4] Clause 38 would change this by creating a new section 9C to the CJA 2009 allowing a coroner to hold an inquest entirely in writing. Section 9C does include a list of considerations the coroner must make prior to deciding to hold an inquest in writing, which include ensuring that all interested persons have been invited to make submissions, considering whether an interested person has put forward 'reasonable grounds' for a hearing to take place, and that there is no public interest in holding a hearing.

The need to safeguard bereaved family's wishes

13. The key concern with clause 38 is that there may be circumstances in which the bereaved family wants an inquest with a hearing, but a coroner deems one unnecessary. Other interested persons invited to make representations may argue against a hearing. Holding an inquest in writing in this context could deprive the family of the opportunity to explore all available evidence and limit their ability to scrutinise the account provided by relevant authorities, including by hearing oral evidence and questioning key witnesses.

14. INQUEST acknowledges that clause 38 does provide some safeguards in this regard. However, we believe these safeguards are insufficient. For instance, clause 38 does not mention the need to consider the bereaved family's wishes in terms and there is no guarantee that they will be given any weight in the coroner's ultimate decision. Therefore, it is not clear that a family's wishes would constitute the 'reasonable grounds' needed to decide against conducting an inquest in writing. The current drafting of this Bill leaves a wide discretion to individual coroners to determine whether 'reasonable grounds' for a hearing have been made out by a family.

15. Further, we know from our experience that at the point at which a family would be invited to make representations to the coroner on whether an inquest should or should not be held in writing, many families would not have legal representation to support them in making their views heard. This would put families at a disadvantage to other Interested Persons with the benefit of legal teams who are also invited to make representations and argue against a hearing. INQUEST's knowledge of the ways in which some lawyers working for state bodies attempt to close down lines of inquiry and limit scrutiny makes us very worried about the lack of safeguards in clause 38. **An amendment to clause 38**

[4] The Coroners (Inquests) Rules 2013, rule 23

should be introduced to ensure that inquests are not held without a hearing if that is against the wishes of the deceased's family. Some families may wish to have a hearing in order that evidence can be fully aired and they should have the opportunity to raise any concerns with the coroner directly.

Case example: *Jessica Durdy*
Jessica died on 16 October 2020 at a Women's Crisis Centre called Link House. Jessica had mental ill health and suffered with an eating disorder and depression for most of her adult life. The inquest into Jessica's death was originally listed as a Rule 23 documentary inquest. However, given emerging evidence that there were serious problems in Jessica's care, representations were made to the coroner seeking an adjournment to the inquest. This request was granted and a pre-inquest review is scheduled for later in the year, where lawyers will be able to argue that Article 2 is engaged.

If clause 38 had been applied in this case, Jessica's family may have struggled to make their arguments for why the coroner should proceed to an inquest hearing clear and an inquest in writing may have proceeded at the coroner's discretion and against the family's wishes.

IV. Additional concerns

16. While clauses 37 and 38 pose distinct issues and require a series of amendments to be raised at Committee Stage, INQUEST sees three additional areas of concern relating to both clauses, as follows:

    - The lack of public funding for families
    - Coronial discretion and inconsistency
    - Unclear evidence base

Lack of public funding for families

17. INQUEST is concerned that clauses 37 and 38 could exacerbate the difficulties faced by bereaved families who are not eligible for legal aid during the inquest process. Very few families whose case falls outside of Article 2 are entitled to legal aid. Therefore, engaging with the inquest process (making representations, putting forward reasonable grounds, submitting that there is disagreement or there is a public interest case for a hearing) could be very difficult for families without legal representation. This is especially problematic given that state

bodies are likely to be represented during the investigation stage of the process and may be better able to influence the coroner's ultimate decision.

