INQUEST has been campaigning for over 25 years for reform of the inquest system. Our work on contentious deaths and their investigation with a particular focus on deaths in custody 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, deaths of military personnel or deaths in custody are subjected to public scrutiny.

For these reasons it is essential the long awaited Coroners and Death Certification Bill is introduced in the next parliamentary session.

1. INQUEST is the only charity in England and Wales that provides a specialist, comprehensive advice and information service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public in England and Wales. Its casework priorities are deaths in police custody and in prison, including secure training centres, and in immigration and psychiatric detention. Through our casework over the last 25 years we have a unique overview of how the inquest system operates from the perspective of bereaved families and their advisers. We extract policy issues arising from contentious deaths and their investigation and campaign with and on behalf of bereaved families and their legal representatives for changes in practice and lessons to be learned which could prevent future deaths.


2.1 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 being

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.

2.2 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

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1 Office of the Leader of the House of Commons, Draft Legislative Programme 2008-09, May 2008
abandoned. This is despite the numerous parliamentary reports which have called for reform of the system since 2003, including:

- 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

It would be a travesty if all of the work, research and consultation which was undertaken as part of the reports listed above is 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. The Bill must be included in the next legislative programme.

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

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.

3.1 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 respond to the findings of an inquest.
6. Specific action to be taken to counter lengthy delays.

3.2 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.

3.3 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.

3.4 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 from the inquest the issues of greatest concern to the family. 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.

3.5 Delays of two or three years to the inquest process are not uncommon. This causes difficulty for all concerned but particularly so for bereaved people who have described how their lives have been put on hold until they have been through the inquest process. 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.

3.6 Families’ legal rights in proceedings are restricted (the rules governing inquests create a structure where the inquiry is not for them) and the administrative framework is not directed at their full inclusion in the process. There is no government-funded information service for families who have to go through the inquest process and often families come to INQUEST having not been advised that they can be legally represented or given any information about the inquest proceedings.

3.7 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.

3.8 The measures the government has indicated will be included in 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 the government to commit to the introduction of the Bill in the next parliamentary session.

INQUEST, June 2008

For more information on any of the issues contained in this briefing please contact INQUEST’s Policy and Parliamentary Officer Yasmin Khan on yasminkhan@inquest.org.uk or 020 7263 1111