Briefing on delays in the inquest system and coronial reform

House of Lords debate, 12 July 2011

July 2011
In December 2010 the House of Lords removed the Chief Coroner and associated offices from the list of bodies to be abolished in schedule 1 of the Public Bodies Bill. The post therefore remains on the statute book. However, in a written ministerial statement of 14 June 2011, the government signalled its intention to put forward an amendment which would re-insert the Chief Coroner’s office into schedule 5 of the Bill and result in the dismantling of the post. The Second Reading of the Public Bodies Bill in the House of Commons will take place on 12 July 2011.

Baroness Miller has tabled an oral question for answer in the House of Lords on Tuesday 12 July 2011 entitled: “Ensuring that inquests are not subject to unreasonable delays”. In advance of that debate, this briefing answers the questions that Peers and MPs frequently ask INQUEST about delays in the coroners’ service and the impact of the government’s decision to dismantle the Chief Coroner’s office and not proceed with the planned implementation of the Coroners and Justice Act 2009. It also highlights issues Peers may wish to ask supplementary questions about.

Why do we need fundamental reform of the inquest system and a Chief Coroner?

1. The current, antiquated system is built on a statutory framework set out in the Coroners Act 1887 with the most recent statute, the Coroners Act 1988, being largely a consolidating measure. The coroner’s system operates as a fragmented, non-professional assortment of individual coroners who operate with no compulsory training and little accountability. There are a growing number of coroners who adopt an efficient, modern approach to running inquests but, overall, there is a ‘postcode lottery’ of service for bereaved families with good practice dependent on the approach of individual coroners rather than agreed and inspected quality standards. 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 prevent other deaths is hindered. Compounding this problem, the current system has no robust mechanism to monitor inquest findings or to take any follow up action with the relevant public bodies based on any issues that arise out of inquests. Findings of inquests proceedings are not effectively and routinely recorded, shared, analysed and acted upon so that issues of systematic failure are properly addressed.

2. INQUEST has extensively documented the failings of the current inquest process and how too often it adds to families’ distress rather than providing a mechanism for addressing concerns and preventing future deaths.1 We are not lone critics. Successive governments have recognised the system is in need of fundamental reform and commissioned three extensive reviews in 1936, 1965 and 2001. The most recent review, chaired by Tom Luce, was a £1.1 million comprehensive analysis of the current system which involved evidence gathering and consultation with over 200 coroners, families, lawyers and organisations. In their final report the independent reviewers concluded that the coronial system had been seriously neglected over many decades and it “must undergo radical change if [it is] to become fit for the purposes of a modern society and capable of meeting future challenges.”2 They went on to make a number of recommendations to deal with critical defects in the current system. Central to their recommendations was the creation of the

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2 Para 1, the independent review of Coroner Services commissioned by the Home Office and chaired by Tom Luce, Death Certification and Investigation in England, Wales and Northern Ireland, 2003.
post of Chief Coroner for England and Wales. Since then there have been a number of other high-profile reviews, parliamentary reports or inquiries also calling for an overhaul of the system.3

What delays are there in the inquest system and why?

3. The Ministry of Justice published their most recent annual bulletin on Coroners Statistics in May 2011 which analyzes deaths reported to coroners in England and Wales in 2010 (see http://bit.ly/lLm9ez). According to those figures, inquests were opened into 31,000 deaths in 2010, representing over 13 per cent of all deaths reported to coroners. The estimated average time taken to process an inquest in 2010 (defined as being from the time the death was reported until the conclusion of the inquest) was 27 weeks, the same as in 2009. The average time taken to complete inquests has been steadily increasing since the Ministry of Justice started the present system of recording in 2004, when it was 22 weeks.

4. The bulletin does not distinguish between jury and non jury cases or contain any detail of those that concluded over 12 months after the death. INQUEST has repeatedly raised with the Ministry of Justice the importance of gathering detailed statistical information on jury inquests and particularly on delay of over twelve months. Effectively the bulletin, and the questions asked of coroners, does not enable those interpreting the statistics to indicate any particular problems. An inquest concluded 13 months after the death is recorded alongside those concluding two, three or more years after the death.

