INQUEST briefing on the Coroners and Justice Bill 2009

Introduction

1. INQUEST was founded in 1981 following a number of controversial deaths in prison and in police custody. Although the scope of the organisation’s work has widened since then, its main focus remains deaths in custody. It provides a specialist, comprehensive, free advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. It provides a comprehensive information pack and referral service where appropriate to any bereaved family facing an inquest. It is consulted widely, by government Ministers and Departments, MPs, lawyers, academics, policy makers, the media and the wider public. Through its casework, INQUEST has a unique overview of how the whole system operates from the perspective of bereaved families and their advisers. It has extracted the policy issues arising from the deaths and their investigation and campaigned with and on behalf of bereaved families and their legal representatives for changes in practice to prevent deaths. Casework also informs our research, parliamentary and policy work.

2. In the last ten years we have worked on 2,300 cases advising over 7,000 family members.

3. The INQUEST Lawyers Group supports and advances the work of INQUEST in three main ways:
   
   (a) It is a national group of lawyers that provides preparation and legal representation at coroner’s inquests for bereaved people;
   
   (b) It promotes and develops knowledge and expertise in the law and practice of inquests, provides training, and acts as a forum for the exchange of ideas and experience;
   
   (c) It campaigns for law reform and for public funding to cover legal costs for bereaved people at inquests.

4. INQUEST and the INQUEST Lawyers Group publish Inquest Law three times a year which informs practitioners, coroners and academics about recent legal and policy developments relating to the inquest system, the investigation of sudden deaths and related areas.

5. This briefing was prepared with the assistance of members of the INQUEST Lawyers Group

The Reform Process

6. INQUEST has contributed evidence to the Fundamental Review of Coroner Services in 2003, the Joint Committee on Human Rights Inquiry
into Deaths in Custody in 2004 and the Constitutional Affairs Committee inquiry into reform of the coroners system in 2006. We have worked with and shared experiences with numerous international bodies including the Victorian Law Reform Committee (from Australia) during their inquiry into coroner’s reform. INQUEST published an extensive report, *Unlocking the Truth: Families’ Experiences of the Investigation of Deaths in Custody*, in 2007.

7. INQUEST is proud to be associated with the process that has led to this Bill finally being considered by Parliament and it is clear that some of our critical thinking has informed the current reform process. However we would wish to emphasise that there remains no room for complacency. The proposed legal instrument retains several defects of principle and practice in its current form which, if not eliminated or modified as outlined below, cause significant concern.

8. The government’s stated objective was to put the bereaved at the heart of the process. We believe that the Bill makes progress in remedying what has historically been an unnecessarily distressing situation for the families of the deceased. Many of our concerns and suggestions for change which have come directly from our work with bereaved families and their legal representatives are reflected in the proposed legislation.

9. We believe it will be a proud achievement if society has a Coroner Service that makes an important contribution to death prevention as the majority of bereaved families we work with are motivated by the hope that there will be accountable learning. A recurring theme common to virtually every family with whom we journeyed through the coronial system is simple: an unswerving desire that other families should not have to suffer the often preventable ordeal which they have had to endure.

10. INQUEST has particular expertise in cases which raise questions of state and corporate accountability. Significant changes in the legal framework governing such situations were made in principle to the investigation and inquest process following implementation of the Human Rights Act 1998 (HRA). However, the reality is that bereaved families and their legal teams have been the driving force behind securing practical applications for these changes, and for making the HRA and its associated rights under the European Convention on Human Rights (ECHR) a functioning reality. In particular, we have worked with families and lawyers to press for a more purposeful interpretation of the core rights, a broader scope of inquiry and the opportunity for the delivery of more meaningful verdicts by juries. The use of narrative verdicts in particular has been a tool for enhancing the participation of the jury in the analysis of systemic failure, and as such is a crucial expression of democratic accountability and aids the prevention of unnecessary future deaths. Many of these inquests have informed change to policies and
practices, but there is undoubtedley more work to do in this important area.

11. **INQUEST believes that the current coronial system is a failing, fragmented system.** In its current manifestation there is no other conclusion but that the system is unfit for purpose. The coroners who preside over it operate with no compulsory training; there is little meaningful accountability; and a postcode lottery service exists with good practice dependent on the approach of individual coroners rather than agreed quality standards with inspection and auditing against rigorous and transparent standards. In short, there is an unanswerable case for urgent and substantial reform.

12. **The legal rights of bereaved families in the proceedings are artificially and unnecessarily restricted, and their current place within it is anomalous and inadequate since the rules governing an inquest create a structure where the inquiry is not for them.** Consequently, the administrative framework is not directed at their full inclusion in the process. There is inadequate provision of information and support to bereaved families facing inquests at all stages which affects their capacity to participate effectively in the inquest process. There is no government-funded information service for families. Thus they often come to us having not been advised they can be legally represented during the process, nor have they been given any or any sufficient information about the inquest proceedings.

13. **This has been recognised by the government and addressed partially in the draft Charter for Bereaved People. But the Charter alone, without accompanying reform to ensure funding for legal representation, mandatory disclosure of information and a fully accountable Coroner Service, will make it difficult for families to enforce the rights outlined in the Charter and transform them from paper rights into genuine expressions of our community’s commitment to enhanced standards of care, decency and justice.**

14. **The system is especially ill-equipped to deal with deaths which involve questions of state or corporate accountability – and this is precisely where such rights are most necessary.** A thorough overhaul is needed in order for the system to have any have value for the families who pass through it and for meaningful public scrutiny of deaths in state custody. A well-funded, professional coronial system with a properly extended remit and decent powers can have a crucial role in preventing deaths in custody and act as an essential hallmark of democratic accountability. The United Kingdom has by virtue of its international treaty obligations a high duty to vindicate the article 2 ECHR, the right to life. The European Court has made plain how that obligation should be expressed procedurally:
The Court considers that the State’s obligation under Article 2 § 1 of the Convention to carry out an effective investigation arises independently of the position taken by the victim’s relatives. The fact that there has been no request for particular lines of inquiry to be pursued or items of evidence obtained cannot relieve the authorities of their duty to take all possible steps to establish the truth and ensure accountability for deaths caused by agents of the State. Furthermore, an investigation will not be effective unless all the evidence is properly analysed and the conclusions are consistent and reasoned. [Nachova v Bulgaria]

15. The irony is that in the coronial courts of England and Wales it has been consistently incumbent upon the families of the bereaved - those with the least power, authority, resources and access to information - to drive the search for truth after a death in the care of the state. It is a remarkable testament to the families we have worked with that through their quiet dignity, moral courage and simple persistence time and again the truth about the death of their loved ones has been slowly and painstakingly revealed. This process has been too haphazard and inconsistent, and must change.

The Coroners and Justice Bill 2009

Clause 1: Duty to investigate

16. We welcome the requirement to investigate "while in custody or otherwise in state detention" which we understand extends the definition to include the deaths of detained psychiatric patients, children held in secure training centres, and immigration detainees.

Clauses 2 and 3: Investigations by other coroners

17. We understand that it is intended that by these provisions, and other relevant parts of Part 1 of the Bill, that it will be possible for a coroner's geographical area boundary restriction to be "relaxed", and for the Chief Coroner to "reallocate work between coroners in the event of backlogs of work building up in a particular area" (see paragraphs 63 and 75 of the Explanatory Notes).