Coronial discretion and inconsistency

18. In its May 2021 report on the Coroner Service, the Justice Committee found there to be "*unacceptable variation in the standard of service between Coroner areas".* In the absence of a national coroner service, a central concern for INQUEST is the widespread inconsistency in approach by individual coroners in relation to all aspects of the inquest process: a postcode lottery. This is a longstanding problem on which there has been insufficient progress since the 2003 Fundamental Review, chaired by Tom Luce, reported:

"The phrase we have heard more than any other during the Review is "the coroner is a law unto himself". Virtually every interest has complained of inconsistency and unpredictability between coroners in the handling of inquests […]"[5]

19. INQUEST is of the view that clauses 37 and 38 will further entrench levels of coronial discretion and inconsistency, adding yet more challenges for bereaved families forced to navigate the inquest system.

Unclear evidence base

20. The government has not evidenced how the above measures would address the stated problem of reducing the backlog of cases in coroner's courts: the latest statistics on the coroner service indicate an 18 percent rise in deaths in state detention.[6] Many of these cases are complex cases meaning the above provisions are unlikely to apply. INQUEST is aware the measures in clauses 37 and 38 were recently recommended by the Chief Coroner in his 2020 annual report,[7] but we are not aware of any other calls for these measures to be introduced. It is notable that none of the conclusions nor recommendations in the Justice Committee's May 2021 report on the Coroner Service provide any justification for these measures, despite its detailed analysis of the current state of the coronial system. We are concerned that the argument that these measures are

[5] Death Certification in England, Wales and Northern Ireland, The Report of a Fundamental Review, https://webarchive.nationalarchives.gov.uk/ukgwa/20131205105739/http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf, June 2003

[6] Ministry of Justice, Coroners Statistics 2020, https://www.gov.uk/government/statistics/coroners-statistics-2020/coroners-statistics-2020-england-and-wales, May 2021

[7] Chief Coroner, 2020, Report of the Chief Coroner to the Lord Chancellor, Sixth Annual Report 2018-2019, Seventh Annual Report 2019-2020, §143 and §145, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932518/chief-coroner_s-annual-report-1920.pdf

needed to address the COVID-19 backlog of cases in the coroner's courts are unevidenced, and will in fact lead to corners being cut and crucial opportunities for hearing and scrutinising evidence missed.

V. Clause 39: Use of audio or video links at inquests

21. Clause 39 would enable remote attendance at inquest hearings by amending the Coroners Rules to allow a provision for the conduct of hearings to be done either wholly or partly by way of electronic sounds or images. Clause 39 (2A) also sets out a provision to allow members of the jury to take part in a hearing virtually. 2A clarifies that all members of the jury must take part in the same way and from the same place.

22. INQUEST and ILG SG support measures to make pre-inquest reviews (PIRs) more readily available remotely and we have seen this working well in many instances. We also understand that, in some cases, remote inquest hearings will be appropriate and are aware of some families who have welcomed them during the COVID-19 period. Further, we are aware that there can be additional benefits of remote hearings in facilitating wider participation for public and media access.

23. However, we have heard a much greater number of very negative views on and accounts of the experiences of remote inquests from bereaved families. The Government claims that clause 39 will bring coroner's courts in line with mainstream courts and tribunals in allowing easier access to remote hearings[8]: we believe this reasoning fails to take into account key distinctions between the inquest system and other court processes. We are concerned that the measures put forward will significantly affect the ability of bereaved families to participate effectively in the inquest process.

24. We have specific concerns about the following:

- The impact of remote hearings on bereaved families
- The introduction of remote juries
- The lack of research or public consultation on these measures
- Accessibility, transparency, participation and open justice

The impact of remote hearings on bereaved families

[8] Judicial Review & Courts Bill, Explanatory Notes, §66, https://publications.parliament.uk/pa/bills/cbill/58-02/0152/en/210152en.pdf, July 2021

25. INQUEST's casework over the past four decades has revealed the uniquely distressing impact inquest hearings can have on bereaved families. The process, which involves hearing details about an individual's last moments before death, can have a re-traumatising effect on families.[9] We are concerned clause 39 will make it more difficult for many families to separate the distress of the inquest hearing from their personal lives.