5. As well as providing a free telephone advice and support service to any bereaved family, INQUEST delivers a free, complex casework service on deaths in state detention or involving state agents and works on other cases that also engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability. INQUEST has, on average, 350 complex cases open at any point. Analysis of 500 of INQUEST’s complex cases where the death and inquest occurred between 2000- June 2011 shows that 48% of cases took 2 years or more to conclude, 24% took 3 years or more and 9% of cases took 4 years or more before the inquest was heard. Recent inquests have been held into deaths in prison which had been outstanding for more than 5 years.4

6. Delays in death in custody inquests are due to a variety of factors: the length of time such investigations take, the lack of resources available to coroners and the fact that these are jury inquests and can last up to two weeks. This is often made worse by the shortage of suitably qualified forensic pathologists and other experts.

7. Delays in completing the inquiries after deaths in custody need to be urgently addressed – not only because of the impact it has on bereaved families but because of the effect on all involved in the aftermath of a death, and on public confidence in the credibility of the whole system. Parliamentarians have raised concerns about the delays in these cases:

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Where the inquest is the means by which the Article 2 duty of investigation is satisfied following a death in custody, then significant delays may breach Article 2, which requires that an investigation into a death be prompt. We are concerned that current delays may in some instances lead to breaches of Article 2. (Joint Committee on Human Rights, 2004)⁵

We emphasise the need for the reviews of the coronial system... to address delays in the system. (Joint Committee on Human Rights, 2004)⁶

8. The lack of timely public scrutiny of the circumstances of the death undermines the preventative potential of the coronial process and the ability of the coroner to report matters of concern to the relevant authorities and play a monitoring role in looking at standards of custodial care. For example, after such delay it is not unusual for witnesses at the inquest to have difficulty in recalling the detail of events and the policies to which they were working at the time. At a recent inquest into a death in prison there was confusion amongst prison officers about which protocols on bullying applied as they had been updated a number of times since the death. Witnesses may have left the institution and not be traceable and the same may apply in deaths in prison to prisoners who may have important evidence to give. Institutions then respond to concerns arising at the inquest by asserting that changes have subsequently been made but this cannot be tested in evidence at the inquest. Coroners are thus effectively discouraged from using their power under CR r43 to report matters of concern and where they do so both their report and any media coverage of the inquest can be dismissed by the detaining institutions as out of date. Further, 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 recurrences in the future, learning the lessons and preventing other deaths is seriously delayed.

What is the effect of delay on bereaved families?

9. The delay clearly causes all concerned great difficulty but this is particularly so for bereaved people. INQUEST's evidence-based research on families' experience of the inquest system has highlighted the detrimental effects that delays in finding out how a relative has died has placed on the physical and mental health of family members⁷. Finding out how someone has died in custody is an essential part of the bereavement process and yet for many families this is profoundly hampered by bureaucratic delay (Home Office Research Study 241).⁸

10. Families describe their lives as being 'on hold' until they have been through the inquest process.

'It is nearly two years since my daughter died. The long wait for the inquest into her death has been an ordeal for all the family. I have many questions about the circumstances surrounding my daughter’s death and I hope to get some answers.' [Family of a young woman who died in prison]

'We have waited nearly five years for an inquest, that’s too long.' [Family of a young woman who died in prison]

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⁶ Ibid
⁷ How the inquest system fails bereaved people, INQUEST 2002, chapter 5
⁸ Experiencing inquests, 2002
‘After fighting for two and a half years to get a thorough inquest we are all totally drained. Our health is still suffering, I feel constantly exhausted, my eldest daughter has had many minor illnesses. My youngest daughter has had glandular fever for eight months – all because we are all at a low. It is a long hard battle and not finished yet. The inquest seemed to be the biggest hurdle for all of us; a lot of time and dedication and heartache went into that courtroom.’ [Family of a man who died in police custody]

‘I have been told the inquest may take three weeks and that I will have to give evidence in front of a jury in London. I am very stressed. There is no certainty about the date which is already extremely delayed.’ [Family of a man shot dead by police]

‘I think the time they take to sort out deaths in an institution is a disgrace, a part of you dies with your child, the emptiness goes on for a long time deep down without having the added depression so many unanswered questions. What they need is to cut the red tape and let not just me but some of these families move on - as every family has got other siblings and relatives who are watching a lot of pain and suffering.’ [Family of a young woman who died in prison]  

What powers would the Chief Coroner have to tackle systemic delay in the inquest system?