18. We welcome these provisions, because it is our experience that inquests are often substantially delayed due to the inability of coroners to find suitable venues within their geographical jurisdiction, or because of their own backlog of cases. Additional costs can also be incurred if a coroner is compelled to hire private facilities for the conduct of an inquest due to a lack of available court rooms within his or her geographical jurisdiction.
19. Our case study on the inquest into the death of Jean Charles de Menezes (Appendix, paras 13-21) is a good indication of the current difficulties caused by the geographical boundary restrictions. Southwark Coroner's Court was too small for the number of lawyers, press and members of the public who would wish to attend the inquest, and it could not be made sufficiently secure for the large number of witnesses granted anonymity. There was some delay while the coroner found suitable accommodation within his geographical jurisdiction, and we understand no Crown Courts could be used (despite there being several within the immediate vicinity) due to the number of ongoing terrorism-related trials creating their own backlog. We understand that venues such as local primary schools were also investigated.

20. Ultimately the only venue that was deemed suitable was the Oval Cricket Ground. As explained in further detail in the case study, this choice led to massive costs to the public purse and time pressures due to the limited time the Oval was available.

21. All these difficulties and costs could have been avoided had the coroner been able to transfer his jurisdiction more easily to a neighbouring coroner, and/or to use a venue outside his geographical jurisdiction such as one of the courts within the Royal Courts of Justice.

22. We therefore welcome the provisions in the Bill that would enable inquests to be more easily transferred to different coroners or venues.

23. In addition the current jurisdictional regime prevents the hearing of complex cases before specialist coroners: there is then a wide variation in approach depending on geographical area. We welcome these provisions that, coupled with the ability for the Chief Coroner to appoint Deputy Chief Coroners, could allow for specialisms to be developed. The Royal British Legion and others have expressed concerns that the expertise accumulated by Oxfordshire and Wiltshire coroners in the investigation of overseas military deaths might be dissipated by arrangements to move hearings. **We would urge an approach by the Chief Coroner to facilitate and encourage the development of specialist areas of knowledge and excellence that could in future serve as a nationwide resource which could be applied to a range of circumstances of death.**

**Clause 5: Matters to be ascertained**

24. The current system is still insufficiently resourced and is failing to perform its preventative function, which is to ensure a decline in preventable deaths. One of the purposes of any investigation into contentious deaths – in particular deaths in state detention and those raising questions of public health and safety - must be to learn any lessons that may arise out of a death so as to prevent similar cases
occurring in the future. For example in Victoria, Australia the emphasis of the coroners system is on death and injury prevention. It has been recognised in Victoria that there is an important public interest in learning from preventable deaths. **INQUEST urges the government to apply a similar ethos to the coroners system in England and Wales and to enshrine a positive duty on death prevention in any new legislation.** We propose the Bill be amended to include a clause that provides that the purposes of an inquest are:

(a) **to conduct a public investigation into a death which occurs in contentious circumstances in order to provide public accountability for the death;**

(b) **to provide an effective mechanism for eliciting and challenging evidence; and**

(c) **to provide a forum for interested persons to contribute to the development of coronial recommendations for the prevention of similar deaths.**

25. We note that clause 5(1) largely replicates the provisions of sections 11(3) and (5) of the Coroners Act 1988; and that clause 5(2) seeks to codify into statute the provisions of *R (on the application of Middleton) v HM Coroner for the Western District of Somerset & Anor* [2004] 2 AC 182.

26. We think that clause 5(1) defines the scope of all inquests too narrowly. There are clearly important cases involving questions of public health and safety where the Human Rights Act does not apply and where there is a need for a broader inquiry. The existing clause 5 creates a risk that limits will be placed on the nature of the inquiry that will frustrate both the opportunity for the bereaved to get adequate answers as well as the opportunity to seek to prevent future deaths. For example:

i. deaths raising concerns about rail, aviation and workplace safety, and multiple fatalities such as the Marchioness, Kings Cross or Hillsborough disasters;

ii. the death of a vulnerable older person in a private nursing home;

iii. death in a private workplace.

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1 In *Middleton*, the House of Lords held that in order for the coronial system to comply with its obligations under the Human Rights Act 1998, "how" in section 11(5)(b)(ii) of the Coroners Act 1988 and rule 36(1)(b) of the Coroners Rules 1984 should be interpreted as meaning not merely "by what means" but "by what means and in what circumstances".
27. We suggest the following replaces clause 5(1):

“[The purpose of an investigation under this Part into a person’s death is to ascertain:

(a) who the deceased was;
(b) how, when, where and in what circumstances (as appear relevant) the deceased came by his or her death.”

28. We suggest the following replaces clause 5(2):

“The circumstances in which the deceased came by his or her death may be relevant to the purpose to the investigation where:

(a) The investigation is required to ascertain such circumstances in order to avoid a breach of any Convention rights (within the meaning of the HRA 1998);
(b) The continuance or possible recurrence of such circumstances may be prejudicial to the health and safety of members of the public or a section of it; or
(c) There is otherwise sufficient reason for the Coroner to so consider in the interests of the public.”

29. One of the primary purposes of an inquest is preventing similar fatalities as recognised in schedule 4, para 6 (‘Action to prevent other deaths’) of the Bill; this is consistent with the recommendations of the Report of a Fundamental Review 2003, Cm 5831, Chapter 8, p89; long established by the Courts; consistent with other jurisdictions; and an essential aspect of any credible inquest system that serves the public interest. It should be explicitly recognised in the Act to prevent inconsistent standards and legal uncertainty.

30. To the extent that clause 5(2) seeks to place the ratio of Middleton on a statutory footing it is to be welcomed, although we remain unclear as to why the introduction to clause 5(2) refers to a breach of “any Convention rights” when it is only likely in practice to be article 2 (or possibly article 3) that is in issue.

31. However, we welcome the fact that clause 5 does not seek to limit the matters that can be explored in an inquest, only those that must be ascertained: this reflects case law which has long recognised that the scope of an inquest can be wider than is strictly necessary to determine those matters that have to be ascertained; and also recent good

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2 For example: R (on the application of Amin) v. Secretary of State for the Home Department [2004] 1 AC 653 at para 31; R (on the application of Takoushis) v. HM Coroner for Inner North London [2006] 1 WLR 461, paras 39, 43 to 47; Inner West London Coroner v Channel 4 Television Corp [2008] 1 WLR 945, paras 7 and 8.
practice, such as the inquests into the deaths of Diana, Princess of Wales and Dodi Al Fayed, where Scott Baker LJ (who presided over the inquests) recognised that the particular public interest in that case justified a far wider investigation than the law would have required\(^4\). It is likely that by conducting such a wide enquiry, Scott Baker LJ did in fact ensure that the inquest performed the important public functions of allaying rumour and suspicion.

**Clause 7: Whether jury required**

32. We consider that juries are fundamental to a democratic system as they are the only opportunity where ordinary people, independent of the state, can participate in the judicial system. They have the effect of diffusing power into the community and in cases of contentious deaths are often seen by families as the key safeguard in terms of public accountability.

