

# HOW THE INQUEST SYSTEM FAILS BEREAVED PEOPLE

INQUEST's Response to the  
Fundamental Review of  
Coroner Services

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# **HOW THE INQUEST SYSTEM FAILS BEREAVED PEOPLE**

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Fundamental Review of  
Coroner Services

INQUEST is the only non-governmental organisation in Britain that works directly with the families and friends of those who die in custody to provide an independent free legal and advice service to bereaved people on inquest procedures and their rights in the Coroner's Court. It provides specialist advice to lawyers, the bereaved, advice agencies, policy makers, the media and the general public on contentious deaths and their investigation.

# INQUEST

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## **How the inquest system fails bereaved people. INQUEST's Response to the Fundamental Review of Coroner Services.**

First published December 2002

Second print July 2003

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Printed by Oldacres Ltd, London EC1

INQUEST's co-directors, Deborah Coles and Helen Shaw wrote this report, with the assistance of Clare O'Brien and Dr Tony Ward. We would like to thank all the families who shared their experiences with us. We would also like to thank the Network for Social Change, Matrix Chambers and Nuffield Foundation for their support.

Deborah Coles and Helen Shaw are co-directors of INQUEST and also work on a consultancy basis on related issues. They have worked for the organisation since 1990 and 1994 respectively. They have played an active role in a significant number of high-profile deaths in custody cases and write regularly and are a frequent commentators on the issues raised by the organisation. Deborah is on the Board of Directors of Women In Prison and Centre for Corporate Accountability that she was instrumental in setting up in 2000. She is also a member of the BBC Appeals Advisory Committee. Helen was appointed (April 2001) to the Department of Health Retained Organs Commission set up following the Alder Hey Inquiry and chaired an investigation into the issue in Manchester that published its report in July 2002.

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## 1. Introduction

INQUEST believes that the current inquest system is failing. This is heightened by deaths that involve questions of state or corporate accountability. The fundamental review and its terms of reference are timely and the review could have profoundly important implications for bereaved people and for society as a whole in relation to public health and safety. We welcome the review and many of the proposals outlined in the consultation document. INQUEST is appalled by the collective failure of agencies and government to act earlier on the well-documented and recognised evidence of a failing system. The consultation process is only the beginning and much depends on how much of a priority this issue is for government as it will require the political will to implement the fundamental changes needed.

INQUEST has always argued that the right to an inquest is fundamental. Any new system needs to operate within a framework that ensures openness, accountability and compatibility with the Human Rights Act and sensitivity to bereaved people and the public. To establish such a framework there needs to be clear national protocols for all aspects of post-death investigation. Those protocols need to enshrine clearly defined mechanisms of accountability, minimum levels of service delivery and a system of sanctions where practice falls below acceptable standards. The protocols need to clearly set out the rationale for each step that is taken, in a manner that is understood by professionals, bereaved people and the public. Above all it needs to be a system that balances the needs of the State with those of bereaved people and ensures that all participants have an equality of resources and information. Whilst the process will be painful for bereaved people it will be more bearable if it is seen to have legitimacy and meaningful outcomes.

INQUEST has a broad overview of the inquest system and has dealt with inquests into deaths in a number of varying circumstances. However we have a particular knowledge of the issues surrounding jury inquests and those that raise questions of state or corporate accountability. We have accrued a unique and expert body of knowledge on issues relating to deaths in custody and seek to utilise this body of experience towards the goal of proper post-death investigation and the prevention of custodial deaths. In the consultation paper we feel there is not sufficient recognition of the specific questions raised by these more complex cases, particularly at a time when key human rights principles must be applied to inquests into controversial deaths under both domestic and European human rights law. There is a clear need for some more radical proposals for the investigation of contentious deaths.

This response is based on INQUEST's 21 years of advising and supporting bereaved families, monitoring post-death investigations and attending inquests around the country. It concentrates on the impact of sudden death and the current investigation system. In particular it relies on partial data from wide-ranging survey responses from a sample of 130 families amongst those who approached INQUEST for support during the years 1997-2000. Whilst INQUEST has prioritised working on cases involving deaths in custody and in other circumstances that raise questions of state or corporate accountability, we have, in the absence of any other specialist support, advised any bereaved family attending an inquest. This response summarises the general concerns raised with us by the families with whom we work and our observations on the problems of the inquest system.

We are currently involved with the Liberty project on the investigation of deaths in police custody and are working on our own project 'Families Experience of the Investigation of Contentious Deaths' funded by the Nuffield Foundation. We therefore offer our comments here in the context described and of that ongoing work.

INQUEST's campaigning to reform the inquest system found little favour outside the penal and civil rights lobbies before 1997. The review takes place in the context of widespread concern and criticism of the inquest system, the investigation process and the relationship with civil and criminal courts after contentious deaths in custody and during disasters. Recent judgements arising in the European Court of Human Rights and the High Court coupled with the new climate created by the Human Rights Act 1998 have also called into question the adequacy of the inquest system.

Public campaigns pursued by bereaved families following controversial deaths in custody and following major disasters have focused public attention on the investigation process following contentious deaths and the inadequacy of the Coroners court as a forum in for the examination of deaths where the state is suspected of bearing some responsibility. People bereaved in controversial circumstances share common experiences of the legal processes following such deaths. INQUEST's monitoring has shown how the state uses the inquest and not criminal prosecution and trial for the public examination of these deaths. The failure of the state to prosecute even when a verdict of 'unlawful killing' is returned at an inquest has caused considerable disquiet.<sup>1</sup>

The Coroner's system is one of the most neglected areas of law and the fundamental review presents an important opportunity to explore the issues involved and influence developments. It is also an acknowledgement at government level that change will be forced through the courts in any event as a consequence of the Strasbourg decisions. In contrast to the constant evolution of other legal and administrative structures and a more rights-based approach generally to public functions and services (e.g. the Citizens Charter), the Coroner's Court has failed to evolve. This means that its standards fail to reflect modern concerns about the rights of those participating in legal proceedings.

There is also a lack of research into and understanding of, the impact of the inquest process on bereavement and the additional stress and grief that it causes to bereaved people. Bereavement agencies have a very limited understanding of the legal processes following sudden death and the particular needs of people in these circumstances.

These factors have serious consequences for families faced with an unexpected or violent death. The narrow focus of the inquiry puts artificial and invidious limits on the scope and style of conduct of the Coroner's inquiry, which often exclude from the inquest the issues of greatest concern to the family. The inquest is usually the only investigation of death to which a family has access. Importantly, for the public interest and democratic accountability it is the only public forum in which contentious deaths will be subject to scrutiny. Inquests are too often at risk, particularly in the absence of legal representation for the family, of being opportunities for official and sanitised versions of deaths to be given judicial approval – rather than being an opportunity for the family to contest the evidence presented, to discover the truth and full circumstances surrounding the death of their loved one.

Secondly, an outmoded administrative mindset means that families are marginal to the overall process, whereas they should be central. Death is far more significant for the bereaved than for the doctors, police, Coroner and lawyers involved, for whom it is ultimately a professional matter.

There have been some developments seeking to soften the hard edges of legal procedures following death, and individual Coroners do often try on an ad hoc basis to be sensitive to families' feelings and concerns. The position however remains that families' legal rights in proceedings are restricted: the inquiry is not for them, and the administrative framework is not directed at their full inclusion in the process. Families are not recognised as stakeholders with an interest in the final outcome. The Government's review is an important opportunity to change the inquest system fundamentally. INQUEST welcomes this step to reform what is one of the most neglected areas of law.

### Jury inquests

The vast majority of deaths are not referred to the Coroner and of the average 201,000 deaths reported to Coroners each year there are inquests held into approximately 25,800. This submission is primarily concerned with the investigation of contentious deaths; in particular

<sup>1</sup> Unlawful killing verdicts were returned at inquests into the Marchioness riverboat disaster and the murder of Stephen Lawrence as well as in a number of custody deaths. See [www.inquest.org.uk](http://www.inquest.org.uk)

those cases that are held before a jury (some 2,000 inquests per annum) which raise questions of public interest. In this situation bereaved people are not able to decide whether the inquest takes place or not. The state has given the inquest as the forum to scrutinise the deaths but does not facilitate their participation either through equal access to legal representation or information.

Following a death in police or prison custody the Coroner is obliged to hold the inquest sitting with a jury. In these cases the State or the institution involved will always be represented, at public expense. Families without legal representation can find themselves facing a barrister from the Home Office or Police Authority. In deaths raising health and safety issues, which will for example include deaths on public transport such as rail crashes as well as workplace deaths, the inquest is again held with a jury and invariably companies will be represented by lawyers paid for by their insurance policies. This lack of equality of arms perpetuates the view that the system is biased towards the interests of institutions, corporate bodies and/or organisations that may be facing criticism for their handling of a case.

A public service relies on public funds to represent its interests at a Coroner's inquest, but the bereaved have a highly limited provision for legal help and funding for representation.<sup>2</sup> It is often the case that the Coroner does not succeed in eliciting the full facts where the family is not represented.<sup>3</sup> Some Coroners have stated publicly that they prefer for a family to be represented.

The key role of the public inquest in contentious deaths is that it is often the only public forum in which there is any scrutiny of the death. The importance of the investigation being in *public* cannot be underestimated.

The theme that runs through our concerns is that bereaved people are at the margins of the process, not provided with sufficient information for it to be meaningful to them or to be empowered to participate properly. There is obviously a balance of needs inherent in the system but this is currently tipped too far towards the convenience of the Coroner and others and not far enough towards the bereaved family or friends.

### Overview of families experiences

In our experience the nature of the circumstances of many of the deaths on which we work inherently attracts prejudice and strong feelings and the majority of families we work with do not experience the system as compassionate. Families feel overwhelmingly excluded, dissatisfied and let down by it as a process for establishing the facts. The Coroner's inquest has become an arena for some of the most unsatisfactory rituals that follow a death – accusations, deceit, cover-up, legal chicanery, mystification; everything but a simple and uncontroversial procedure to establish the facts.