11. Individual coroners have little powers to tackle delays: there is currently no statutory provision for timetabling inquests or for setting deadlines to reduce inordinate delays. There is currently no statutory provision for establishing how far in advance of inquests the (voluntary) disclosure of relevant documentation might occur. The coroner does not have the authority to insist that an investigation is completed within a specific time frame. The current situation means there are no clear lines of responsibility if there are delays. PPO, IPCC or police investigations can hold up coroner’s inquests and conversely in some cases inquests can proceed before completion of the investigation. Some coroners have adopted a procedure whereby they timetable all inquests but they are not able to compel completion of the PPO/IPCC reports within that timetable as they have no powers to do so.

12. Acknowledging this situation, parliament created the office of Chief Coroner in the Coroners and Justice Act 2009. The Chief Coroner was intended, for the first time, to bring transparency and accountability to the coronial service by providing judicial oversight and national leadership. The Chief Coroner was intended to spearhead reform of the system and the postholder was given specific and significant statutory powers to tackle deep-seated issues relating to the operation of the coroners system as a whole – in particular delays.

13. According to the statutory provisions in the Coroners and Justice Act 2009 and the Ministry of Justice’s own ‘Job Description’ or ‘Main Activities of the Chief Coroner’10, the Chief Coroner would:

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9 Taken from Shaw, H. and Coles, D. Unlocking the Truth: Families’ Experiences of the Investigation of Deaths in Custody, INQUEST 2007
INQUEST Briefing on Delays July 2011

I. Manage coroners’ courts by allocating cases in order to deal with particularly complex cases, backlogs or delays, or to cater for unexpectedly large numbers of deaths due to a major incident (s.3 of the Coroners and Justice Act 2009 and paras 5-6, Main Activities of the Chief Coroner). Crucially, this would have been a step towards tackling the unacceptable delays that plague the current system.

II. Drive up standards in the system through training (s. 37 of the Act gives the Chief Coroner powers and responsibilities to make regulations about training). It was also envisaged the Chief Coroner would issue guidance to coroners on ways of working, lay down practice directions, set national standards of service (s.42 of the Act and paras 8-9, Main Activities of the Chief Coroner).

III. Work with the Lord Chancellor and Ministry of Justice to make regulations and rules overhauling practice and procedure at inquests which would likely include case management, timetabling and other measures which could be used to tackle delay (s.43(2) sets out regulations may only be made if a judicial office holder, envisaged as the Chief Coroner, agrees).

IV. Deal with appeals made against coroners’ decisions, including on issues such as whether to investigate a death or not or any finding as to cause of death (s.40 of the Act). The new appeals system overseen by the Chief Coroner would have offered families a route to resolve poor decision-making by coroners and spared some of them from only being able to challenge decisions through expensive and time-consuming judicial reviews.

V. Develop and operate an effective scheme for ensuring that recommendations and warnings relating to public safety emerging from coroners’ investigations are brought to the attention of those responsible for creating the relevant risks, regulatory bodies and the public. Critically, the Chief Coroner would be able to take steps to ensure that such recommendations and warnings are acted upon (para 20 Main Activities of the Chief Coroner).

VI. Monitor the performance of the coronial system, including via provision of an annual report to the Lord Chancellor addressing, amongst other things: levels of consistency between coroner areas; the number of investigations that have been ongoing for over a year; identification of specific resource issues; and any other matters which the Chief Coroner wishes to bring to public attention (s.36 of the Act and paras 11-12 of Main Activities of the Chief Coroner). The annual report would have been published and laid before Parliament, offering an opportunity for further scrutiny and debate.

Why, given the Chief Coroner’s central role in tackling issues of delay, is the government proposing to dismantle the office?

14. In December 2010 the House of Lords rejected the government’s attempt to abolish the post by voting overwhelmingly (by 277 votes to 165) in favour of an amendment tabled by Baroness Finlay of Llandaff to remove the Chief Coroner and associated offices from the Public Bodies Bill. INQUEST is disappointed that, despite a clear message from Peers, the government will press ahead and attempt to re-insert the Chief Coroner’s office into schedule 5 of the Bill.11

15. The government has acknowledged that the fundamental reason for trying to dismantle the Chief Coroner’s office is cost.

“We can’t afford it”

16. Jonathan Djanogly MP explained to the House of Commons in October 2010 that

the purpose of abolishing the Chief Coroner post is, first, to save the £10 million start-up costs and then the £6.5 million running costs, but also so that some of the Chief Coroner’s leadership and operational functions can be transferred to an alternative body.