33. We also welcome the widening of the custody element of this provision to include all those in custody "or otherwise in state detention". As we submitted in 2006\(^5\), it is important that juries are permitted to adjudicate on deaths not only in prison or in police custody but also immigration or mental health detention and secure training centres.

34. However, we raise a note of caution in that new clause 7(2) differs from the current Coroners Act 1988 clause 8(3) in that it does not specify that an inquest must be held with a jury if the death occurred in prison and was neither violent nor unnatural, or where the cause of death was unknown, or does not fall within the other criteria set out in 7(2) a – c. The intention here is to allow coroners discretion not to have a jury in cases of deaths of detainees where there is clearly no reason to do so. **However the new system must ensure that in those deaths that occur in prison or otherwise in state detention that are initially classified as by natural causes this does not become the default position.** Some of the deaths that fall within this category have raised important questions about standards of care or have upon investigation raised issues of significant concern about the treatment of detainees prior to a “natural death”. Systemic issues may arise, issues which may adversely affect the lives of a very large number of detainees. Such context may constitute an important part of the circumstances surrounding a death, and should not be relegated to the realm of in consequence depending on which side of natural causes dividing line the case happens to come. What remains of supreme importance is the effective investigation of deaths in state custody, achieved through the optimum mode of democratic accountability – the jury.

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\(^4\) The *Middleton* obligation did not apply, the deaths having occurred prior to the coming into force of the Human Rights Act 1998; and on one view the investigation was even wider than *Middleton* would have required if it did apply.

\(^5\) INQUEST Legal Submission on the Coroner Reform Bill 2006
35. We note that clause 7, while being modelled on the current s.8(3) of the Coroners Act 1988, widens the circumstances in which a jury must be summoned; gives coroners a wide residual discretion as to when they may summons a jury (if they consider that there is "sufficient reason" for doing so); and that there will be a right of appeal to the Chief Coroner against a coroner's decision with respect to the summoning of a jury.

36. We would, however, argue that in addition to the general discretion provided for under the new clause 7(3), the law should continue to require an inquest jury in those cases which would currently fall within section 8(3)(d), namely those deaths that "...occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public". It seems to us that this is a discrete category of cases which would merit specific provision.

37. We therefore broadly welcome these provisions. They will ensure that juries continue to be summoned in those inquests which raise the most important public interest issues; and that juries will carry on performing their vital role in ensuring state and (to some extent) corporate accountability.

Clause 8: Assembling a jury

38. At present, inquest juries must consist of between 7 and 11 members. Clause 8 proposes reducing this number to between 6 and 9.

39. While we note that this is some improvement on the equivalent provision in the Coroners Reform Bill (which proposed reducing the number of inquest jurors to as low as five), we remain firmly opposed to these proposals for the same reasons we set out in our response to the 2006 Bill.

40. As we have said above, we have every confidence in the inquest jury system and consider that inquest juries perform a vital public service.

41. We do not accept, as para 90 of the Explanatory Notes states, that "the nature of the inquisitorial task [inquest juries] are required to undertake means that they do not need to be of the same sizes as juries in the criminal courts".

42. On the contrary, since Middleton, inquest juries have enhanced responsibilities for providing narrative verdicts, so there is an even greater need to ensure that the quality of their decision-making remains of a high standard. It is also our experience that inquest juries take their responsibilities seriously and are perfectly capable of absorbing large
amounts of evidence, asking incisive questions and producing highly informative narrative verdicts and factual findings that can form the basis of a coroner's rule 43 report. It takes little more than a moment to understand the fallaciousness of the Explanatory Notes in this regard. There is no less of a requirement for the highest quality of decision-making in what is alleged to be an unlawful killing by the state of a citizen in its custody as compared to lower level cases of dishonesty and public order regularly dealt with by Crown Court juries.

43. We are concerned that any reduction in the number of jurors in inquests will lead to a reduction in the quality of this decision-making. Moreover, as a matter of principle, the role of an inquest jury is at least as important a public function as that performed by a jury in a criminal trial. We believe that it would be wholly wrong for issues as crucial to the public interest, for example the deliberate killing of a civilian by an agent of the state, to be determined by a jury consisting of as few as six members.

44. We note that there has been no costs justification advanced for these proposals (nor indeed any other justification). However, to the extent that cost is an issue, we do not believe that there would be any substantial saving by reducing the numbers of inquest jurors.

45. We are therefore firmly of the view that the law in this respect should remain as it is. The arguments to the contrary are weak, unconvincing and motivated by short-sighted administrative convenience and cost-cutting which will be of limited effectiveness and which have disproportionate consequences to the overall quality of justice produced.

Clause 9: Determinations and findings by juries

46. This clause makes provision for majority verdicts. We consider that it should be amended to maintain the jury numbers under the current law; as we do not consider that a verdict by as few a number as six jurors is conducive to proper decision-making and accountability.

Clause 10: Outcome of investigation

47. Clause 10 is linked to clause 5 in that it governs the outcome of investigations. Clause 10(2) enshrines in primary legalisation rule 42 of the Coroners Rules 1984.

48. When these words were in the secondary legislation it was held on a number of occasions that they could not defeat the purpose to ascertain how the deceased came by their death, which is contained in section 11 of the current act. Thus, an unlawful killing or a neglect

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verdict could be returned, both of which would by definition “appear to determine” a question of civil liability (which does not carry the similar imprimatur against naming a person). As presently drafted those verdicts would be prevented by clause 10(3). Moreover, there continues to be a debate in the courts as to whether the wording of an article 2-compliant inquest can contain judgmental words such as “serious” or “unreasonable”. INQUEST regards these types of debate as arid. They speak to a period of public life where judicial review, regulatory law and professional accountability were not as developed in the way that they are today.

49. An inquest, separate to civil proceedings, should discharge a duty upon the state to learn about how deaths occurred and how they might be prevented in the future. In Scotland, where there is a Fatal Accident Inquiry, deaths are investigated in this way, allowing the investigating Sheriff to determine, amongst other things, (a) where and when the death and any accident resulting in the death took place, (b) the cause or causes of the death and any such accident, (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided, (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death, and (e) any other facts which are relevant to the circumstances of the death. It is unjustifiable that Scotland should have the facility to make more meaningful determinations than an English inquest. We suggest the following is included clause 10(2): “A determination under subsection 1(a) may not be framed in such a way as to determine any question of criminal or civil liability on the part of any named person or body”.

50. At the very least, clause 10 should contain the words, “Subsection 2(b) shall not prevent a determination that the deceased was unlawfully killed or died as a result of neglect”. Moreover, in order to comply with article 2 ECHR, we suggest a new clause 10(4): “Subsection (2) shall not prevent a determination which describes how and/or in what circumstances the deceased came by his or her death, including the reasonable precautions, if any, whereby the death might have been avoided or prevented”.

51. INQUEST has long argued that the prohibition on verdicts appearing to determine an issue should be removed from coronial law altogether. The issue in an inquest is responsibility, not liability. Thus, it would be far better to maintain the prohibition on naming persons publicly (in all circumstances), but otherwise free a coroner (or a jury) to describe the acts or omissions which are responsible for the death. In order to protect parties to an inquest who might be criticised, the Act should contain a clause which underscores that (a) any determination of

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7 Fatal Accidents and Sudden Death Inquiry (Scotland) Act 1976, section 4(7).
an inquest shall not affect the criminal or civil liability of any party and
(b) a determination of an inquest shall not be admissible as evidence in
any subsequent legal proceedings.