#### What are the problems that have emerged?

It is clear from our case work and in survey answers that very few people even know what an inquest is before they find themselves confronted with its reality – many confuse the term with the post mortem – the medical examination undertaken to determine cause of death. 75% of those surveyed knew absolutely nothing and the remaining 25% very little

In INQUEST's experience there is a high level of dissatisfaction with the inquest system amongst bereaved people. Of those we surveyed 69% said their level of confidence in the inquest system decreased after their experience and for 83% this applied to the law in general and 87% for the criminal justice system. (See Figure 1 below)

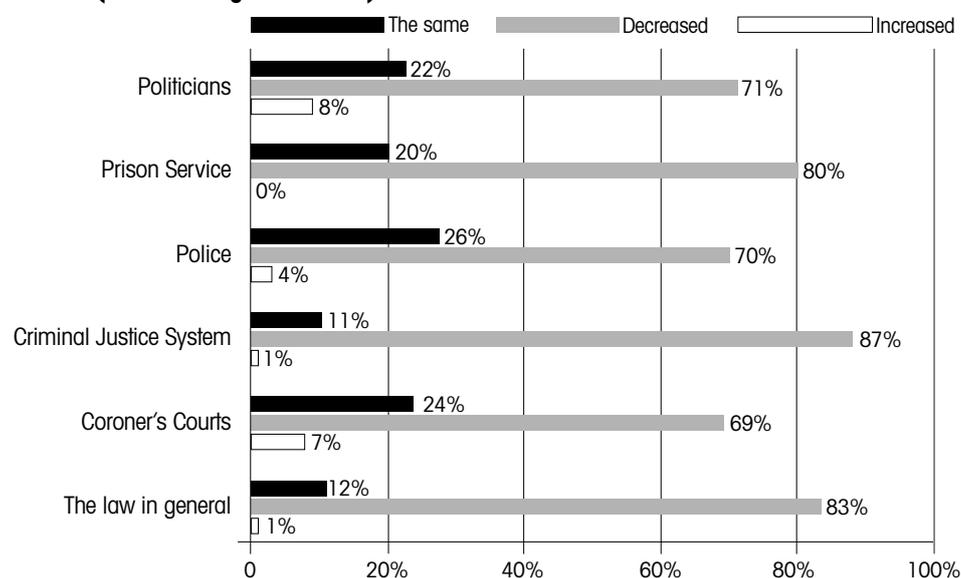
People tend to have a sense of trust in the fairness and impartiality of the criminal justice system and it is clearly a matter of concern that experience of a legal process can have such dramatic effects on individuals' faith in important institutions. This experience appears to be replicated regardless of circumstances of death, geographical area, class, ethnicity or educational background.

Bereaved families have frequently described the experience as one that adds to, rather than diminishes, distress and that it marginalises them leaving them with more questions than answers. Many agencies have little or no understanding of the particular experience of the inquest system including lawyers, generic advice agencies and bereavement agencies. Lawyers

**2.** Since the 1999 Access to Justice Act in 'exceptional cases' at the discretion of the Lord Chancellor and in deaths in custody cases if financial eligibility criteria are met.

**3.** 'Investigating suspicious deaths in police custody', Tony Ward and Deborah Coles in *Deaths of Offenders*, Waterside Press, 1998

**Figure 1: How would you describe the effect of the inquest on your level of confidence in (the following institutions):**



are not routinely taught about inquests during their training. This, coupled with the lack of access to public funding in most inquest cases, means that often families have sought advice from lawyers that has been inadequate, expensive and sometimes wrong.

There have been some important procedural changes but little substantial systemic change. Some of the more recently appointed Coroners do have a different approach to their work but like many institutions what is needed is a culture shift. There are important developments taking place in the wake of the Alder Hey scandal and the beginnings of a greater understanding of the support needs of families following sudden and unnatural death. However, we remain concerned that the mainstream provision of bereavement support is delivered in the absence of evidence-based research on the particular impact of bereavement and the inquest process.

Overwhelmingly our survey has resulted in an outpouring of anger and distress from bereaved people and raises some fundamental questions about society’s collective ability to deal with the aftermath of death. It affirms what we suspected, that it is not only isolated deaths that the system is ill equipped to deal with, but more a question of most deaths and as a result the majority of families suffer additional distress and grief.

Regrettably, our survey indicates that the majority of bereaved families facing inquests lack access to appropriate information and assistance. Furthermore – and a probable related result – most 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 significant finding of a major social and public health problem at a national level – which, to date, has escaped both public notice and the attention of government decision-makers’ almost entirely. Although not all sudden deaths involve an inquest, and the fact that grief trauma can also follow a “natural” death, the significance in this context of the Coroner’s court (the point of contact with public services for most “at risk” families, regardless of how and where their loved one’s death occurred) is at once clear. Its potential role in guaranteeing informed and effective access to appropriate bereavement intervention options for bereaved families must therefore be a central focus in developing a new system.

Many of the issues raised are under-researched elsewhere and our work points to the urgent need for further investigation and research. We aim here to give voice to the families behind the headlines and contribute to the search for a more modern and humane way of dealing with sudden and unnatural death.

## 2. Post-mortem examination

A number of key concerns have emerged from our work and are summarised as follows:

- Lack of information to bereaved people;
- Lack of understanding of religious and cultural beliefs
- No shared understanding of the function and purpose of post-mortem examination;
- Lack of explanation about their rights and funding for a second post-mortem;
- Problems with the legal status of the body and access to the body;
- Insensitivity of Coroners and others in relation to post-mortem evidence;
- Quality and extent of Coroner's post mortems.

### Introduction

*"The autopsy is central to death investigation and many coronial jurisdictions rely almost entirely on the medical death investigation to the exclusion of the other death investigation processes that might be of value...[In our experience when working with eminent forensic pathologists] this overly narrow approach can be avoided. Their input encourages a broader view, and results in an investigation that is more comprehensive and likely to prevent avoidable harm. Their practice is particularly appropriate in deaths involving medical treatment and other health care issues, as well as those deaths associated with crime and violence. On a global scale the autopsy can play a significant role in health care audit and so contribute to direct improvement in patient care".<sup>4</sup>*

We agree with the above sentiment and believe that the UK system is over reliant on autopsy. Changes need to be made but it is important not to lose the benefit of properly conducted autopsies within a more holistic approach to the investigation of death. We hope that the proposals to reform the system, which include a medical auditor/Coroner, will result in such an approach because the number of post-mortem examinations should be reduced. We hope that this would focus resources and thus enable those that are carried out to be of a higher quality and more appropriately performed by adopting the kind of approach described below by forensic pathologist Derek Pounder.<sup>5</sup>

*"There are three very important aspects when investigating deaths.*

- *Examination of the body*
- *Examination of the scene of the death*
- *Examination of the medical and other history of the deceased*

*Initially the medical psychological history should be examined and then the body is examined by a doctor. The investigation seeks to integrate the information from all these three sources... You can test whether there has been an effective investigation by looking at how well these three aspects have been examined."*

*The State should intrude as little as possible into deaths of loved ones and regarding inquests and autopsies the fewer are needed the better. The need for public investigation must be weighed against the right of privacy for families. In Scotland the facts surrounding deaths are automatically confidential. In my view the quality of the investigative process in Canada and Scotland is higher than in England... a senior judge presides and the quality of recommendations stand out.*

*A mechanism of follow up is needed. In Alberta the annual report of the Attorney General lists the inquests, recommendations and the changes to government policy as a consequence. These transparencies are very helpful.*

*In relation to autopsies, these are very intrusive procedures and are objected to by*

<sup>4</sup>. 'The Autopsy', David Ranson in *the Inquest Handbook*, Editor Hugh Selby, The Federated Press, Sydney 1998.

<sup>5</sup>. In *Coroner's Inquests – do they deliver justice? Report of a Joint Law Society and INQUEST Seminar 2001*.

*many, especially Muslims and Jews. 24% of all deaths in the last year in England and Wales were subject to autopsy. That figure is half in Scotland and is only 8% in America. We need to ask ourselves why there are so many autopsies in England? The system relies on autopsy as a screening procedure to make up for poor investigation particularly in relation to the scene and the history. The autopsy in England and Wales is needed to provide information. In Scotland information is provided by an external examination without autopsy known as a "view and grant". This is a thorough and full inspection of body and a review of the records.*

*In the United States there are specialised scene of death investigators who are trained nurses and these contribute to the process and help the family. In England and Wales there are a large number of autopsies by rotational contractors on a fee for service basis and quality is sacrificed as a result.*

*There is no quality control in England and Wales and there is no way to deal with poorly performing pathologists. There is no structure or central control. Some are NHS and some are from other jobs.*

*In relation to the structure of the system, if the Coroners system is to be maintained the NHS needs to provide services. If there was a Pathologist's Institute in major cities as for example there is in Australia, this would help enormously. In other jurisdictions these come in different forms and there are different models in Canada and Australia. In England and Wales there is no centre of excellence and most of the work is done by private practitioners. We could look at the North American medical examiner system which separates the investigation from judicial proceedings and considers the investigation to be a matter of science and not legal skill... The medical examiner has no judicial role and the inquest is run by a member of the judiciary. The investigation is medical and I think doctors should be allowed to deal with it. I consider this system is best able to deliver the facts.'*

Recent inquiries began to reveal some of the trauma that has been caused by the current practice of post-mortem examination and investigation, and the inadequate oversight and system of accountability associated with the process. It also highlighted how bereaved people are marginalised in relation to the deceased's body where State investigation takes place. Any new system needs to take account of the current problems.<sup>6</sup>

In addition to Coroners' legal powers and duties in relation to post-mortem<sup>7</sup> a number of "good practice standards" are intended to regulate Coroners' and pathologists' practice in this area.<sup>8</sup> They are clearly not working in all cases but again there are standards in place to guide practice and these can contribute to developing a new system that addresses some of the concerns outlined.

### **How does a post-mortem impact on bereaved people and what are the issues?**

#### **Lack of adequate information to bereaved people**

Many people do not understand or realise what a post mortem examination is or that it will be ordered by the Coroner and that they will have no right to prevent it. Poor provision of general information to bereaved people about the coronial process is no different in relation to post-mortem examination.

In our survey of 130 families who had experienced sudden and unnatural death between January 1997 and December 2000 only one-quarter (26%) were given information about post-mortem examination and what it involved. INQUEST caseworkers regularly spend time with bereaved people explaining what a post-mortem is, why it is carried out, the law in relation to it and then what the post-mortem report means.

The wishes of those families who may not want to know full results must be respected. However, those who do must be provided with the fullest possible information in a sensitive and timely manner. This should take place in an appropriate environment, from a person capable of answering their questions regarding the post-mortem procedure and its findings, and also its potential impact on an inquest and any subsequent legal proceedings.

In many cases where there is suspicion or doubt about the cause of death, a post-mortem examination by an independent pathologist at the family's request can provide vital

**6.** Reports from the Redfern Inquiry January 2001 and the Public Inquiry into the Identification of victims following Major Transport Accidents March 2001.