17. In December 2010, in response to requests from members of the House of Lords, the Ministry of Justice finally provided an estimate of costs for full implementation of the coroners’ provisions in the Coroners and Justice Act. INQUEST believes the figures relied on by the government are taken from an impact assessment conducted by the Ministry of Justice in December 2008. It is inappropriate to rely on these calculations as the impact assessment was conducted on the assumption that the fundamental reforms in the Coroners and Justice Bill would be implemented.

18. However, the current, failing system incurs huge costs to the public purse. Pertinently, in relation to this debate on delay in the current system, the 2008 impact assessment did not evaluate the costs of the current failing system, including:

- Financial costs of adjourned and delayed hearings.
- Costs to the NHS of the impact of delays in the current system on bereaved families’ physical and mental health. Research conducted by INQUEST in 2002 has demonstrated this is likely to be substantial.
- Expensive judicial reviews against coroners’ decisions.

19. Most significantly perhaps, given the current system is failing to learn from previous fatalities, the costs of repeated and expensive investigations and inquests into similar deaths are not included in this cost assessment. The government has been unable to respond to requests, through parliamentary questions, to provide comprehensive information about the public funds currently spent on deaths in all forms of custody (police, prison and psychiatric detention). The Home Office’s submission to the Justice Committee on its Findings of Inquests and Deaths in Custody recorded that: “The Home Office is unable to provide comprehensive information...”

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12 19 October 2010, HC Deb, col 795 in response to a parliamentary question from Caroline Lucas MP
13 The two page document setting out the Ministry of Justice’s estimation of costs has been deposited with Parliament and can be found at: www.parliament.uk/deposits/depositedpapers/2010/DEP2010-2203.doc
15 In 2002 INQUEST published the results of a detailed survey which indicated that the majority of bereaved families facing inquests suffer some serious adverse effect to their health and personal lives in the medium to long term. Given the number of sudden deaths each year in the UK, this translates into a finding of a major social and public health problem at a national level – which, to date, has escaped the attention of government and decision makers almost entirely. We asked respondents whether their physical health had “improved, deteriorated or stayed the same” since the death. Of the 130 families surveyed, almost two-thirds (64%) identified a deterioration. Asked the same question in relation to their “state of mind,” again two-thirds (66%) felt this had deteriorated. Of yet more serious concern was that, when asked subsequently whether they had experienced “serious physical” or “serious mental health problems” since the inquest, approximately one-third of all respondents answered positively in response to each category (30% and 31% respectively).
16 See the answer of 27 June 2011 to Bob Ainsworth MP’s parliamentary question about the Ministry of Justice’ estimate of the average cost of appealing against a coroner’s decision through judicial review, to which the Parliamentary Under-Secretary of State responded: “No analysis of the cost of judicial review applications against coroners’ decisions has been made by this Department.”
Office has been unable to provide figures for the costs to the public purse of IPCC investigations and legal representation at inquests following deaths in police custody. The Ministry of Justice has confirmed that in relation to deaths of prisoners, the costs for legal advice and representation of Ministry of Justice bodies at inquests was £2.7 million in 2009/10 alone. The average cost of each Prisons and Probation Ombudsman investigation is approximately £16,000 and 179 deaths were investigated in 2009-10 at a cost of £2.8 million. The government’s approach to date has been “we can’t afford” to implement Chief Coroner’s office. INQUEST argues that a brief examination of the costs of the current system - in relation to failing to prevent deaths in custody alone - demonstrates that the government’s approach should be “we can’t afford not to.”

20. Setting up the Chief Coroner’s office and implementing the reforms in the Coroners and Justice Act would improve the ability of the coronial system to learn from deaths and, ultimately, prevent further unnecessary deaths which saves emotional costs to families and financial costs to society. INQUEST believes that when the government’s figures are analysed in the light of this, proper reform of the inquest system with a Chief Coroner and implementation of reforms in the Coroners and Justice Act offers good value for money. In correspondence and meetings with Ministers, INQUEST has urged the government to conduct a proper cost-benefit analysis of a fundamentally reformed system. The government has so far refused.

