INQUEST has been campaigning for over 25 years for reform of the inquest system. Our work on contentious deaths and their investigation has highlighted a system in crisis and one which is currently failing bereaved families. For democratic accountability it is crucial that the inquest system works, as it is usually the only public forum in which contentious deaths such as accidents, deaths at work, of military personnel or in custody are subjected to public scrutiny. We urge parliamentarians to support introducing the long-awaited Coroners and Death Certification Bill in the next Queen’s Speech.

1.1 In the draft legislative programme 2008/2009 the government included a Coroners and Death Certification Bill. The purpose of such a Bill was stated as:

To deliver an improved system of death investigation for families so that they can be assured that the cause of death of their relative has been properly established and that, where possible, lessons can be learned to prevent future deaths.

1.2 INQUEST has long supported reform in this area and believes it is imperative that the Coroners Bill does not fall off the parliamentary agenda. The Bill was due to have been included in the legislative programme for the last two years but has twice been

---

1 Draft Legislative Programme 2008-09, Office of the Leader of the House of Commons, May 2008
INQUEST Briefing on the Coroners and Death Certification Bill – November 2008

abandoned. This is despite the numerous parliamentary reports which have called for reform of the system since 2003, including:

• The Luce Review in 2003 - *Report of a Fundamental Review of Death Certification and Coroner Services*
• The third report of the Shipman inquiry which looked at ‘Death Certification and the Investigation of Deaths by Coroners’ 2003
• The Joint Committee on Human Rights inquiry into deaths in custody in 2004
• Sir Nicholas Blake’s Deepcut Review in 2006
• The Constitutional Affairs Select Committee inquiry into reform of the coroners' system and death certification in 2006
• Baroness Corston’s review of the treatment of vulnerable women in prison in 2007

1.3 It would be a travesty if all of the work, research and consultation undertaken as part of the reports listed above are unused. Taken collectively, these reports demonstrate that there is universal acknowledgement from those working in the service and those who use it that the current system does not function properly.

2. Why a Coroners and Death Certification Bill is urgently necessary

2.1 The coroner’s system is one of the most neglected areas of law in England and Wales. In contrast to the constant evolution of other legal and administrative structures and a more rights-based approach generally to public functions and services, the coroner’s court has failed to evolve accordingly. This is of concern not only for the families who have lost loved ones in contentious circumstances, but also the general public.

2.2 The present system is under-resourced and fragmented with no central accountability or compulsory training for coroners. This results in a postcode lottery of service with good
practice dependent on the approach of individual coroners rather than agreed and inspected quality standards.

2.3 The system is especially ill-equipped to deal with deaths that involve questions of state or corporate accountability. At present the system of investigating deaths in custody continues to indicate a systemic failure to learn: to review, revise and implement policies, instigate new training, to share and disseminate information and guidance across different state agencies.

2.4 Despite some recent reforms in light of the Human Rights Act 1998, the inquest system still has a narrow legal remit that places artificial and invidious limits on the scope and style of conduct of the inquiry. This often excludes the issues of greatest concern to the family from the inquest. Inquests are too often at risk of being opportunities for official and sanitised versions of deaths to be given judicial approval rather than being an opportunity for the family to discover the truth and full circumstances surrounding the death of their loved one.

2.5 Delays of two or three years to the inquest process are not uncommon. As there is no public scrutiny of the death for such a long period, the opportunity for identifying what went wrong and to seek to prevent further deaths is set back.

2.6 Most crucially the current system has an inadequate mechanism for monitoring inquest findings or ensuring follow up action is taken by the relevant public bodies based on any issues that arise out of inquests. Unless the findings of inquests proceedings are centrally recorded, analysed, published and acted upon, issues of systematic failure will not be properly addressed and more unnecessary deaths could occur.

2.7 Our casework over the last 25 years has indicated that the most pressing reforms that are needed are:

1. An extension of the remit of the inquest system.
2. Changing the structure to create a national coroner service to improve service delivery and ensure high standards and accountability.
3. Improvement to the support and information available to bereaved people.
4. The introduction of a system of monitoring inquest verdicts and a statutory obligation on public bodies to act on the findings of an inquest.
6. Specific action to be taken to counter lengthy delays.

2.8 A Coroners and Death Certification Bill would make significant and positive changes to the coroners system in England and Wales and to ensuring better treatment of bereaved people. For this reason we urge parliamentarians to ask the government to commit to the introduction of the Bill and ensure it is included in the Queen’s Speech.

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

Helen Shaw
Co-Director
helenshaw@inquest.org.uk
020 7263 1111
www.inquest.org.uk

Yasmin Khan
Policy and Parliamentary Officer
yasminkhan@inquest.org.uk