**Clauses 11 – 13: Certified investigations; discontinuance of
investigation; intercept evidence**

52. INQUEST is strongly opposed to these measures, just as it opposed
the very similar clauses in the Counter Terrorism Bill last year, which
give the Secretary of State power to intervene in inquests where
sensitive information is involved. The proposals amount to a fundamental
attack on the independence and transparency of the coronial system in
England and Wales; are fundamentally flawed; disconnected from legal
principles and have come about without any consultation with
stakeholders. This has generated significant anxiety amongst some of
the families of those who have died in contentious circumstances, in
particular following deaths in detention and of military personnel.

53. These clauses are proving to be the most controversial in the
Coroners section of the Bill. On 3 February 2009 the Secretary of State
for Justice told parliament that:

"...I think that the House now accepts that there is a problem that
cannot be dealt with simply by PII certificates. ...I think that there
are some practical problems because we are dealing with extreme
circumstances in which there is a very severe risk, not of damage
or embarrassment to the Government, but of an individual—a
covert human intelligence source, say—being killed... At present
there are two inquests that cannot proceed because the
arrangements made in the de Menezes and Nimrod cases are not
regarded as satisfactory... I repeat to the House that I do not
regard the proposals as copyright. We are happy to consider other
alternatives, but the House has to face the fact that there needs to
be additional provision that is currently not in the law, because
otherwise some bereaved relatives will go without an inquest at
all." 8

54. This is the clearest statement from the government that the
clauses are intended to deal with very specific circumstances and it is
welcome that there has been assurance that they would not apply in
other outstanding cases. INQUEST is working closely with the families
and lawyers in the cases referred to and we recognise the difficulties that
arise. Similar issues have never arisen before and the current law is
more than adequate to deal with other cases that raise different issues
about sensitivity of evidence. We also note the comments made by a
number of coroners about mechanisms they have used to ensure
inquests could proceed – for example anonymity of witnesses, evidence

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8 House of Commons Hansard 3 Feb 2009: Column 685
by video link and the use of voice distortion, in camera evidence and use of Public Interest Immunity (PII). (See also the appended case study on the case of Jean Charles de Menezes).

55. We question whether potentially bad law is being made on the back of two challenging cases where there are legitimate concerns about the state’s duty to protect the life of all of its citizens. The proposed solution is wrong and we are frustrated that the promised consultation with ourselves and the family lawyers did not take place before publication. Consultation with those with knowledge of the cases and procedure, including the investigation bodies, may have enabled a more acceptable solution to be found. This should be much more tightly formulated than the clauses currently before parliament. The Justice Secretary acknowledged in the Second Reading Debate that as raised by Chris Mullin: “The danger is that once one opens this little gap in the law, it will be exploited. Mr. Straw: I do not deny the temptation” 9

56. If it is the case that the law needs to be changed specifically to deal with the issues outlined by the Justice Secretary on 3 February 2009 we urge the government to withdraw the clauses as currently worded and bring back a proposal which addresses the pertinent issues rather than create wide-ranging powers which would be potentially open to abuse in the future. Currently there is no clarity about the mechanism by which the Secretary of State would be able to make a judgment as to whether special measures were needed and as currently worded there is no mechanism for consultation with the investigation bodies. This leaves too much influence with the agencies who have been involved in the death.

57. It was a drafting oversight that ss. 17-18 of the Regulation of Investigatory Powers Act (RIPA) did not include coroners as designated judges. This should be amended to include Senior Coroners in all cases. RIPA issues are likely to be more frequent in the future anyway, even in much more routine cases which would not be suitable or appropriate for the Chief Coroner or a judge to deal with.

58. INQUEST proposes that the government withdraws clauses 11-13 and simply amends RIPA along the lines proposed for example:

“Inquests: intercept evidence

(1) In section 18 of the Regulation of Investigatory Powers Act 2000 (c. 23) (exceptions to section 17), after subsection (7)(c) insert -

\footnote{9 House of Commons Hansard 26 Jan 2009 : Column 32}
“(d) a disclosure to a coroner or to a person appointed as counsel to an inquest or to members of a jury or to any properly interested person where –

(i) the coroner holding the inquest is a judge of the High Court; and
(ii) the coroner has ordered the disclosure to be made to - (a) the coroner and, if he or she is satisfied that the disclosure will not prejudice national security, the person appointed as counsel to the inquest and to members of a jury and to any properly interested person; or (b) the coroner and, if he or she is satisfied that it is necessary to avoid prejudice to national security, in redacted form to the person appointed as counsel to the inquest and to members of a jury and to any properly interested person.”

(2) In that section, after subsection (8A) insert -

“(8B) A coroner shall not order a disclosure under subsection (7)(d) except where the coroner is satisfied that the exceptional circumstances of the case make the disclosure essential to enable the matters that are required to be ascertained by the inquest to be ascertained”.

(3) In that section, after subsection (11) insert -

“(11A) References in this section to a coroner apply only where the coroner is a judge of the High Court.”

(4) This section has effect in relation to inquests that have begun, but have not been concluded, before the day on which it comes into force as well as to inquests beginning on or after that day”.

59. This proposal introduces a small change to RIPA to allow an article 2-compliant inquest to take place where such material exists and when, crucially, a High Court judge determines that the material concerned is central in ascertaining how a person came to die.

60. Accepting this clause would bring the treatment of such material at inquests broadly in line with the way it is treated in criminal proceedings. It deals with an anomaly in RIPA, because RIPA simply did not envisage such material causing any problems in inquest proceedings.

Schedule 1, part 1, clause 2

61. We note that this clause largely replicates s.16 of the Coroners Act 1988, save that it dictates that a coroner can only refuse to adjourn an
inquest when there are parallel criminal proceedings when there is "exceptional" reason to do so (clause 2(6)(c)). At present the test is that there is "good" reason not to adjourn (s.16(1)(b)). **We do not know what the rationale is for this change, and we would urge the government to leave the test as it currently is.** The Health and Safety Executive, for example, generally prefers to await the outcome of an inquest before deciding what charges to bring, if any\(^{10}\), and it would be regrettable if the proposed new section ran counter to their objectives.

**Clause 17: Notification by medical practitioner to senior coroner**

62. This gives the Lord Chancellor the power to make regulations setting out the circumstances or cases in which a practitioner should notify a senior coroner of a death of which the practitioner is aware. Given that there is already a duty to investigate violent or unnatural deaths and deaths where the cause is unknown, it is unclear quite why such a power is needed. However, it is accepted that there may certain individual or certain categories of medical-related deaths which occur in circumstances which may require future investigation by a coroner. **We suggest there should be a duty to consult an independent medical body, the General Medical Council or a body that is aware of or monitoring possible suspicious medical deaths.**

**Clause 23: Provision of staff and accommodation - Resources for Coroners**

63. While, for the reasons set out herein, we welcome several aspects of the Bill, we are genuinely concerned that without measures to ensure appropriate resources and administrative support for the coronial system, the lofty intentions of the Bill will not be translated into realistic and effective change.