“The functions of the Chief Coroner can be transferred to alternative bodies”

21. The government’s current intention is to include the Chief Coroner in schedule 5 (Power to Modify or Transfer Functions) by amending the Public Bodies Bill later in this parliamentary session. This would result in the effective dismantling of the office. The government proposes to transfer some of the statutory functions of the Chief Coroner to the Lord Chancellor and some to the Lord Chief Justice. Other powers will not be transferred and will remain unimplemented, including the requirement for an annual report on the coroner’s system addressing levels of consistency between coroner areas, length of delays and other issues (see para 13(VI) of this Briefing for details) which would have been laid before Parliament.

22. The Secretary of State acknowledges the limited nature of the proposed changes: “as the functions to be transferred are limited, and the Office of Chief Coroner not filled, neither the judge nor any other individual will be responsible for the leadership, culture or behaviour of coroners.” In contrast, the Coroners and Justice Act created a single senior judicial post with the statutory powers to lead legal and cultural reform to the system. INQUEST believes the Secretary of State’s proposals ignore the collective experience of parliamentarians, bereaved families and the voluntary sector who have consistently called for leadership and fundamental reform to make the system more effective, responsive and transparent. Instead, the government proposes to add yet another layer to the current fragmented structure where lines of accountability are opaque and clear leadership is absent. If the Secretary of State for Justice convinces parliamentarians to adopt his scheme the result will be that no single person is in a position of judicial authority with an overview of the system as a whole, empowered to identify and deal effectively with the recurrent issues - such as delay - that are a feature of the current system.
“It is possible to make substantial improvements to the coroners system without implementing the office of Chief Coroner”

23. The government’s proposals for coronial reform are no more than tweaks of a system that is in need of fundamental root and branch reform. In the most recent written ministerial statement on coroner reform, the Secretary of State for Justice has proposed the creation of a Ministerial Board which would “look at specific issues that may exist and consider whether there may be appropriate action to address these.” This Board would be advised by a Bereaved Organisations Committee so that “direct feedback can be given to Ministers on the overall administrative standards of service that coroners provide.” Those standards of service would be as contained in the draft Charter (see paras 27-30 below).

24. Although a potentially useful forum to raise specific issues, a Ministerial Board which meets a few times a year is not a substitute for a single, dedicated post empowered to implement changes. INQUEST sits on the current Ministerial Board on Deaths in Custody but is still continuing to campaign for the establishment of the Chief Coroner’s office and implementation of the reforms in the Coroners and Justice Act because of the specific statutory powers the post-holder would have.

25. The government’s current proposal is particularly strange in the context of the Ministry of Justice’s decision, just 4 months ago, to abolish similar bodies: the Coroners Service Stakeholders Forum (CSSF) and the Voluntary Sector Forum (VSF). INQUEST was a member of the CSSF, a high-level body whose purpose was “to provide a forum for all key stakeholders of the system to participate in identifying, considering and resolving significant current and future issues affecting the Coroners Service.” Other members included: senior civil servants from the Ministry of Justice and the Department of Health; the Coroners Society; the Coroners Officers Association; the Royal College of Pathologists; the Local Government Association; the General Register Office; the Office of National Statistics; the Association of Chief Police Officers; the Welsh Assembly; the Coroners Court Support Service; and Cruse Bereavement Care. The Minister with responsibility for coroners’ issues was kept informed of CSSF discussions. However, in January 2011 members of the CSSF received an email newsletter from the Ministry of Justice informing them that the Forum had been abolished. At the same time they were informed that the Voluntary Sector Forum (VSF) was also being abolished. This was a regular meeting, attended by the Minister, where voluntary sector bereavement organisations (including charities such as INQUEST, Cruse, Action against Medical Accidents, Cardiac Risk in the Young, RoadPeace, Survivors of Bereavement by Suicide [SOBS] and The Compassionate Friends) were able to provide direct feedback to the Minister on the operation and reform of the coroners system.

26. The government’s plan to reconstitute these forums as a Ministerial Board and a Bereavement Organisations Committee also raises the question: what guarantee is there that the issues raised by these new forums will be acted on by the Minister given that the views of independent reviewers, expert bodies, parliamentarians, bereaved people and voluntary sector organisations have been so comprehensively ignored thus far?

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“The draft charter will improve people’s experiences of the current inquest system”

27. The written ministerial statement of October 2010 announced plans to take forward “a national charter for bereaved families.” However, in May 2011, the Ministry of Justice published a consultation paper on a Charter for all interested persons who come into contact with the inquest system. This is fundamentally different.