**7.** Coroners Act 1988 and Coroners Rules 1984.

**8.** Home Office Models Coroners' Charter pt 13, Coroners' Society Practice, Notes for Coroners, Appendix A, Home Office leaflet *When Sudden Death Occurs*, Home Office Circular 30/99.

information. Where post-mortem results are in agreement as to the cause of death this can allay suspicions of medical malpractice (particularly where the death occurred in hospital or following recent medical treatment). Alternatively, a second opinion can provide evidence essential to an effective challenge during the inquest hearing to a disputed account of the cause of death presented by those then responsible for the deceased's care, and form the basis for a verdict more closely aligned to the family's understanding of events leading to death.

Thus post-mortem is "a necessary evil" in the eyes of many bereaved families despite in the vast majority of cases a lack of specialist knowledge and ability to interpret pathologists post-mortem results. However, the absence of a supportive and informative approach from staff within the Coroners' system contributes to making the post-mortem examination a source of severe additional distress to bereaved relatives because:

1. It subjects the body to invasive procedures, which may be perceived as further violation of the deceased's person. This is particularly so where multiple post-mortem examinations are required by interested parties to an inquest (e.g. responsible custody authorities or homicide suspects);
2. Such interference with the body is contrary to many religious and cultural beliefs;
3. It prolongs the period before the deceased's body is released to relatives, thereby delaying burial or other religious rites. This is of particular importance to religious traditions requiring expeditious burial.

### Organ retention

We have dealt with a significant number of cases where major organs (hearts and brains) have been retained without families' knowledge. This had been a concern of INQUEST's for some time before the Alder Hey scandal drew national attention to the practice – in a number of high profile custody deaths it was subsequently discovered that the heart and/or brain had been retained. It has always been that lack of knowledge about the procedure that has caused the anger and distress. We endorse the sentiments expressed in a report by the Retained Organs Commission:<sup>9</sup>

*'...procedures happened that resulted in short term retention of organs that they (families) did not know about. It is this "not knowing" that has ... caused much of the harm. Families said that they were given no information at the time about what would happen at a post mortem... that no explanation or information had been given to them about what would happen. This is not even about the debate on informed consent but merely a question of knowledge. At Coroner's post mortems consent (or more properly speaking 'lack of objection') is not required but the distress caused by "not knowing" is exactly the same. For many ...the lack of feedback about the outcome of the post mortem on their child or children rendered the process one which was perceived to be in the interests of practitioners not the patient or their family.'*

### Lack of explanation about their rights and funding for a second post-mortem and problems with access to the body

In addition to the lack of information the distress of the death is often added to by the realisation that the body does not belong to them. The effect of CA 1988 s19 coupled with the Coroner's common law powers means that many relatives face the traumatic legal reality that they have few rights in relation to the body of the deceased.

CR 1984 r7 lists the 'interested parties' whom the Coroner 'shall' notify of the time and date of post-mortem. The problem with this rule is that it is predicated on the family notifying the Coroner of their wish to be informed and in reality in the aftermath of a sudden death families are often unaware of this right until the post-mortem is over. Less than one –in ten families (9%) in our survey were informed of their right to have a representative attend the Coroner's post-mortem examination if they wished. Our day to day contact with bereaved people at the time of writing further supports this and indicates that little has changed.

### Case study

**A young black man who was a patient in a medium secure unit was certified dead in the early**

<sup>9</sup> Report of the Independent Investigation into Organ retention at Central Manchester and Manchester Children's Hospitals trust – Retained Organ Commission July 2002.

hours of Saturday 31 October 1998. His death followed an incident involving the use of restraint.

The police had visited the home of one of his sisters with the news of his death. They told her to contact a particular A&E department and left without giving her the telephone number. It took several phone calls for his sister to track down the hospital and more calls to begin to obtain sketchy details about what had happened.

When his sister phoned the institution in which he had been detained she was given one version of the circumstances of the death. Another sister was told she could have no information as the hospital was carrying out an inquiry. They were given no information about where their brother was or how to contact the A&E department and had to phone directory inquiries to find out the number.

On contacting the A&E department she was told a different story. When she asked to see her brother's body she was told he had been taken some 50 miles away for a post-mortem, which was due to start at any minute. So when the police came to tell the family that he was dead the body had already been transferred to the location for the post-mortem and that had been arranged before the family was even aware of the death.

### Access to the body

Access to the body of the deceased for a bereaved family is important. We are concerned that families have been prevented from seeing the body before the post-mortem. Also that bodies have been left in a poor state and improperly stored leading to families being advised not to view the body. This has caused lasting distress and sometimes suspicion about what has been done to their loved one. Families who have been denied access are frequently left with unresolved suspicions and feelings of guilt and loss. For some faiths and cultures access is profoundly important in relation to their expected duty to their relatives. Less than two-fifths (39%) of our survey respondents had access to the deceased's body before the Coroner's post-mortem was performed, and one-third (33%) felt they had not had adequate access to the body during the period before it was released to them (50% felt they had adequate access).

"We were advised not to go and view our son's body. We were never given any reason for this, but we took the advice, as we didn't know what to expect. We often wonder if some of his organs had been removed."

"Advised not to see our son's body. No real explanation given we were never given a reason."

### Multiple post-mortems

Where the death is controversial multiple post-mortems and delays in the release of the body cause additional distress. In the case of Roger Sylvester<sup>10</sup> the post-mortem examinations were so extensive that it resulted in his body being returned to the family in two body bags.

"On arrival at the Coroner's Office we were shown our son through a dirty window. He was covered by a dirty blanket and because of his weight loss, we found it difficult to recognise him. There was a 'flattened' lager can lying beside his body. The Coroner remarked on how light our son's body was and said it could be lifted with two fingers!"

While just over half those in our survey (53%) had the body returned within one week, one-quarter (25%) waited between one week and one month, and 10% waited more than one month.

16% felt their cultural and religious needs had not been respected (only 44% responded that these needs had been met) – which is a high figure considering the small number of ethnic minority respondents in the survey.

"We were unable to get close to touch him while his body was at the Coroners. They did accept a bible from us and we requested it be placed on his body and be opened at a particular reading, but whether this was acknowledged/respected throughout the time the body remained there we don't know."

<sup>10</sup> See INQUEST briefing on the death of Roger Sylvester 2001.

“John was in a long nightie thing not his own clothes and the whole thing felt artificial; taken out of the context of normality – in a little institution box-room with a fish tank type window.”

### Second post mortems

A second or independent post-mortem is often very important to families of people who have died in suspicious circumstances. However only one fifth (21%) of those we surveyed were informed of their right to have an independent post-mortem performed, of whom one-third were informed by their solicitor, and just over half by a Coroner's Officer. At least half of those informed of this right in fact had a second post-mortem performed. In most of these cases, the pathologist was found by their solicitor, and paid for by families themselves, and cost at minimum £200.<sup>11</sup>

<sup>11</sup>. This low cost was usually due to the pathologist being contacted by INQUEST or INQUEST Lawyers Group members.

The current inadequate structure of pathology services means that finding the appropriate expert is often difficult. INQUEST and the lawyers with whom we work have knowledge of the area but there needs to be a better way for families, and indeed, Coroners to access appropriately experienced and qualified experts. Proposals to bring the forensic pathology service within the NHS and possibly set up an Institute may go some way to address some of these concerns. In any case the current system relies far too much on chance. In responding to point 55 in the consultation document if there were a better system which ensured there was a centralised evidence base it would be possible to demonstrate where post-mortem examination had exposed untoward issues about the death but also to ensure better learning about public health issues (vCJD, industrial and work related disease, unsafe methods of restraint).

The importance of a second post-mortem examination has been demonstrated in a number of cases involving the use of force by state agents. In many cases it has been pathologists instructed by families who have ensured that inquests have addressed the complex, controversial and difficult questions of forensic science, sometimes raised for the first time and exposed systemic and practice problems that have contributed to many deaths in custody, for example positional asphyxia. In these cases the pathologists have adopted a thorough and holistic approach, indeed some of them will not give a final cause of death until the inquest evidence has been heard. This is particularly important where the events surrounding the death are a matter of dispute.

We remain concerned about the lack of understanding about the potential importance of a second post-mortem examination to the inquest fulfilling its function and to the role of lawyers in assisting the Coroner. We agree with the sentiments expressed in point 54 of the document in that there must be clarity of purpose. But it also must be understood that where a death has occurred in suspicious circumstances, particularly in custody, there may well be suspicion and rumour about foul play and the second post-mortem can play an important part in reassuring the family that there has been no involvement of a third party. Some Coroners remain obstructive and unhelpful to those assisting families as detailed below

### Case study

#### Recent experience of INQUEST Lawyers Group member and family of man who died in prison in October 2002:

The lawyer was instructed by the family a week after his death. It had taken them a week to find appropriate legal advice because they had not been given information about INQUEST. Their solicitor, when instructed, advised a second post-mortem examination because of family concerns about circumstances of the death. The solicitor contacted the Coroner to advise him of the family request for a second post-mortem after he had already decided to release the body. The solicitor wanted the Coroner to postpone release so that the body was still in his possession (if released to family they would incur significant costs in keeping the body in the local mortuary). The Coroner refused. The leading pathologist engaged by the family was able to negotiate with the hospital that the body could remain in the mortuary until after the second post-mortem for a fee of £100. In conducting the post-mortem it was apparent that it had not been as thorough as the family pathologist would have expected. If the first examination had been the only one (if the family had not been able to find early legal advice) it would have laid

the Coroner open to potential judicial review for a less than thorough investigation of a prison death.

The family were away when the man died. When they returned home there had been no communication at all from the Coroner's Office. When they contacted the Coroner's Office they were told they couldn't see his body and were told not to attend the inquest. They described the Coroner's Officer as callous, rude and arrogant. When they complained about this officer, who had put the phone down on the mother they were told "the Coroner's Officer is under a lot of stress".

The post-mortem examination is often a vital part of the investigation of a sudden and unnatural death. Provision of adequate and timely information is crucial for proper investigation of the cause of death. Pathologists who have been instructed on behalf of bereaved families to conduct second post-mortems have told us that it is much better for them if they can perform their examination alongside the Coroner's pathologist so that the body is only subject to a full examination on one occasion. If they are asked to carry out a second post-mortem sometime after the first, important forensic evidence may have been damaged during the initial examination. It therefore vital that there is a process that protects the rights of all involved whilst balancing the needs of the state to ensure timely and thorough investigation of such deaths.

The symbolic importance to a bereaved family of having their representative at the state post-mortem cannot be underestimated particularly in cases of deaths in institutions. This means it is vital that the post-mortem does not proceed until proper efforts have been made to contact the family. We think that within the new system there should be an agreed period of time that should elapse before the post mortem goes ahead if it is not possible to contact the family. This also means that the new system must ensure that it is not just the right to be represented that is facilitated but that access to those who can provide that representation is also provided. We are aware that some may be concerned that this would result in many families instructing solicitors to be present at the post-mortem. In our experience this is not what our colleagues in the INQUEST Lawyers Group would want – rather that it is easier to ensure the presence of an independent pathologist who in the most contentious cases can carry out her/his post-mortem at the same time as that carried out for the Medical Coroner/auditor.