64. The members of the INQUEST Lawyers Group with whom we work closely are reporting frequently to us that a lack of resources for coroners is drastically limiting their abilities to perform their responsibilities fully and promptly.

65. Coroners, for example, often argue that they do not have the resources to make proper disclosure to families, and so rely on other state bodies to perform this task. Frequently, proper disclosure is not made as a result, or is not made in a timely fashion, or made at all: this is clearly not acceptable under the common law or article 2.

66. There are also often issues about unsuitable accommodation being used for inquests, or delays occurring while venues are identified. These

\(^{10}\) See the Work Related Deaths and Inquests: Chronology of Proceedings section of the Health and Safety Executive's Enforcement Guide [http://www.hse.gov.uk/enforce/enforcementguide/wrdeaths/chronology.htm](http://www.hse.gov.uk/enforce/enforcementguide/wrdeaths/chronology.htm)
problems add to the difficulties already faced by families and should be avoided if possible.

67. Coroners may also feel inhibited in making particular inquiries because of the limitations on their resources, even if those inquiries are necessary for the proper discharge of their statutory duties; again this is not acceptable.

68. While we welcome the fact that in the most high-profile recent inquests, funding has been made available for the instruction of solicitors and counsel specifically to assist the coroner with some of these issues, it is essential that coroners are provided with adequate resources generally.

69. In some recent inquests, the sensible use of computer facilities has led to valuable savings in time and costs. We have given some examples of this in our case study on the Jean Charles de Menezes inquest (See Appendix), and believe generally that it was only because that inquest was properly resourced in terms of support for the coroner, funding for the family and the sensible use of computer facilities, that it was able to run as relatively smoothly as it did.

70. On many occasions, a lack of resources simply prevents coroners from accessing these sorts of systems, which is highly regrettable. We therefore believe that the exclusion of any provision for resources from the Bill is a missed opportunity.

71. The government’s decision to leave responsibility of appointing and funding coroners with local authorities is problematic. All local authorities are under tremendous financial pressures with competing budgetary demands and many have to cut or reallocate their budgets. There is an important issue regarding the perceived independence of the coroners system from local government which is responsible for facilities where deaths may occur – for example of people in local authority care homes, of a child under the care of children’s services, and on the roads. Clearly it is desirable and in the public interest that the coroners system should be a nationally-funded service so that there can be no perception of any possible conflict of interest.

Clause 24, schedule 4 paras 1-5: Powers to gather evidence and to enter, search and seize relevant items

72. We welcome the provisions under schedule 4 (1) which give power to the coroner to compel a person to give evidence and produce relevant documents or other material for inspection examination or testing.

73. However given that disclosure of evidence has been one of the most problematic and controversial issues in the current inquest system, we suggest it is made explicit that these clauses
mean that the coroner has the power to require full and appropriate disclosure and inspection to be provided by each interested person to all other interested persons.

Clause 24, schedule 4 para 6: Power to report if risk of future death

74. One of the ways in which bereaved families seek meaning from their experience and engagement with the inquest process is in the hope that some good or learning will come from the death of their loved one. This is recognised by LJ Bingham:

"The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."\(^\text{11}\)

75. INQUEST welcomes this power as one of central functions of the inquest system – the prevention of other fatalities. One of the most important roles of the coronial service is the prevention of similar fatalities and to seek improvements in public health and safety by ensuring that lessons are learned. That aspect is all the more important in article 2 cases. It was no doubt in recognition of this that in 2008 the government strengthened the provisions of rule 43 of the Coroners Rules 1984 (enabling there to be greater follow-up of r43 reports and publication/circulation of the same).

76. We welcome the changes to rule 43 and the indications from the Ministry of Justice in its guidance on the new rule\(^\text{12}\) that it proposes to introduce a regular bulletin of r43 reports. However we consider that the work that is being done on the Bill is an opportunity to strengthen this work, and we would invite the Minister to consider amending the Bill to include a requirement to monitor and analyse inquest findings and in order to make this a meaningful power it must been backed up by effective enforcement mechanisms.

77. A number of coroners have valued the important role they have in the prevention of future fatalities and have made regular use of their powers under the existing rule 43. Despite the best endeavours of these coroners and juries there is abundant evidence that their recommendations and findings have often vanished into the ether, undermining the investigation and inquest process.

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\(^{11}\) R v. Secretary of State for the Home Department ex parte Amin [2003] UKHL 51 para 31
\(^{12}\) See http://www.justice.gov.uk/guidance/coroners-guidance.htm
78. INQUEST has already proposed that:

(a) Where a coroner believes that action should be taken to prevent the recurrence of similar fatalities, he or she should be under a duty not a discretion to report the matter to both the person who may have power to take remedial action and the Chief Coroner.

(b) There should be a duty on coroners to make recommendations whenever appropriate about preventing further deaths in similar circumstances and on any matter connected with the death including public health and safety or the administration of justice.

(c) The office of the Chief Coroner should prepare detailed guidelines and training for coroners in relation to the formulation of such recommendations.

(d) All coronial recommendations be made publicly available and coroners should be empowered to refer findings and/or recommendations to any individual or agency and require that individual or agency to provide, within six calendar months, a written response including a report as to whether any action has been taken or is proposed to be taken in response to the recommendation.

(e) The coroner should then be required to provide a copy of the response referred to in recommendation above to: the senior next of kin of the person whose death is mentioned in the coroner’s findings, or their representative; a witness who appeared at an inquest into the death who is the subject of the findings; and any other person who the coroner considers has sufficient interest in the inquest or investigation.

(f) The office of the Chief Coroner should have the power to call for such further explanations or information as he or she considers necessary, in relation to the implementation of recommendations.

(g) The office of the Chief Coroner to include in its annual report to Parliament: (a) a summary of all coronial investigations in which recommendations have been made; and (b) a summary of responses to the recommendations made in the previous year, including a list of those recommendations which are still awaiting implementation or response.

(h) Parliament should then ask the relevant government department to report on what action has been taken. There should be a statutory obligation on departments to respond within agreed time limits. They should be required to present an action plan.

(i) National Coroners Information System should be created to enable data on all inquests and their findings to be collated and available for all coroners to access. It should be complemented by a research unit established within the Chief Coroner’s office.
with the capacity to properly utilise the National Coroners Information System database to conduct research relevant to individual cases on behalf of coroners, and to identify trends and clusters of deaths requiring further investigation.

(j) The Chief Coroner should also notify investigation and inspection bodies of coroner's reports and jury findings as they happen and ensure they receive the annual report.

(k) There should be an obligation for those who receive reports to respond not only to the coroner, but to the investigation bodies and the family concerned. Consideration should be given to a mechanism whereby such reports must be acted upon or explanations published for why reasonable action has not been taken.\(^13\)

79. We suggest the Bill be amended to impose a positive duty on the coroner to make a report if he or she believes action should be taken. The Bill is currently says a coroner "may" report and this should be replaced by "must". We also suggest the Bill be amended to:

(a) impose sanctions for a failure of authorities to respond to the report;
(b) require disclosure of the report to all interested persons and its publication;
(c) include a mechanism for the monitoring and scrutiny of such reports and responses to ensure that there is effective accountable learning and a provision requiring the central collation publication and analysis by the Chief Coroner in respect of all jury findings, reports and responses and an annual report to Parliament so that there is proper scrutiny and action where appropriate.