28. Two comprehensive consultations on a Charter for bereaved people were conducted in 2006 and 2008. The Charter for the Bereaved that resulted from that process was published alongside the 2009 Act. It was intended to supplement the provisions of the Act and enshrine the standards of service bereaved families could expect from the reformed system thus supporting the intention to “put the bereaved at the heart of the system” and rebalancing a system that so often overlooks the needs of bereaved people. It was systemically linked to the new legislation. The current charter for all who interact with the coroners service will not achieve this without implementation of the legislation.

29. Central to previous versions of the Charter was the Chief Coroner’s role in resolving complaints and adjudicating in appeals. The Chief Coroner was to have overall responsibility for establishing and overseeing a system for responding to, investigating, resolving and acting on complaints about the service provided by coroners. In the absence of a Chief Coroner, the Charter is toothless. It is telling that the government’s version does not set out any effective alternative proposals for monitoring and enforcement to ensure that the new document has any impact in improving the service offered to bereaved people who come into contact with the coroners courts. INQUEST does not believe the Charter would have any discernible impact on tackling delays in the system.

30. INQUEST and other bereavement organisations are disappointed that what had originally intended to be a robust set of standards putting bereaved people at the heart of a reformed system has been watered down to a generic document with no enforceable provisions.

“Those who oppose our proposals are frustrating any reform of the system”

31. Over thirty years, INQUEST has supported tens of thousands of bereaved people facing an investigation and inquest. This experience directly informs our work to ensure bereaved families are better treated in a fundamentally reformed coronial system. INQUEST firmly believes that losing the Chief Coroner’s office and all the benefits it would bring in overhauling the system is a disproportionate way to achieve the small gain the government proposes.

32. The provisions in the Coroners and Justice Act 2009 were the result of a consultation and parliamentary process which lasted over six years during which bereaved families shared their painful experiences of the inquest system with policy-makers. They did so with the expectation that the system would be reformed and other families would not have to undergo the unnecessarily distressing process they were forced to endure. Having been fully engaged in the governmental and legislative processes to reform the coronial system, INQUEST was dismayed at the inclusion of the Chief Coroner in the Public Bodies Bill. Other organisations have also condemned the government’s decision: in December 2010 a coalition of 13 charities supporting

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bereaved people wrote to The Editor of The Times to express their concerns. As well as INQUEST, the signatories included:

- The Royal British Legion
- CRUSE Bereavement Care
- Victim Support
- Action against Medical Accidents (AvMA)
- Cardiac Risk in the Young
- Child Bereavement Charity
- Disaster Action
- Support after Murder and Manslaughter (SAMM National)
- Survivors of Bereavement by Suicide
- The Compassionate Friends
- RoadPeace
- BRAKE

INQUEST remains concerned that if the Chief Coroner’s office is dismantled and the reforms set out by Parliament in the Coroners and Justice Act are abandoned, the opportunity to create an inquest system fit for the 21st Century which saves lives will be wasted. This is a false economy if there ever was one.

21 The letter can be found at: www.thetimes.co.uk/tto/opinion/letters/article2841682.ece
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About INQUEST

INQUEST is the only organisation in England and Wales that provides a specialist, comprehensive 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 has a proven track record in delivering an award-winning free in depth complex casework service on deaths in state detention or involving state agents. It works on other cases that also engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability. It monitors public interest inquests and inquiries into contentious deaths to ensure the issues arising inform our strategic policy and legal work.

INQUEST undertakes research and develops policy proposals to campaign for changes to the inquest and investigation process. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; holds those responsible to account and disseminates the lessons learned from the investigation process in order to prevent further deaths occurring. INQUEST is represented on the Ministerial Council on Deaths in Custody and the Ministry of Justice Coroner Service Stakeholder Forum.

INQUEST publications include: briefings on individual cases and on thematic issues arising; Inquest Law, the journal of the INQUEST Lawyers Group; specialist leaflets on deaths in prison and in police custody; a regular e-newsletter; and three groundbreaking books: In the Care of the State? Child Deaths in Penal Custody in England and Wales (2005); Unlocking the Truth – Families’ Experience of the Investigation of Deaths in Custody (2007) and Dying on the Inside – Examining Women’s Deaths in Prison (2008).

INQUEST was the Winner of the Longford Prize in 2009; Joint Winner of the Liberty/JUSTICE Human Rights Award in 2007 and Winner of a Campaign for Freedom of Information Award in 1999.

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