26. We are also concerned that families engaging in the inquest process remotely will be unable to access in-person support from charities such as the Coroner's Court Support Service (CCSS). In the context of the Justice Committee inquiry on the coroner's service, the Chief Coroner emphasised the crucial role of CCSS volunteers to *"greet and meet families and make sure they are not by themselves".*[10] Justice Committee MPs picked up this point and made recommendations to make these services more available. It is our view that the provisions of this bill, rather than strengthen, would roll back on this.

27. Despite the distress, frustration and pain that can be caused by the inquest process, bereaved families go through it to understand the circumstances around their family member's death and to bring to light harmful practices with a view to prevent similar deaths in the future. INQUEST is concerned that remote hearings may disconnect families and key witnesses from this important process which serves a wider public interest.

28. While bereaved families have different experiences of remote inquests, and we know in some cases, remote inquest hearings may be appropriate and welcomed by families, for the large part, families are very concerned about inquests proceeding in remote form. We evidence some of their recent experiences as follows.

[9] INQUEST, Submission to the Justice Select Committee Inquiry into the Coroner Service, §45, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e404f863-cdfb-47b6-8e34-a65118520331, September 2020

[10] Justice Committee, The Coroner Service, https://committees.parliament.uk/publications/6079/documents/75085/default/, May 2021

Chris

Chris died after suffering cardiac arrest on 24 March 2019. Chris had been sectioned under the Mental Health Act and was under the care of Pennine Care NHS Foundation Trust. The inquest into his death took place in April 2021 – it was deemed an Article 2 inquest and was conducted with a jury. Following the inquest, Chris' family wrote to the local Senior Coroner to highlight the challenges they faced due to the remote technology used at the inquest. There were two main issues. Firstly, Chris' family saw a witness who was giving evidence remotely and representing Pennine Care "laughing and pulling faces with a colleague" on their screen. This came just after another member of staff gave evidence concerning the failure to observe Chris properly while he was sleeping. Secondly, the family accidentally saw CCTV footage of Chris' last hour which was to be used by another witness. Unsurprisingly, the family found these moments very distressing and wrote to the Senior Coroner to "ensure relatives of the deceased are not put through unnecessary additional distress".

Darrell Sharples

Darren died of suicide at his home on 21 July 2018. He was under the care of Cornwall Partnership NHS Foundation Trust. Darrell's family were informed at a very late stage in the inquest process whether the case would be wholly or partly remote. The family informed their lawyers that this caused them great concern because the family did not want to participate remotely. In addition, they did not have the facilities in their home to do so. The inquest was ultimately conducted as a hybrid hearing, with some parts carried out online and others in-person.

The introduction of remote juries

29. Clause 39 also proposes introducing remote juries to inquest hearings, justified on the basis that it would bring the coroner's courts in line with other jurisdictions where it is presently an outlier. However, clause 168 (as introduced) of the Police, Crime, Sentencing and Courts Bill, which would introduce remote juries in criminal trials, is still under consideration in the Lords and prompted a joint briefing from the Bar Council and the Law Society raising 'wide-ranging' concerns which included:

"…the risk of alienating juries and/or witnesses; ensuring security of proceedings (both in terms of the privacy of the process and individuals, and data privacy);

additional expense to the taxpayer; the requirement of new technology and IT systems; and the associated issues arising out of these aspects."[11]

30. For families this brings the additional challenge of them being unable to witness a jury's reaction to evidence being heard. ILG lawyers have told us of inquests they have sat on where the jury has sat in a separate room to the coroner, watching the hearing via video link. In more than one instance, lawyers have reported seeing members of the jury sleeping and eating, without the coroner having any knowledge. INQUEST is concerned this type of situation would be very hard to prevent if the proposals in clause 39 are enacted.

The lack of research or public consultation on these measures

31. The Government states remote hearings will reduce the *"additional distress"* of the inquest process for bereaved families – a claim for which it provides no concrete evidence.[12] We are not aware of any evidence base in academic or other research to support this move. Instead, as we evidence above, remote or partly remote inquest hearings can in fact add to the distress of bereaved families.