Families have told us:

"We were informed (of our right to an independent post-mortem) by the doctor and that is when I accused the hospital staff of negligence and I told them I did not want the PM carried out at that hospital. I wanted an independent PM. This was not carried out. This is when the conspiracy began. I feel that the Coroner or his assistant should have contacted me or a member of my family to inform us when and where the post mortem would be carried out. Also we should have been informed who would be carrying out the PM, which they are obliged to do. We would not be suffering as much as we are now if they were to stick to this tiny rule. I feel it would improve the system."

"I had to phone every time I wanted information, and was made to feel as if I were a problem – telling me, 'I shouldn't believe everything you see on TV' when I asked why blood results were taking so long and when approximately did my son die. I was made to feel stupid and inferior. Although from the outset the Police said, 'No suspicious circumstances', I was never at any time allowed to hold my son, or allowed any time alone with him. I was only told this (right to second PM) AFTER the first PM and at a time when it was impossible to locate a Home Office pathologist as it was a Bank Holiday weekend (end of May). From photographs taken by myself of bruises and marks on my son's body (as he was in his coffin) Dr Carey was able to come to the conclusion that this was not self-inflicted and it was on his words that we were able to get an Open verdict."

"No one did [inform family of right to independent post-mortem]. I decided I would have another.

I should have been informed about their one, and I would have had another one there and then. I feel as the country pay for their one the bereaved should also have the same advantage.”

“The post-mortem was automatic I was told on behalf of the Coroner after my son died, in regards to my right we might have had, we were like nothing.”

“INQUEST also informed and advised us to have one done.”

“Our solicitor did inform us but too late because the funeral had already taken place.”

“Was given on the date the inquest opened (a week following death) and AFTER the PM had been carried out. This should be given before the PM carried out so that families know their rights.”

“I was never informed of my rights to this(second post-mortem). I feel that if I had known this I would have had one as I have never really been sure of the results.”

“But had we known (of right to second post-mortem) that we could have, we would have.”

### Right to copy of the Coroner's post-mortem report

There is a misconception that bereaved families do not have the right to a copy of the post mortem report. The Coroners Rules 1984 r57 (1) require the Coroner to supply it to ‘any person who in the opinion of the Coroner is a properly interested person’ on payment of the prescribed fee. Since there is no prescribed fee we would argue it should be provided free of charge. In all cases the family would be recognised as a properly interested person by the Coroner. We believe that the misconception arises from the culture of paternalism that pervades the current system. It is clearly the case that most people will not understand the technical language of the post mortem report and indeed the recent scrutiny of such reports has found many of them to be of poor quality. Notwithstanding those concerns families should be aware that they are entitled by law to a copy of the report.

In the leaflet issued by the Home Office to Coroners to give to bereaved people ‘When sudden death occurs’ it states:

#### *6. Post Mortem Report*

*This report gives details of the examination of the body. It may also give details of any laboratory tests which have been carried out. Copies of the report will normally be available to the next of kin...A fee may be payable.*

It is important that practice changes and that families are able to receive the information in a manner that facilitates their understanding of its findings.

(26%) of the families we surveyed were informed of their right to a copy of the official post-mortem report, of whom 68% informed by a Coroner's Officer.

“The Coroner's assistants and hospital were very good in that the body was kept at the hospital mortuary for three months, while I was in hospital, before I could have/arrange/go to the funeral. I asked my solicitor to get a copy (OF THE PM REPORT) after the inquest. But I have never received one. I asked to see the police photographs before the court case, which I am ‘glad’ I saw before the magistrates case, as it would have been a terrible shock to see them in court with no prior knowledge. But these were never shown at the inquest.”

### Insensitivity of Coroners and others in relation to post mortem and evidence

In addressing these issues attention must also be given to the way post mortem evidence is handled during the inquest hearing – institutionalised approaches from Coroners including waving post mortem photographs about without regard to the family are not, in INQUEST's experience uncommon. Some pathologists have also displayed insensitivity to families in their delivery of evidence during inquests.

“The Coroner was extremely insensitive... Her demeanour was condescending – she ate a Kit Kat during the morning. When the post-mortem was dealt with my husband and I left the court but my brother-in-law remained and was appalled that the Coroner found humour in trying to convert the weight of our son’s organs!”

In contrast to this we have attended inquests where Coroners have been very sensitive to the needs of families explaining that the post mortem evidence is about to be heard and that the family can leave the court if they wish. INQUEST staff and lawyers group members advise families likewise and this practice needs to be encouraged in any new system. This and the other issues of sensitivity need to be integrated into training for all of those working in the new system.

### Problems of accountability and control

As a national average, Coroners order post mortems in about two-thirds (126,000) of reported cases yearly; this proportion has declined since the 1970s when post mortems were performed in about 88% of cases.<sup>12</sup> However, post-mortem rates vary widely amongst Coroner districts – from just over 40% up to 100% of reported deaths<sup>13</sup> – which has raised concerns that some Coroners may be subjecting bodies to post mortems unnecessarily and against the wishes of families while others may be breaching their statutory duties, for example by failing to order a post mortem in circumstances where one is clearly required by the law. A number of recent major public inquiries have expressed grave criticisms of aspects of practice under the current coronial regime.

The role of post mortem has been under intense scrutiny since the Redfern and Kennedy reports were published. We shall not repeat their findings here. There are also important findings in the report of the BSE Inquiry, Marchioness non-statutory inquiry and the consultation document issued by the Shipman inquiry. The findings come as no surprise to INQUEST that the paternalist culture exposed is exactly that which we and the families we work with have argued needs to be changed.

### Recommendations and response to Consultation document

We support the division of the current system into two linked but discrete processes.

Our major concern is that any new system ensures that bereaved people receive the information that they need and that there are appropriate resources and staff to improve standards.

It should be possible for there to be a system where there is an independent forensic service properly integrated into NHS accountability structures. This would provide a single post mortem examination that would be acceptable in all but a tiny minority of cases. We note the practice in Melbourne, Australia of one post-mortem being accepted by all parties in the majority of cases.<sup>14</sup>

In relation to post mortems we think there needs to be a clear understanding and consent procedure for the retention of body parts beyond the need to retain to establish the cause of death.

Although significant work is being undertaken on this issue within the NHS this does not impose any change of practice on Coroners. Any reform of the current system should ensure that the post mortem examination process is much more fully integrated into mainstream NHS activities so that NHS authorities can exercise the degree of oversight and control which most people believe they already do – but in fact they do not. This would be both in relation to the employment of pathologists, the supervision and oversight of their work individually and also in relation to integrating the whole practice into the system of inspection and regulation operating with the NHS (CHI etc).

These recommendations for change use the term Coroner and Coroner’s Officer. However if there is significant change these functions may be carried out by other office holders. It should be assumed that the proposals should fall to the most appropriate new post.

<sup>12</sup>. Home Office Research Survey 181 – The Coroner Survey – Tarling 1998.

<sup>13</sup>. DJ Pounder BMJ 1999: 318 1502

<sup>14</sup>. Meeting with David Ranson, pathologist, National Forensic Institute, Melbourne.

#### Lack of adequate information to bereaved people

- There should be a new system that obliges Coroners to inform families of their rights and about organisations from whom they can receive support and advice.
- They should be required to give families, free of charge copies of the post mortem report.
- Provision should be made for bereaved people whose first language is not English.

#### Lack of explanation about their rights and funding for second post mortem examination

- Coroner's Officers should be trained in giving information to bereaved people in a manner that ensures they can understand.
- The new system should ensure that pathologists adopt the good practice referred to in our submission.
- The quality and extent of post mortem examination should be governed by the circumstances of the death not money.
- The current practice of Coroner's being constrained by budgetary concerns is wrong and we believe this, coupled with the problems of over-reliance on the examination alone, leads to conflict about cause of death and mistrust of current Coroner's post mortems.
- Coroners should be helpful to bereaved people who request a second post mortem examination
- Public funding should be available for second post mortem in cases that raise issues of public interest.
- An independent forensic pathology service under governance of the NHS should be set up.



### 3. Support for bereaved people

The way bereaved people are treated at the time of death, in the time before an inquest and the quality of support and advice they receive has an important impact on their ability to participate in the process. Our concerns can be summarised as follows:

#### Initial communication about death

- Poor communication from those giving news about the death and lack of back up support
- Lack of integrated service between the Coroner's Office and other institutions

#### Contact with the Coroner's court before the inquest hearing

- No information provided to families
- Insufficient information provided to families
- Insensitive treatment of families by Coroners and Coroner's Officers
- Lack of update and contact between date of death and inquest
- Inability and/or unwillingness to direct to appropriate advice and support

We are supportive of the overall approach in the consultation document in proposing changes to place the 'support of bereaved people at the centre of a reformed inquest process'. The comments below set out the experience of bereaved people in relation to their contact with the Coroner's court from the point of death until the inquest. We hope that this will help to inform proposals for a new system. We also set out our findings about the impact of the current process in section six of this document. We support the notion of standards to cover the issues outlined by the Coroners Review team at paragraph 103.

*We plan to recommend an agenda for putting the support of bereaved people at the centre of a reformed inquest process. We have in mind to propose a set of standards covering promptness of inquests following the death, clear and timely notification of all inquest arrangements to the family; a service which explains to people what an inquest is and what happens at it; decent premises, with disability access and provision for families to wait or consult advisers without being forced into the close company of other participants; proactive support in finding sources of bereavement counselling and other expert help for particular forms of loss. We shall be considering methods to monitor the delivery of such standards, over a period of years for premises improvement but more quickly in the other respects. We shall be considering whether an inspectorate might check the delivery of these administrative standards.*

However we believe that the system for ensuring that these standards are followed and are used to inform practice needs to be more robust with a system of sanctions if practice falls below an agreed acceptable level. We agree in principle with the idea of an inspectorate. We think that any inspectorate would need to have representation from bereaved people and organisations that provide support to ensure a balanced perspective. We think more work needs to be done to understand what bereaved people need and hope that our response contributes to that understanding.

In contrast to the constant evolution of structures elsewhere in the judicial system the failure to evolve and develop the role and function of the Coroner has over time meant that legal and administrative standards fail to reflect modern concerns about the process, to address the rights of those participating in legal proceedings, and to function within the more rights-based approach now generally applicable to other public functions and services (e.g.

see for example, Citizen Charter). The Model Coroners Service Charter produced jointly by the Home Office and Coroners Society attempts to set minimum service levels however the experiences of bereaved people illustrate that in many cases it has had little effect.