80. The mainstream courts have gone a long way in recent years in embracing information technology, and it is now possible to obtain virtually all civil judgments from the appellate courts on the internet for free within 24 hours of the judgment being handed down. This shows that information technology can be deployed to ensure a better sharing of information throughout the legal community, with mutual benefits for all, and we would like to see similar initiatives being adopted in the coronial system, particularly in light of the specific lesson-learning function that inquests have.

**Governance: Chief Coroner (clauses 27-31, schedules 7-8)**

**Clause 27 and schedule 7: Chief Coroner and Deputy Chief Coroner**

\(^{13}\) Helen Shaw and Deborah Coles – *Unlocking the Truth: Families’ Experiences of the Investigation of Deaths in Custody*, INQUEST 2007
81. We welcome the creation of the office of Chief Coroner and Deputy Chief Coroner and the important element of judicial oversight it introduces into the system. Under schedule 7 paragraph 1 the Chief Coroner and the Deputy Chief Coroner can be a High Court judge or a Circuit Judge. Given the importance of the role, INQUEST believes that the Chief Coroner must be a High Court judge. This is the requirement in relation to the chairs of the Special Immigration Appeals Commission and the President of the Asylum and Immigration Appeals Tribunal (see, respectively, schedule 1 paragraph 5(a) of the Special Immigration Appeals Commission Act 1997 and section 5 of the Nationality, Immigration and Asylum Act 2002). Given the powers he or she will have and the critical role that the Chief Coroner will play in the overall system, it is clear that the same principle should apply here.

82. The consequence of the appeal system introduced under clauses 30(2) and (8) will be to remove ordinary judicial review from coronial law, with appeals to the Court of Appeal limited to points of law. Experience in the immigration setting makes it absolutely essential that the standard of review provided by the Chief Coroner must be the equivalent of an experienced judge who has held high judicial office.

83. We also welcome the power to appoint additional Deputy Chief Coroners to assist. We urge parliament to consider a process whereby an existing coroner could become a Deputy Chief Coroner as the increasing expertise amongst some coroners would benefit the office of the Chief Coroner. It is important that unnecessary barriers are not created to that experience being made available.

Clause 28: Regulations about training

84. We welcome the discretion given to the Chief Coroner to make regulations, with the agreement of the Lord Chancellor, dealing with the training of coroners. Providing coroners with proper accredited training is essential to ensuring a modern coronal system compliant with the HRA, particularly given the developing complexity of coronial law and the plethora of decisions from the European Court of Human Rights. Consequently, the Chief Coroner should be under a duty rather than having discretion to institute a system of national training requirements. Without a guarantee of such mandatory training it is difficult to see how the government can "ensure that all those working within the service are aware of and apply best practice, relevant guidelines and standards .... and other developments in legislation" – see Explanatory Notes.
Clause 30(5): Appeals to the Chief Coroner

85. The appeals provisions need to be clarified and this includes clarification on what further decisions could be included in this regulation-making power. The conduct of coronial proceedings is well known; consequently decisions which attract a statutory right of appeal should be clearly stated on the face of the Bill so that they can be subject to full parliamentary scrutiny, as has been the case in other contexts such as immigration law.

86. We welcome the proposals for a simpler appeals procedure which affords the opportunity to bereaved people to raise concerns in a more informal manner. Currently the only options are judicial review on law and the Office of Judicial Complaints on the conduct of a coroner.

87. However we are concerned that as the only further appeal is to the Court of Appeal on a point of law it means that the possibility of any challenge by way of judicial review in respect of most if not all coronial decisions will no longer exist.

88. If that is to be the case, then it becomes imperative that the Chief Coroner should be a High Court judge (rather than a Circuit Judge14) in order to ensure that the standard of review provided by the Chief Coroner is equivalent to that available from an experienced judge who has held high judicial office.

89. It is unclear how the new procedure will operate in complex cases and how families’ interests will be represented.

Clauses 32-34: Governance: Guidance, regulations and rules

90. The Bill contains a large number of regulation-making powers. Regulation-making powers must be justified and explained to Parliament during the passage of the Bill.

91. Despite the time it has taken for this Bill to reach Parliament there are as yet no draft rules published. The rules underpin the procedure at inquests – procedures which frequently raise pressing concerns for bereaved families and their representatives. It is vitally important that there is proper consultation.

92. At present there is no mandatory right to pre-inquest disclosure of documentary evidence and this is a serious omission in the Bill. Paragraph 25 of the revised draft Charter for Bereaved Families says “Disclosure of all relevant documents to be used in an inquest will take place, on request, free of charge and in advance of an inquest to those family members, whom the coroner has determined have an interest in

14 Schedule 7 para 1(a).
the investigation". Whilst some voluntary protocols were introduced in 1999 in relation to deaths in custody, there is still no automatic right to advance disclosure. In many controversial cases we have worked on, disclosure has been difficult to obtain and furthermore sometimes even when it has been provided, the delay in its provision has not allowed sufficient time for adequate preparation by families' legal teams. We remain concerned about the pace at which documents are disclosed, the lateness of disclosure and the withholding of critical documents until the day of the hearing. Documents should be disclosed to the family as soon as they become available.

93. By giving an automatic right to disclosure, all parties would be assisted and it would remove some conflict from the hearing itself. It also reduces unnecessary pain for bereaved people in that they do not have the shock and distress of hearing information about how someone died for the first time in public.

94. **INQUEST recommends there should be full mandatory disclosure of all information (irrespective of whether the coroner intends to call the witnesses) and clear rules about when and how it will be made.**

95. Clause 33 enables the Lord Chancellor, with the agreement of the Lord Chief Justice, to make regulations for regulating the practice and procedure in connection with investigations (excluding inquests), post-mortem examinations and exhumations. These powers cover a wide range of core work carried out by coroners, including, for example: when they can discharge an investigation (including provision as to fresh investigations following discharge); the suspension or resumption of investigations; the delegation by a senior coroner, area coroner or assistant coroner of any of his or her functions; and allowing information to be disclosed or requiring information to be given. It is of concern that the mechanics of how these functions will be carried out and regulated is not clear on the face of the Bill. This gives the impression such functions have not yet been adequately thought through.

96. **We suggest there should be a rules committee including at the minimum coroners and practitioners similar to the rules committees operating in relation to the Civil Procedure Rules.** We think this would assist in maintaining confidence in the process as controversy may arise in relation to rules making provision for evidence, anonymity, disclosure, exclusion of specified persons during the giving of evidence by a witness under the age of 18 or by reasons of national security, etc.
Clause 36: Interested persons

97. This clause sets out the definition of interested persons and is a slightly expanded version of current rule 20. It does introduce a power for the coroner to determine that any other person is an interested person. This expands slightly the list of interested persons in rule 20(2) of the Coroners Rules 1984 and is intended to capture, for example, the role of the Independent Police Complaints Commission in conducting and managing some investigations (see Explanatory Notes para 292).