32. The only evidence we are aware of into the experience of remote juries was a limited pilot study by JUSTICE which did not look specifically at inquests. As a result of its pilot, JUSTICE concluded that whether remote inquests are appropriate is *"highly dependent on case's circumstances: its facts, complexity, attendees, and vitally the impact of a remote hearing on access to justice for the bereaved family who already face barriers to effective participation",* and that vital safeguards for families, greater investment in technologies and a pilot and evaluation are essential.[13] We share this view: the Government must be asked to produce evidence to support these dramatic changes, or be asked to conduct further research and consultation with bereaved families into the implications of remote hearings prior to enacting clause 39.

Accessibility, transparency, participation and open justice

[11] Bar Council and The Law Society, Briefing on the Police, Crime, Sentencing and Courts Bill, https://www.barcouncil.org.uk/uploads/assets/91e75e09-336b-4f00-ba16baf568b78457/Bar-Council-Briefing-PCSC-Remote-Juries.pdf

[12] Judicial Review & Courts Bill, Impact Assessment, https://publications.parliament.uk/pa/bills/cbill/58-02/0152/ETCoronerandOPRCImpactAssessmentfinal.pdf, July 2021

[13] JUSTICE, Judicial Review and Courts Bill (Part 2, Courts, Tribunals and Coroners) House of Commons Second Reading Briefing, https://files.justice.org.uk/wp-content/uploads/2021/10/12104430/JUSTICE-JR-and-Courts-Bill-Briefing-HoC-Second-Reading-Part-2-Courts-Tribunals-and-Coroners.pdf, September 2021

33. Hearings in public are a central and cardinal feature of the coronial system[14] and there is an obvious public interest in ensuring transparency and openness. Since the beginning of the pandemic, practice with regard to the ways inquests are held has become extremely variable. Coroners have been sitting in court throughout the pandemic because PIR and inquest hearings must be held in public.[15] The current variation in wider access relates directly to the availability of premises and the very different approaches taken by different coroners. This has meant families face extremely different experiences. The same relates to access for journalists and other members of the public, who have at times been denied remote access to hearings on various grounds.[16]

34. The Bill is unclear on the precise circumstances in which inquests would sit remotely and provides no stipulations on the way Interested Persons and the wider public should be able to access hearings. As a result, we are concerned that these measures will crystallise a gradual process towards reduced access, rather than being motivated by the opportunities of new technologies to increase it. We think it would row back on the important principle outlined by the Chief Coroner at §12 Guidance no.9:

"In public means not just open to the public but arranged in such a way that a member of the public can drop in to see how an opening is conducted."[17]

35. INQUEST and ILG SG support measures to conduct pre-inquest reviews (PIRs) remotely and we have seen this working well in many instances, but it would appear that clause 39 will amend s.45 of the CJA 2009 to allow coroners to attend hearings remotely more generally. This must be clarified: the new s.45 does not explicitly say that coroners can attend remotely from outside court or that coroners can attend remotely from outside court *as long as the hearing is still held in public*. This may be appropriate where an inquest is set to take place otherwise remotely with the family's consent but we have concerns where this is not the case. **We believe the Government must outline the rationale for the precise implications of clause 39 to be spelled out by government and halt the introduction of these provisions (beyond PIRs) until further research on the risks and benefits as well as a public consultation has been carried out.**

Contact

[14] Coroners (Inquests) Rules 2013 r11(1)
[15] Rule 11(3) Coroners (Inquests) Rules 2013 subject to the exceptions in 11(4) or (5). The importance of this principle was recently confirmed in Chief Coroner's Guidance no.38.
[16] Open Justice Coroners' Courts Survey, https://www.georgejulian.co.uk/wp-content/uploads/2021/10/Open-Justice-Coroners-Court-Survey161021.pdf, October 2021
[17] Chief Coroner, Guidance No.9, Opening Inquests, §9

Louise Finer, Head of Policy: louisefiner@inquest.org.uk
Rosanna Ellul, Senior Policy and Parliamentary Officer: rosannaellul@inquest.org.uk

October 2021