These factors have serious consequences for families faced with an unexpected or violent death. This outmoded administrative mindset means that families are marginal to the process overall, whereas they should be central, as ultimately death is more significant for them than anyone else – doctors, police, Coroner, lawyers – for whom it's merely a professional matter.

Individual Coroners and their officers do often try on ad hoc basis to be sensitive to families' feelings and concerns but this is entirely dependent on the personal qualities of the individuals concerned. The combination of law and administrative backwardness exerts such powerful force that even these small measures – which pull in a different direction than the prevailing culture – are being neglected on a huge scale. The position therefore remains, as families are made too painfully aware, that their legal rights in proceedings are restricted, the inquiry is not for them, administrative framework is not directed at their full inclusion in the process; they are not even recognised as stakeholders with an interest in the final outcome.

### Being informed of the death

The way families are informed of a death and the treatment they receive from officialdom at this stage can crucially set the tone for the way they are able to interact with the whole process. Inevitably the information about the death is not normally provided by those running the coronial system but the importance of an integrated approach in the new system cannot be overstated.

Most people know nothing about inquests unless they have experience of a sudden and unnatural death or work very closely with the issues involved. Bereaved people are plunged into a process where they have to negotiate a maze of different official bodies. It is a system that is confusing without clear lines of accountability and reporting.

Of those who responded to our survey a third (33%) of respondents were informed of the death by a police officer; 16% by a doctor or nurse; other hospital deaths 3% by hospital manager; 6% by prison staff. Nearly one-third of respondents (31%) answered "other" revealed by their further comments to have been family, friends, or neighbours.

The manner in which that information was conveyed also has an impact – it is clear that the ideal is a personal visit from someone who is trained to understand how to convey this difficult information. In our survey two-fifths (41%) were informed by a personal visit, and 34% by telephone call. It is also clear from our experience that there is very little liaison at this stage between those informing the bereaved person of the death and the Coroner's court. As we set out in our submission to the Health Select Committee<sup>15</sup> in 1999 there must be a more integrated approach right from the beginning to ensure that bereaved people can access the support and information they need.

"The police officer who informed me that my son was in hospital could give me no details other than that he was 'poorly'. He showed no concern how I was to get to the hospital and offered no help or advice."

"Both police officers had very little information and remained detached and somewhat embarrassed."

"It should never be delivered by phone. I am convinced that news such as this delivered by phone will one-day cause major injury/death to the recipient where the recipient has a life-threatening condition e.g. heart condition."

"Inept. Was anxious to press us to identify the body. We asked to be left alone for a while. PC rang again at doorbell and asked us to hurry up. A personal visit from a trained counsellor would have been more appropriate."

"The nurses and doctors were totally insensitive – they asked the family to clean up my dead grandmother's body."

**15.** INQUEST's Memorandum to the Parliamentary Health Committee Inquiry into Adverse Clinical Incidents.

"I live within a 30-minute driving distance of the hospital and could have been with my brother before he died."

Two fifths (39%) felt the information given as to how, when and where the death occurred at this stage was "incomplete" whereas only 2% felt it was complete. One in six (17%) felt "accurate" information was given, whereas roughly same number felt "misleading" information given.

"I was given different times of death."

"Very misleading!"

Over half were informed within six hours of the death, but one in eight waited between six to 12 hours to be informed, and one-in-twenty waited 12 to 24 hours. Almost half felt they should have been informed sooner. It is recognised that being informed as quickly as possible has important implications for the grieving process, particularly where there is a chance of the family getting to the deceased before death.

#### Contact with the Coroners' court

In this context a good and high quality service from the Coroner's Court could be expected to have an important effect on how bereaved people subsequently coped with the combination of sudden death and the inquest. However at this stage, only one in five (19%) was given any information about inquests and only one in three respondents had received the 'Work of the Coroner' or 'What happens after sudden death' leaflet. While one-third found that the Coroner's Officer was 'sympathetic', only one quarter said that the office was 'informative' while one-third said staff were 'obstructive'. Only one in five respondents felt that the information provided by the Coroner's Office prepared them for what followed. We have always asked families about what they were told about the inquest by the Coroner's Officer. In our survey 73% were not told about an inquest or given any information that could help them with the process.

#### **Were you told anything about the inquest and related procedures that would follow?**

"A little. We were told it would take several months before the inquest would take place."

"The majority of the information was obtained from INQUEST."

"Nothing."

"Only that there would be one."

"I was sent in the post a document about the working and guidelines of the Coroner Court nothing more. And in my understanding they was very restricted."

"I made 100 phone calls to Police, Coroner's Office etc, myself and A... 's mother were only asked if we had brought a solicitor with us as we were just entering the court."

"Yes, because I asked. I kept in touch with the Coroner's Office myself. I rang often."

"All information came from you."

"Very poor. Information lacking in every respect."

"Just told that as 'interested' parties we would be informed of the date & time. That we could attend but that it was not essential."

**Did you receive a copy of the 'Work of the Coroner/What happens after sudden death' leaflet? If yes, how useful was it?**

"Was given on the date the inquest opened (a week following death) and AFTER the PM had been carried out. This should be given before the PM carried out so that families know their rights."

"I wasn't given or told anything."

"In hindsight it was of no use whatsoever."

"It was tell(ing) me reading between the lines I am only allowed to ask certain questions."

**Did anyone from the Coroner's Office explain to you what an inquest was and the reasons why one would (or would not) be held?**

"Had I been provided with such information perhaps I would have felt empowered to participate to some degree."

"The Coroner's administrator told me verbally over the phone some of what would happen."

"We understand what an inquest is from what we have known from past comments – but it would be nice to have some personal understanding of what is going on."

"But we had to ask otherwise the information would have been partial and superficial."

"Although informative, factual, a person not 'handling' bereavement may misinterpret/not understand jargon."

"They were very wary."

"Very basic explanation – that inquest would look at cause of death, who, where and when."

"Following questioning."

"Not to my knowledge. They acted high handedly like archaic mandarins from some hierarchical society – especially the god-like Coroner himself who couldn't appear to care less about our hurt over not being informed and therefore unable to attend."

"Just said inquest would be held."

"Just told we would be told of date and time and that as 'interested parties' we could attend I knew already."

"It was me who initiated contact with the Coroner's Office. Then he reluctantly went about his sluggish and fruitless job as indicated above."

Although information cannot prepare people for every aspect of an inquest we know from experience that clear and accessible information can ensure that the actual process of the inquest does not additionally distress people. However it is clear from comments from bereaved people that many felt surprised by aspects of the inquest and this caused them more distress.

**Do you feel that the information you received from the Coroner's Office prepared you for the events and experiences that followed?**

We were told there would be a jury and there wasn't one. The inquest was much longer than we expected.

"I was stunned and extremely upset to receive a summons to court."

"Although it would have been comforting to hear direct from Coroner's Office before (the) inquest."

"Because of the guidelines and rules its like going to a hearing with your hands tied behind your back. Please believe me Sir, I was my own worst enemy, I was inexperienced in a very bad situation."

"I had no idea that the information I gave to the Coroner's Officer would be read out in the Court. I also had no idea that other people could be present in the courtroom during the opening of the inquest. I found this very alarming."

"What can possibly prepare a mother/father when facing the inquest of their son?"

"Nothing could have prepared me for the lies and incompetence of the police."

"Whilst I felt that the Coroner's Office's intentions were good – it is very difficult to prepare someone for the events and experiences of the actual inquest. These are shattering experiences and unique."

"I did not realise it was going to be such a long drawn out process. I thought it would just cover the facts (i.e. medical and police) regarding the death and mention evidence given in court."

"As far as possible – however nothing could really have prepared me for the emotional turmoil and strain of the inquest and giving evidence."

"Scant information was supplied by the Coroner's Officer I contacted by phone regarding my request for information. His attitude was insensitive, and obstructive."

"Absolutely categorically NOT – completely let down by them."

"We were told 15/2/2000 son did NOT OD but that the actual cause of death could not be given until inquest. It came as a tremendous shock when the Coroner said what our son died from."

And over two-thirds (69%) felt they were not kept sufficiently informed of events by the Coroner's Office.

**Do you feel that the Coroner's Office kept you sufficiently informed of progress and important decisions before the inquest hearing?**

"I wasn't informed in any respect whatsoever."

"I had to telephone many times but in fact the office was always helpful."

"I think to a Coroner, it was just another hearing. No progress on important decisions before the hearing just one letter telling me its rules and we are only here to find out the cause of death."

"I was kept informed of progress by my solicitor. He found the Coroner's Office to be helpful and co-operative and did I if I ever had occasion to contact them."

"I had to phone every time I wanted information, and was made to feel as if I were a problem – telling me 'I shouldn't believe everything you see on TV' when I asked why blood results were taking so long and when approximately did my son die. I was made to feel stupid and inferior."

## HOW THE INQUEST SYSTEM FAILS BEREAVED PEOPLE

“The inquest did not take place for possibly three months. I feel in a way this was helpful as we had time to prepare for it yet the actual date was not set until a fortnight previously which was not good.”

“We did not hear from the Coroner’s Office from the day of our son’s death in July 1998 until February 1999, three weeks before the hearing date, and that was by my ringing the office and not them contacting me.”

“We had no information from them whatsoever. When our solicitor attempted to get information there was quite negative feedback – information being denied him etc.”

“Felt that no one could be bothered to make much effort. Several times I was told that ‘your phone didn’t pick up’. Why couldn’t they try again or write.”

“Only contact was when I rang them.”

“Kept me informed when something happened – however less clear on the length of delays that would take place.”

“All their decisions were taken without any consultation.”

“The Coroner’s Office only gave us the cause of death and the dates of the inquest hearings.”

“No other information was obtained from them. Although we did request to see any information they had obtained. We were allowed none until we got legal help.”

“I contacted the Coroner’s Officer regarding enquiries of events on my own initiative.”

“You jest. As I’ve said due to the ‘unfortunate’ fact that it was a bank holiday we (the entire family) were ‘overlooked’. There you go. These things happen. Just go away and don’t bother us you little people.”

“I had to pay a solicitor, to write a letter, a) to make sure that the Coroner received it, b) to make sure that I was informed as to the date of the second inquest (also adjourned).”

“I had to call in – at the Registrar’s who would ring the Coroner’s Office for me. That was quite hard to bear – the waiting.”

### **How would you describe the conduct of the Coroner’s Office towards you overall?**

“All a load of lies. Because I was not informed of my rights to be represented or to have access to documents/reports.”