98. An additional category should be added, for instance “in circumstances, where an interested person willing to represent the interests of the deceased does not exist, a coroner may recognise as interested person an organisation or person who would be otherwise recognised an interested party for the purposes of judicial review proceedings”.

Omissions from the Bill

Funding for families’ legal representation

99. The Bill is silent on the question of funding for legal representation for bereaved people at inquests. While INQUEST welcomes the government’s recognition of the rights of bereaved persons in the inquest process, without adequate legal funding the role will remain defunct. It is imperative that proper provision is made for families to have representation in inquests.

100. Without such representation, they cannot properly protect their article 2 rights. The state’s obligations following a death in custody were recognised in Jordan v UK – the investigation must be independent, effective, prompt, open to public scrutiny and enable the participation of the next of kin. For families or other interested parties of the deceased to participate effectively in the investigation process they need legal representation.

101. At present there is no automatic right to non means-tested public funding for families who are thrown into an inquest process through no choice of their own. Although funding for representation is available in "exceptional" cases those representing families have to make lengthy, complicated, intrusive and time consuming applications to the Legal Services Commission for the little funding they receive. Many families are excluded from such support simply by virtue of the fact that they own their own home, even if this does not mean in real terms that they have substantial disposable income to be spent on legal fees.

102. At all inquests into deaths in custody the institutions of detention will be legally represented by experienced and well-qualified lawyers at
unlimited public expense. As Tom Luce pointed out, “if a police authority or a health authority is involved in an inquest, its legal costs will be met by its budget, which is a publicly tax-financed budget”15.

103. To our knowledge, lawyers representing public authorities are provided with funding which appears not to be restricted or constrained (as is the situation for bereaved families) and does not appear to be assessed and/or have its merits examined in the manner prescribed within the statutory framework. INQUEST is not aware of a single death in custody inquest where the state has not had lawyers in attendance.

104. Our Lawyers Group members are increasingly reporting situations where wide representation of state bodies and their employees (such as the Chief Constable/Metropolitan Police Commissioner, Prison Service, trades unions and professional associations, Primary Care Trusts,) is secured at inquests. This can often have the effect of creating a substantial appearance of - and actual - inequality between the family’s representation and that of the other interested persons.

105. No family would question the model of the inquisitorial regime established for the coroner’s court. But an investigation that throws up article 2 issues - a death in custody or otherwise in state detention, in an army training establishment, or a death on military service overseas - all too frequently is met with what appears to families to be a concerted offensive by the authorities to engage in damage limitation, restrict the public inquiry and defend the status quo. While Legal Aid may be provided in "exceptional" circumstances, experience would suggest that the "exception" is too narrowly drawn, that decisions are subject to demoralising delay, and that bereaved families resent being means-tested for what in all conscience should be their right to effective representation.

106. This leads to imbalance in legal representation and reduces the chances of having an independent, fair and balanced investigation. Indeed many coroners have welcomed the contribution and assistance that families’ lawyers bring to these inquests. It has been lawyers representing families that have helped to expose systemic and practice problems contributing to deaths.

107. INQUEST recommends that measures are introduced to provide full, non means-tested public funding for families as supported by the Joint Committee on Human Rights in their *Deaths in Custody Third Report of Session 2004–5* and most recently by Baroness Corston in *The Corston Report* on women in the criminal justice system.

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108. Funding for bereaved families could and should be simplified. The Means Assessment could be abolished. The reforms could impose a non means-tested regime. The Merits Test could be removed or properly codified – i.e. exceptional funding could be extended to include preparation and the requirement to use legal help could be abolished.

109. In view of the small number of applications for funding (we understand in the region of 200-250 per year), the processing of applications for funding could be within the remit of the Chief Coroner’s department and/or remitted back to the Ministry of Justice.

110. In summary we recommend that consideration should be given to:

(a) having a simplified scheme based in the national office to provide funds for bereaved families in respect of preparation and representation at inquests as outlined above, or alternatively, a simplified scheme could be remitted to the MoJ and arrangements similar to those in place for near-death investigations could be adopted.

(b) The financial resourcing of local coroners could fall within the control and direction of the national office with clear service level agreements with local authorities. Alternatively, there could be clear service level agreements with local authorities on financial resourcing to ensure a national standard and consistent delivery of coronal service across the country. This would be preferable to importing the situation that exists for patients seeking healthcare who experience the postcode lottery.
APPENDIX

Case Study: Inquest into the death of Jean Charles de Menezes

Introduction

1. The inquest into the death of Jean Charles de Menezes, which was held at Oval Cricket Ground between 22 September and 12 December 2008, provides a good illustration of why some of the reforms proposed in the Coroners and Justice Bill pose an unnecessary restriction on the important principle of the openness of inquests, albeit that some of the practical proposals are likely to be helpful.

2. As is well-known, Mr de Menezes was shot and killed by officers of the Metropolitan Police at Stockwell underground station on 22 July 2005, having been mistaken for one of those who had attempted to detonate suicide bombs on the London transport network the day before. The office of the Metropolitan Police Commissioner had been tried and convicted of a breach of health and safety legislation in 2006. That trial, and the investigations of other bodies such as the Independent Police Complaints Commission and the Metropolitan Police Authority, had revealed a series of organisational and individual failings that led to Mr de Menezes' death. The inquest was the first time that evidence from the passengers in the underground train carriage and the officers who shot Mr de Menezes was heard. It was also the first opportunity that the family (through their lawyers) had to test the evidence that was given.

Certified investigations by a judge without a jury

3. The proposed reforms to introduce what are effectively secret inquests, by certification under clause 11 of the Bill, have attracted widespread concern. A number of commentators have remarked that the de Menezes inquest is one that, under the terms of the Bill if passed, would have been subjected to certification had this procedure been available.

4. The de Menezes inquest did involve the consideration of evidence that was highly sensitive, such as the details of the Metropolitan Police's operational response to the threat posed by suicide bombers (including Operation Kratos), the assistance they had had from countries such as Israel and the USA in developing this, and other aspects of undercover and surveillance operations. The widespread concern that the Metropolitan Police had been operating a "shoot to kill" policy without any parliamentary approval or oversight made it particularly sensitive. A large number of witnesses also sought anonymity before giving their evidence. The inquest would therefore potentially have been covered by all of the reasons under clause 11(2) of the Bill that would justify certification under clause 11(1).
5. In fact, the de Menezes inquest managed to deal effectively with highly sensitive evidence and the protection of witnesses, whilst remaining largely open and accessible to all, showing that it was perfectly possible to conduct a full inquest without the need for certification.

6. This was done, firstly, by appointing a High Court judge as coroner who would be able to consider Public Interest Immunity (PII) applications by the police in respect of highly confidential policies and documents. National security issues were clearly central to the subject matter of the inquest, most importantly the Metropolitan Police strategy for dealing with suicide bombers. Where needed, the coroner granted full PII in relation to certain documents. However, he ruled that many of the documents could be provided to the legal teams, upon strict undertakings as to confidentiality, not making copies, keeping the material secure, etc. On that basis the family's lawyers were permitted to see highly sensitive documents, and to question witnesses based on that material. In relation to the most sensitive material, a gist document was prepared summarising the material that could be shared with the family, and their lawyers were provided with the material underlying the gist document, again on strict undertakings.