“Very nice. The Coroner’s Officers I spoke to were extremely helpful.”

“I had no contact until I phoned them.”

“Mr B thought I should just accept my husband killed himself, and not look any further. He was very pushy, but very polite.”

“Sympathies were offered during a phone conversation. But the actual inquest was totally geared to clearing any government body of possible litigation.”

“The Coroner’s Officer assigned to my son’s death was biased, prejudiced towards anyone with a drug problem. This I found to be infuriating especially when she knew nothing (on her own

admission) about drugs. She made this comment to me of the witnesses about my son's death – in fact his best friend – she asked this witness to give her a lesson on the different effects of cannabis, heroin, cocaine – ending the lesson with the comment, 'I never knew such things went on in B...'. And yet she was the person chosen to investigate a drugs related death."

"When I tried to ask for information from the Coroner's Office about my son's death, the Coroner was very rude and completely insensitive towards me and also on a separate occasion to my son's father."

"No complaints at all – they were most sympathetic and informative."

"Long awaited inquest. I had to write/telephone. They complained of excessive workload. I believe that at that time whoever was in control was having problems maintaining the office structure, and the Coroner's Office was in disarray."

"We had to contact the Coroner's Office to find out when the hearing was. We had been told on the day of our son's death we would be interviewed by the Coroner's Office. When I rang for the date I was told everything had been completed and we didn't need to be interviewed. I insisted on being interviewed, and that interview was very important in balancing the court evidence."

"One individual only – but this was basically as part of his job. This is what he would say to any family under the same circumstances. He was not necessarily overly informative because we were still left confused with lots of questions unanswered. We did get a contact number and were told we could ring him but I felt that he really didn't have the time to explain when he was contacted."

"After I made a nuisance of myself I got to speak to someone."

"Initially very insensitive – suggesting that the family should accept it."

"Very sympathetic at the inquest itself."

"Coroner's Officer. She made a potentially intolerable situation bearable with tact, sympathy and support."

"It was an ongoing battle for almost three years – (information denied) – (refusal of our witness list) – 'I'm god, you're nobody' attitude."

"The Coroner gave us the information that was required by law, no more and no less than they had to."

"The Coroner's Officer with whom I dealt with was very sympathetic and tried his best to explain the procedures of the Coroner's Office."

"Came across as 'he's a criminal, it doesn't matter'. Constantly blocking our request for info and 'passing the buck'."

"I felt they were just going through the motions."

"The gentleman that came to take details was informative – but calls to the office were very unhelpful."

These experiences illustrate how far the service is from providing the necessary basic information to bereaved people. The standards fall far short of service level objectives set out below in the Model Coroners Service Charter – suggesting inadequate training, monitoring, reporting and complaints mechanisms.

The Model Coroners Service Charter was described by the Home Office as containing the “minimum information which should be provided [to families] about the Coroner service and its standards” adding however that “there is no reason why additional relevant information should not be provided”. The Charter provides guidance on a number of issues including: sensitivity to faith and cultural traditions; that bereaved people should be treated with courtesy and sympathy; that clear information should be provided; that time limits should be adhered to in responding to requests and that there should be clear information about who bereaved people can contact and that ‘every effort will be made to avoid causing any additional distress to close friends or relatives of the deceased’.

As we have illustrated the service is not meeting those minimum standards and we hope that any new system builds upon these standards and supports a culture that supports bereaved people and ensures that they are not disadvantaged by insensitive treatment and lack of access to information.

## 4. Coroners and the public inquest

“This was the worst day of our lives.” Parents of young prisoner who died.

“Although we knew how to obtain legal advice we were under the impression that an inquest was an impartial investigation – not a game of advocacy/opposition”. Mother whose adult child died in psychiatric institution.

The key role of the public inquest in contentious deaths is that it is often the only public forum in which there is any examination and scrutiny of the death. The importance of the investigation being in *public* cannot be underestimated.

### The Issues

The main issues we address in this section are:

- Administrative issues – lack of information about rights, formality more than any given to expect, variable quality of courts;
- Insensitive treatment of families during the hearing – by Coroner and other advocates for Interested Persons;
- Disclosure;
- Rights of Interested Persons – witnesses;
- Restrictive remit of the inquest;
- Hostility to families’ legal representatives;
- Importance of the jury;
- Verdicts/outcomes;
- Rule 43.

We address the question of the kinds of cases that come to full inquest, the question of verdicts and outcomes, and Rule 43. The question of support for the bereaved raised in paragraph 103 is commented on throughout the document but in particular in section 3 and the question of Legal Aid raised in paragraphs 104 and 105 in section 4.3. In addition we address some of the questions in the chapter on the judicial investigation.

We are also concerned here about the ideas floated that public inquests may not be considered necessary in certain cases – in particular the suggestion that deaths at work may not be publicly scrutinised<sup>16</sup>. We believe this potentially creates a lower standard of accountability for corporate bodies than state bodies. We would like to draw your attention to the submission from the ‘Centre for Corporate Accountability’ with whom we have a close working relationship.

### Introduction

In contrast to the constant evolution of structures elsewhere in the judicial system the failure of the inquest system to evolve and develop has meant that legal and administrative standards fail to reflect modern concerns about the process, fails to address the rights of those participating in legal proceedings and fails to function within the more rights-based approach now generally applicable to other public functions and services.

These factors have serious consequences for families faced with an unexpected or violent death. The narrow focus of the inquiry puts artificial and invidious limits on the scope and style of conduct of the Coroner’s inquiry. This often excludes the issues of greatest concern to the families from the inquest, which is often the only investigation of the death to which the family have access.

<sup>16</sup> Consultation Paper By The Fundamental Review Of Death Certification And The Coroner Services In England Wales And Northern Ireland August 2002.

There have been some developments – discussed below- seeking to soften the hard edges of legal procedures following death and individual Coroners do often try on an ad hoc basis to be sensitive to families’ feelings and concerns. But in INQUEST’s experience, the combination of the outmoded legal and administrative approach exerts such a powerful force that even these small measures – which pull in a different direction from the prevailing culture – are being neglected on a huge scale. The position remains that families’ legal rights in proceedings are restricted; the administrative framework is not directed at their full inclusion in the process; they are not recognised as stakeholders with an interest in the final outcome; the inquiry is not for them.

We are attracted to the idea of a medical examiner/Coroner and judicial Coroner proposals in this document and in the document from the Shipman Inquiry. However we are concerned that any new system does not repeat the mistakes of the past in leaving a dual accountability structure that makes it difficult to monitor, quality assure, train and complain about or indeed remove those whose practice is poor. We are very aware that there are examples of good practice but that these are entirely dependent on the traits of the individuals involved rather than the framework and systems within which they operate. The theme that runs through our concerns is that bereaved people are at the margins of the process and are not provided with sufficient information for it to be meaningful to them or for them to be empowered to participate properly.

Coroners, more than other judicial officers, have very wide discretion in the running of their court and have been described as ‘kings in their own court.’ If a bereaved family wants to make suggestions to the Coroner about witnesses, issues they think should be addressed, disclosure etc, there is no clear procedure on how to go about this or how to challenge any decision made. Before the inquest, families cannot usually speak directly to the Coroner, but rather must communicate through the Coroner’s Officer. Judicial review is often the only avenue open to them to challenge a Coroner’s decisions. Pre-inquest hearings are frequently used in the more complex cases to ensure a dialogue about these issues. We suggest that dialogue with bereaved people and their lawyers from the outset and greater use of such hearings would lessen any potential conflict, make families feel they are part of the process and reduce the need for recourse to judicial review which is prohibitively expensive and increases delay.

### Disclosure

There is no **mandatory** right to prior disclosure of documentation although there is a *voluntary* protocol providing for such disclosure in deaths in police and prison custody. This has been a controversial issue and while there has been some reform in this area it continues to remain problematic. The experience of the INQUEST Lawyers group members is that it depends on their tenacity as to how forthcoming disclosure is and at what stage in the process. In controversial cases disclosure has been difficult to obtain and has not allowed sufficient time for lawyers to adequately prepare. *We support the proposal that there should be full mandatory disclosure of all information in all inquests irrespective of whether the Coroner intends to call the witnesses, and with clear rules about when and how the disclosure will be made.* In arguing for disclosure in deaths in custody cases we proposed that it would assist all parties and potentially take some of the conflict out of the hearing itself which has indeed been the case. It also reduced some of the unnecessary pain for bereaved people in that they did not have the shock and distress of hearing information about how someone died for the first time in public. This applies to all circumstances of death.

The Coroner’s Society Practice Notes are indicative of the attitude of many Coroners to families and their advisors. Advance disclosure in cases of death in custody is dealt with at some length and the Society’s advice is generally in line with the new approach of increased openness. Coroners are asked to accede to advance disclosure in these cases where they “*believe that generally the inquest would not be compromised*”. Some practical problems are canvassed together with the possible need to place restrictions on disclosure to prevent possible interference with witnesses or their use to “*substantiate a media or other campaign*”.

### Narrow remit of the inquest

For many families it is hard to understand the narrow remit of the inquest. Their only experience of courts will be of the adversarial kind and they cannot understand the inquisitorial concept. They are shocked to discover the limits to the issues that will be discussed as many see systemic failings as responsible for their relative's death and want the court to look more deeply at the underlying events.

There is a perception that the Coroner is not impartial but on the side of the authorities. This is heightened particularly in deaths in custody cases where the Coroner is dependent on the police/prison investigation and depends on a close working relationship with the police and Home Office. Many Coroner's Officers are seconded or ex police officers. However the common experience in all cases involving institutions (hospitals, care homes etc) is that there is a perception of a professional closing of ranks and institutional bias from Coroners in favour of professionals. In many cases this perception is reinforced throughout the inquest by the manner in which the Coroner questions witnesses and allows or disallows questions from the family lawyer. The family has no right to call their own witnesses at the inquest: they can bring them to the attention of the Coroner but once again the discretion rests with the Coroner as to whether they should be called. There are frequently cases where an inquest has to be adjourned because the official investigation that the Coroner has depended upon has not questioned a relevant witness or made the Coroner aware of their existence. This is of particular concern in a death in prison where prisoners have complained that they were not interviewed as part of the 'official' investigation but have something relevant to say and it has been down to the family lawyer to make the Coroner aware of the potential witness and request that they be called to give evidence.