7. Where discussion in open court touched upon the contents of any such protected documents, agreements were reached in the absence of the jury and the public as to what could be explored and, although some aspects were regarded as too sensitive to be investigated publicly, overall a reasonably fair exploration of the issues was allowed whilst national security and other policing concerns were protected.

8. Secondly, suitable arrangements were made for the protection of witnesses (a reason for certification under clause 11(2)(b) of the Bill), without the need for certification. There were over 40 police officers who worked in highly sensitive anti-terrorist operations or covert surveillance whose witness evidence was required at the inquest. They were all granted anonymity by the coroner as a result. They gave evidence from behind a screen in court, and careful provision was made at the venue for their arrival and departure, to protect their identities. The inquest was nevertheless able to hear evidence from those witnesses. The jury, the family, one of their supporters and the lawyers were all permitted to see the witnesses giving evidence, so as to assess their demeanour (the police having carried out police checks on the family members and their chosen supporter beforehand). This was done without any risk or compromise to the identity of any of those witnesses, whose anonymity has been maintained despite the huge attention from media organisations.

9. In this case there was a huge public interest in hearing as much evidence as possible in the open, given the repercussions this very public shooting of an innocent man raised. We believe that by applying the safeguards
such as those identified above, the inquest was able to remain public and accessible, yet with due respect for the concerns set out in clause 11(2).

10. Had this inquest been certified in accordance with the Bill then the family would have been prevented from participating in the inquest, and the actions of the police would not have been exposed to the full public scrutiny that the common law and article 2 requires.

11. Furthermore, if no jury had been sitting to pronounce its verdict, there would have been no public involvement in scrutinising of one of the most appalling tragedies in police history.

12. We therefore believe that the de Menezes case shows that in practice, certification is unnecessary; and in principle, it is wrong.

The venue and costs

13. The official website of the inquest records that its total costs were in excess of £5,000,000. This includes the costs of the venue, the technological support, the coroner and his legal team among other things. It is understood these costs are payable by the local authorities covering the coroner's jurisdictional area, namely the London boroughs of Southwark, Lambeth, Lewisham and Greenwich. These costs do not include other costs to the public purse, including the five separate legal teams representing the police and one legal team representing the family of the deceased. The latter’s legal costs are currently funded by the Legal Services Commission (although efforts to recover these costs from the Metropolitan Police will be made in subsequent civil proceedings).

14. In respect of the £500,000 costs of the inquest itself, the Stockwell website does not provide any “detailed breakdown because of commercial confidentiality”. Nonetheless, it is believed that the costs were particularly high because a commercial venue, The Oval Cricket Ground, was used. (By way of example, it is understood that a lunch of sandwiches and fruit was provided by the venue at a price of £16 per head plus extra for coffee and tea. The family were permitted to discretely bring in their own sandwiches but lunch was provided to all jurors and the other legal teams at this price).

15. The costs of this particular inquest are clearly extremely high. Although such a broad inquiry was plainly justified by the need for the family to understand the circumstances surrounding Mr de Menezes' death, the huge range of issues of public importance the case raised, and the unprecedented national and indeed international media coverage it generated, there must be a question as to why the residents of Southwark, Lambeth, Lewisham and Greenwich should be required to foot a large part of the bill.
16. Why, therefore, was such an expensive venue used? The answer lies in the present law, which dictates that an inquest must be held within the jurisdiction where the death occurred.

17. It was recognised that Southwark Coroner's Court itself was too small to accommodate the number of lawyers, press and members of the public who would wish to attend the inquest. There were also concerns that it could not be made sufficiently secure for the large number of witnesses who had been granted anonymity.

18. Extensive efforts were made to find an alternative venue, but it had to be limited to the coroner's geographical jurisdiction, which caused a certain amount of delay. We understand that no Crown Courts could be made available (despite there being several within the immediate vicinity of Southwark Coroner's Court) due to the number of terrorism-related trials then current in the Crown Court system, creating their own backlog. We understand that venues such as local primary schools were also investigated.

19. Ultimately the venue that was chosen was the Oval Cricket Ground, as it was only this that was deemed large and secure enough for the inquest. As explained above, it is likely that this led to frankly massive costs to the public purse. It also caused some time pressures during the inquest itself because the venue had only been booked for a finite period of weeks and even an additional day's worth of jury deliberations over that allocated time would have had to have been accommodated elsewhere.

20. Had the law permitted the inquest to be held outside the coroner's jurisdiction, then an obvious venue would perhaps have been the Royal Courts of Justice, which had recently been able to accommodate the comparably sensitive inquests into the deaths of Princess of Wales and Dodi Al Fayed, at what was inevitably a much lower cost, and a cost borne out of central government funds (the Court Service) rather than at local taxpayers' expense.

21. The provisions in clauses 2 and 3 of the Bill, enabling the geographical boundary restrictions to be relaxed and cases to be transferred more easily between coroners, would therefore have made the conduct of the de Menezes inquest substantially cheaper and logistically easier.

Resources

22. The de Menezes inquest ran relatively smoothly bearing in mind the number of interested persons, and the sensitivity of the issues to be covered. It was also completed within the strict three month time estimate that had been set by the coroner and agreed by all interested
persons. However it is likely that this only occurred because it was well-
resourced in terms of funding for support for the coroner, for the family,
and the provision of IT facilities.

23. The coroner was assisted by a firm of solicitors specially instructed
to act on his behalf. This meant that they were able to manage the
disclosure process, liaise with witnesses, and deal with the range of
logistical and legal issues that arose during and before the inquest. The
volume of material and administration required in this inquest would
plainly have been too much for a conventional coroner and his or her
normally very limited staff.

24. The family was also provided with public funding, enabling them to
be represented by a Queen's Counsel and a junior barrister, as well as
their solicitors. The police parties had much greater combined
representation, but the legal support the family had meant that they
were able to make informed submissions on the scope of the inquest
(including as to the exclusion of otherwise prejudicial and irrelevant
material), properly question the witnesses and test the evidence, push
the issue of PII as far as possible, and make detailed submissions on
appropriate verdicts to be left to the jury. Had they not had such
representation it is quite likely that they would not have been able to
protect their article 2 rights properly.

25. In terms of the computer facilities:

a. All of the disclosure was scanned on to disc, with an "E-bible"
search function, so that the material was easily accessible and
searchable. This also meant that any document could easily be
called up in court and displayed on screen.

b. "Livenote" was used to ensure a contemporaneous and accurate
record was taken of the evidence, which was fed on to screens for
all parties in court and the public to see. This meant that it was
easy to follow the evidence, easy to check what evidence had been
given, and meant that each interested person did not have to have
someone taking notes in court. It also meant that there were no
delays in the evidence while manual notes were taken, and overall
we would estimate that the use of Livenote saved around one sixth
of the court time that would otherwise have been needed

c. "Trial Director" was used to enable documents to be displayed
electronically in court. This was simply a scanning machine that
was linked with the computer screens in court, which meant that
any document could be easily shown to all without the time or
resources necessary for making physical copies.
Each of these functions saved valuable time and resources, and also contributed to the smooth running of the inquest.

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