The Coroner's Society practice notes remind Coroners *'to be fair, to avoid bias and not to have a point of view, to allow all relevant interested persons to have their say before reaching decisions, not to base decisions to adjourn when sitting with a jury on practical difficulties that may arise, and to make decisions promptly.'*

However there is a warning that some lawyers may view Coroners *"as though they were their opponents in litigation"* and see the inquest as *"a potential opportunity to obtain legal aid for other proceedings"*. Coroners are reminded of the limited purpose of the inquest *"and you will need to disallow questioning that goes beyond that limited purpose"*.

This attitude towards lawyers who are trying to assist bereaved people to find out the truth of their loved one's death is illustrative of the culture that needs to change. This mindset contributes to the adversarial feel of many inquests. What appears to be missing here, is an understanding that the inquest is more often than not the *only* opportunity to discover the truth. For most bereaved people there is no opportunity to take any other legal action, and indeed many do not want to pursue the legal route.

### Verdicts, Outcomes and Findings

We think that there needs to be a different outcome at the end of an inquest – a longer report with findings that can reflect the evidence and where appropriate findings critical of the state. This report could be in the form of a judgement issued by the Coroner incorporating the jury's findings. The jury should be able to come to more rounded findings or verdict and comment. Properly directed they could produce the quality of findings required. We go into this in greater detail in the separate section on juries.

This is particularly important in deaths in custody where the conduct of state agents and institutions have been considered by an inquest jury.

After all the witnesses have been questioned barristers may request, or the Coroner might invite, submissions to be made on the law in relation to possible verdicts. If there is a jury they will be asked to leave the court until the legal submissions have been made. Some Coroners do not announce at the beginning of their summing up what verdicts they intend to leave and the family has to wait until the end of a long review of the evidence. *We believe that legal representatives should have the right to sum of the evidence and that it would assist the Coroner and ensure a more central role for bereaved people in the process.* For the reasons outlined above the Coroner is not seen to be impartial.

In our survey 8% believed the summing up to be accurate, 14% fair, 8% easy to follow, 16% inaccurate, 68% that it omitted important facts, 9% that it was unfair, 19% that it was biased and 13% that it was confusing. When asked if they were satisfied with the conduct of the inquest 67% answered no.

Whilst we are supportive of proposals to extend the findings of an inquest we think that the symbolic importance of the short form verdict should not be overlooked and that it should be included in the new format. We do agree that the form of words in many of the commonly used verdicts needs to be considered and possibly changed. We believe it is vitally important that the jury is retained (see below). In jury cases they should have greater power to participate in forming the findings/verdict. The verdict is an important although often unsatisfactory outcome at many inquests. The content of the verdict will always be very significant to the family of the deceased. Our practice and that of INQUEST Lawyers Group members has been to work with families to focus on the totality of the evidence. However it is often completely meaningless for families (as stated at paragraph 96) at the end of a gruelling and distressing experience if the verdict does not reflect the evidence heard.

All verdicts have to be established to the test within the balance of probabilities except for suicide and unlawful killing. These verdicts have to be established to the test beyond reasonable doubt.

When it is believed on the basis of the factual evidence, that the person intended to kill him or herself a suicide verdict can be returned. The term suicide is gradually being phased out replaced by the words 'she killed herself'/'he killed himself'. For this verdict it is not enough for there to be circumstantial evidence to suggest someone took their own life there has to be evidential proof that it was definitely the persons intention to take their own life and it was not something they did without that clear intention. *We are concerned about the consideration in paragraph 98 being given to phasing out a reflection in any verdict or finding that the death was suicide has implications for public health strategies such as the Health of the Nation.*

In particular this is an important issue in relation to prevention of self-inflicted deaths in prison. *INQUEST has always maintained that the verdicts/findings in these cases influence policy.* We are careful to describe such deaths as self-inflicted before any inquest verdict. But the problem of prisoners intentionally taking their own lives needs to be addressed separately inside the prison service strategy to prevent self-harm and self-inflicted death. There are deaths that are self-inflicted but are clearly proven to be cries for help and there needs to be a clear distinction made here. Of course there are many cases where the question of intention cannot be settled, and which are provided for by the open verdict.

In our view the public interest is paramount – any revamped inquest system should avoid altogether the holding of inquests that add nothing to the sum of knowledge about any particular death. Inquests should only take place in clearly defined circumstances where it is in the public interest to do so.

It is clearly in the public interest that any unexplained death should be enquired into, if after the post mortem it still appears necessary to hold an inquest, the inquest should only be held in public if the case raises a matter of wider public interest than merely the need to determine the cause of death. Conversely, any death that does raise matters of wider public interest should result in a public hearing, however painful that may be for the next of kin. But families should have the right to request or challenge an inquest, and to request or challenge a public hearing.

It is crucial that any reformed inquest system properly reflects the human rights of all parties. An inquest should provide a fair hearing and that, insofar as is compatible with the public interest, protects the right to privacy. Nothing should be done to damage the right of any person who may be responsible for a death to receive a fair trial, and such persons should retain the right not to incriminate themselves. In particular, inquests must comply with the procedural requirements of Article 2 of the European Convention on Human Rights.

*We note with interest the use in Australia of 'in chambers hearings' where Coroners in sensitive cases will not hold a public inquest but the transcripts and findings are publicly available and the right to a public inquest can be sought by an interested party.*

## Findings of an inquest

In paragraph 100 some interesting points are raised.

*A further possibility for a general approach to inquest outcomes might be to place the main emphasis on establishing the facts clearly and authoritatively, addressing issues of causation and possible systems defects, and then for the Coroner to add a rider or general comment suggesting that the circumstances appear to justify, or as the case maybe, not to justify, further attention in the relevant public service redress or disciplinary procedure, or the civil courts. Such a comment would have no decisive effect in such proceedings but might be a helpful signal to the family and a salutary though non-incriminating public comment.<sup>17</sup>*

There are problems with inquests not addressing the chain of causation and only very rarely addressing systems defects. This paragraph has inherent problems. If the inquest is to remain 'inquisitorial' then there are serious objections to the Coroner (or presumably jury) adding a comment that ascribes blame or could be perceived to, unless the procedure is modified so that those who might be blamed (as well as those who might wish to blame them) have adequate opportunities to present their case. This implies significant changes to the whole procedure, and logically should then include some of INQUEST's longstanding proposals about the right of families' lawyers, and those representing persons who might be criticised to sum up evidence etc.<sup>18</sup> A fortiori this applies to the suggestion in paragraph 101 that inquests should determine some questions of civil liability. It is not clear to us how this would work, and any such proposal will need to be very carefully thought through.

The Model Coroners Charter goes a little further in the direction of openness when it states:

*After the inquest*

*20. If, in the interests of preventing further fatalities, the Coroner decides to report the matter to a relevant person or authority, he will do so within 10 working days of the inquest outcome. He will also send copies of his letter to all the interested persons. A copy of any subsequent reply will be sent within [5] days of its receipt. Even where the recommendations are made in public, the lack of a public procedure for monitoring the response can make the process seem meaningless and can lead to a view that such recommendations are ignored. A public procedure which is so distorted by selective release of information and which relies on another procedure at its conclusion which then exits the public domain, perpetuates the culture of secrecy surrounding these deaths. What would reassure many bereaved families and would increase confidence in the procedures would be a response from the relevant authority detailing what action has been taken in the aftermath of a death.*

The reality is that the only time that families hear about any follow up action after an inquest is where INQUEST, either through personal correspondence or via an MP, elicits a response from the relevant government department or Minister.

One of the ways in which families seek meaning for their experience is the hope that some good or learning will come from the death of their loved one. We cannot count the number of times in our experience that families have expressed a wish that their experience might contribute to preventing another family going through the same painful process. Despite all the difficulties families have encountered, their expectations are high about what the inquest can achieve. Although many find their experience to have dashed those hopes if the Coroner openly acts under Rule 43 it can help both the family and society learn from the death. It can make the inquest seem a meaningful process and actually fulfil its function of preventing similar fatalities. Similar issues are raised here to those about the need for centralised information on post mortem findings and the role they can play in policy making.

*In commenting here we would draw attention to the need for the new system to produce a meaningful and systematic way of learning from the deaths. Currently there is a failure to learn lessons because findings of Coroners are not published or shared and recommendations are not monitored. There should be a mechanism to monitor and subject to public scrutiny action taken in response to Coroners findings.*

<sup>17</sup>. Consultation Document Fundamental Review *op cit*.

<sup>18</sup>. See INQUEST's Coroners Amendment Bill.

There are a number of Coroners who have taken seriously the role that they can play in the prevention of future fatalities. In the early 1990s following a spate of self-inflicted deaths in Brixton prison that raised questions about the standard of medical care, in particular of mentally ill prisoners, the former Southwark Coroner Sir Montaque Levine presided over a series of inquests where he made wide-ranging recommendations. Similarly in a number of restraint related deaths in Metropolitan police custody he used his recommendations to highlight concerns about the training of police officers in the dangers of positional asphyxia.

At the conclusion of the inquest into the death of Rocky Bennett, a detained psychiatric patient who died after being restrained, six searching recommendations were made by Coroner William Armstrong who read them out to the court before handing out a copy of them out to all interested parties and the members of the press present. He told the inquest that Mr Bennett had been 'let down by a system that should have protected him' and used his recommendations to address matters of public concern. At this inquest the Coroner acted within the remit of the current system but to the highest standards demonstrating what is currently possible. For the family although there were other reasons why the inquest was unsatisfactory – primarily the problem with verdicts – this use of rule 43 allowed for work to be undertaken after the hearing and culminated in an extended inquiry commissioned by the Department of Health.

We are attracted to the idea of a judicial Coroner and in particular to the idea that the new system could make use of judges to hear inquests into the more complex and contentious cases. If the medical examiner system is introduced there should be a reduction in the number of inquests taking place. It would also take away a large amount of the Coroners' current work-load. Many of the problems we will describe below are attributable to the lack of procedure, structure and uniformity of approach within the current system. We believe that judges should have a better approach as they are already acting within a more accountable and structured system.

### Experience of attending inquests and families concerns

One of the most frustrating experiences families have about the inquest system is in accepting and understanding it as a court of inquiry. In reality the inquest has frequently been approached both by families and other bodies as an adversarial forum. This has been particularly the case in controversial deaths.

We have already addressed the issue of lack of information and support prior to the inquest and here describe some of our findings on the inquest hearing itself. There is more detail from bereaved people and their suggestions for change in section six.

### Lack of information about rights

This is a constant theme that runs through bereaved people's experience of the Coroners system. So many families have not been given information about their rights so that they could exercise a choice about how they participated in the process and, if they wished to participate fully, could do so prepared for what would happen

"We didn't know that we could asked for the inquest to be stopped if all the witnesses that should have been there were not there until such a time that they would be there."

### Notice about the inquest

Frequently where families are not legally represented, and sometimes when they are, the notice given about the date of the inquest has been insufficient for the preparation needed. It also appears that little consideration is given to the importance of the inquest to the family.

"I had to make a nuisance of myself. My husband died in September 1995 and the inquest took place in February 1997."

"Coroner failed to inform me of the two-day hearing only gave me the date of one day. I found out the omission by phoning his office."

“We only had good notice because I rang the Coroner's Office.”

“We were told only that our attendance was a matter of choice but not necessary. However we were never told that we could have legal representation at the inquest. No one told us anything, as far as we were concerned we had no input – only our forms.”

### Poor quality courts – no private space to wait

In our attendance at inquests we have been struck by the wide range of venues deemed appropriate to hold inquests. We have attended purpose built Coroners courts that have no private waiting facilities; no tea or coffee facilities in those that do and inquests that have been held in magistrates courts, crown courts, council chambers. In all of these venues it is a minority that afford the family a private space to wait or meet with their legal team. This has been particularly distressing for families where the death has occurred within an institution and they have had to wait or discuss their case next to people who they believe may have been responsible for the death. We also think that it is wrong that in the majority of inquests into custody deaths interested parties from the institutions and those they represent are able to use the court offices as if they are their own.

Any new system must ensure that families have privacy as a matter of course. In our survey 66% reported no private waiting space.

### Insensitive treatment of families – by Coroner and other advocates or Interested parties

Frequently families have complained to us or we have witnessed insensitive and sometimes prejudiced behaviour by Coroner's and their staff. This has been evidenced by a lack of understanding that the whole process is alien and frightening to many lay people and for every bereaved person their loved one's death is the most important issue. We have observed institutionalised behaviour that has led Coroners and their staff to dismiss the emotional impact on the bereaved. This is heightened in custody deaths where families have frequently described that because their loved one died in custody they feel criminalised.

### Formality more than many given to expect

We have heard numerous comments from families who have been told they don't need legal representation because the procedure will be informal and they will find it easy to ask questions. On arrival at court they are completely over awed by the formality of the procedure and the phalanx of lawyers acting for other interested persons. Those who asked questions themselves reported that in 8% of cases they felt confident, 11% self conscious, 5% intimidated, and an overwhelming 68% felt 'kept quiet by the Coroner'.

### Custodial deaths

As the review team are aware there are particular concerns about inquests and custodial deaths. The review must also take into account the ECHR cases which looked at deaths in custody in England and Wales and Northern Ireland and the failure of the state to comply with Article 2. No examination of the inquest system can ignore the other mechanisms for investigating custodial deaths, the police and prison investigation, the Crown Prosecution Service and the police complaints system. We have submitted to the team a substantial amount of material including all issues of Inquest Law, INQUEST Annual Reports, reports on particular cases and other publications that provide an overview of our concerns in this area. We have also met with the review team on several occasions and co-ordinated a meeting of bereaved families with a particular emphasis on custodial deaths. Members of the review team have met our Lawyers Group on two separate occasions. We have also acted as consultants to the Liberty project on deaths in police custody whose report was published in March 2003. Given our own research project we concentrate here on where the problems lie and initial suggestions for change. *This is a highly complex area and we hope our forthcoming research will contribute to the development of new mechanisms for the investigation and public scrutiny of custody deaths.*

In a free and democratic society it is essential that custodial deaths are subjected to anxious public and judicial scrutiny. When someone dies in custody often the only witnesses to the death are the custodians themselves and the death takes place within the closed custodial environment of the police or prison cell.

We believe that there should be public inquests into all deaths in custody – these will include deaths that involve the police, prisons, immigration detention and psychiatric detention. In any new system these cases should be heard at a higher level with a jury.

As we have written elsewhere<sup>19</sup> about prison deaths (although this applies equally to other custody deaths) the current methods for investigating custodial deaths do not allow for a thorough, full and fearless inquiry; encourage suspicion and defensiveness; do not allow for discussion of the wider policy issues; do not allow for accountability of those responsible at an individual and institutional level and do not enable an honest and open approach to ensuring changes are made to prevent future deaths in similar circumstances. *In our view all custodial deaths must be subjected to external, independent scrutiny.*

Until bereaved families are given more access to the investigative process and treated with greater respect, and there is an acknowledgement that a proper, open examination of all the facts surrounding a death is in the interests of all involved, there will not be an adequate focus on policy change to prevent more deaths occurring in the future. Greater openness and transparency in the process will reduce the current adversarial nature of the investigations. What must occur is a change in attitude and culture towards families and their lawyers. Families are too often perceived by the State and the Coroner as motivated by the need to blame and to obtain compensation. Time and time again bereaved families tell us that what they want is for the inquest to result in changes which will ensure another family does not have to endure the same distressing experience. It is correct that where there has been wrongdoing or mistakes have been made families want an admission, an apology and to see those responsible brought to account. The defensiveness displayed at inquests and the automatic closing of ranks in the face of any possible criticism does not inspire public confidence in the current investigations. In fact the opposite is the case and people suspect that there is something to hide. Greater openness can only be positive for all concerned.

“We believe suicide was the method of our son’s death but not the cause. The prison service and the prison medical service were neglect(ful) in their care of our son. The prison service total(ly) disregarded family, family information and views about the people in their case. Although our family members have committed crimes, the prison service still have a duty of care, to provide a safe and secure environment along with a quality medical service. If they continue to treat people in their care as the dregs of society who don’t deserve the same service that the rest of society are entitled to, they only continue the cycle. In our dealing with our son, we have had to deal with police, health authorities, social services, courts, education authorities, not one of other service ever treated us with such total disregard and had the total arrogance that we found in the prison service staff. They also used the system including the Coroners courts to protect themselves and continue their god like reign. They need to be answerable and not the lip service answerable that happens at the moment. With the help of INQUEST the whole process was made so much [more] bearable. On that note the family owes you all a very big thank you for the past and future.”

“Without the help of INQUEST we could not have been represented at the inquest. We could not get legal aid for this. But the prison service could. We feel this is totally unfair.”

“We feel you cannot win against a government institution.”

“The whole system requires a full overhaul. The families should be treated with respect, we were made to feel that we had committed crimes ourselves”.

“It was an on-going battle for almost three years. The Coroner and HM Prison Service...place no emphasis on the inquest as a form of learning and prevention.”

“Treated as if David was just another statistic and not our son.”

**19.** INQUEST’s Submission to HM Chief Inspector of Prisons Thematic Review into Suicide and Self Harm in Prison 1998  
Deborah Coles and Helen Shaw.

## 4.2 The importance of juries

The reasons why the jury is important can be summed up under the headings of *legitimacy* and *accountability*.

### Legitimacy

It is important not to underestimate the symbolic importance to the bereaved family of a jury. As we have seen, when bereaved families are faced with the contradictions and narrow remit of the inquest system they often doubt the independence and impartiality of the Coroner. But they know that the jury is not part of the establishment, and that their peers are judging the circumstances of the death. Moreover, the pace and tone of the proceedings are tamed by the presence of the jury. Evidence must be presented in a manner that is accessible to the jury, and hence also to the family and the public. Juries do not become jaded and emotionally drained by the same types of death on a regular basis.

The jury's role is particularly vital in cases involving the use of unreasonable force or gross negligence. In the leading case on gross negligence, *R v Adomako*,<sup>20</sup> Lord Mackay said that it was 'supremely a jury question' whether 'the conduct of the defendant was so bad in all the circumstances as to amount in their judgement to a criminal act or omission'. Similarly, the limits of 'reasonable force' are matters of moral judgement which a jury is pre-eminently qualified to decide.<sup>21</sup>

More broadly, the jury can be considered a better qualified fact-finder than the Coroner in the many cases that turn on judgements of the credibility of testimony. Deciding which of two or more witnesses to believe according to the impression their evidence makes on a lay jury may not be a highly accurate procedure, but is widely accepted as a fair means of breaking the deadlock. It is fairer, and probably more accurate, to rely on the collective impressions of a group than on the possibly idiosyncratic perceptions of a single individual.<sup>22</sup> This is particularly important where the evidence of police officers or medical professionals conflicts with other testimony. In the nature of their work, Coroners are accustomed to placing a high degree of trust in the police and medical professionals (some, of course, belong to the medical profession themselves). However free Coroners might be of any culpable kind of bias, their judgements of credibility must inevitably be shaped by their life experience.

### Accountability

This refers both to the accountability of the institutions where many of the deaths that juries inquire into occur, and the accountability of the process of investigation itself.

Since the early nineteenth century the Coroner's jury has been viewed as representing the local community in inquiring into the circumstances of a death.<sup>23</sup> This democratic tradition represents the positive side of the historical legacy of inquests, on which it is important to build.

While juries are prevented from determining questions of liability, they can use their verdicts as a way of rejecting the official version of events and attempts of state authorities to legitimise their actions. This often occurs in apparent suicides in prison or custody. The evidence typically focuses on the personality problems of the individual, 'rather than looking at the psychological distress caused by regimes, conditions, isolation and lack of education, training and support'.<sup>24</sup> Yet time and time again juries refuse to rubber-stamp such proceedings with a suicide verdict. Even when a verdict of 'lack of care' is not left as an available conclusion, the jury uses either the accident or open verdict to express an opinion that such self-inflicted deaths occur in a context and that causation/responsibility is collective.

The robust independence that some juries display goes some way towards remedying an important weakness of the inquest as an inquisitorial procedure. In sophisticated inquisitorial procedures, such as a French criminal trial, the preliminary investigation is supervised by one judge, and other judges (sometimes with a jury) conduct the public court hearings.<sup>25</sup> The investigating judge or prosecutor is accountable to the trial court for the quality of the investigation. By contrast, the Coroner both supervises the investigation and presides over the public judicial hearing. This creates an obvious danger that the inquest will merely rubber-

20. [1994] 3 All ER 79 at 86.

21. Coles and *op cit* pg. 114.

22. See Lord Devlin, *Trial By Jury* (1959). Assuming a single juror does marginally better than chance in determining who is lying, the unanimous view or seven or more jurors will be significantly more accurate.

23. J. Sim and T. Ward, 'The Magistrate of the Poor?' in M. Clark and C. Crawford (eds.) *Legal Medicine in History* (Cambridge, 1994); I. Burney, *Bodies of Evidence* (Baltimore, 2000).

24. D. Coles and H. Shaw, 'Death in Prison: Breaking the walls of silence', (1998), Prison Report – Prison Reform Trust.

25. See for example B. McKillop 'Anatomy of a French Murder Trial' (1997), 47 Am. J. Comp. Law 527.

stamp the results of the preliminary investigation.

Juries, however, often show that they have the courage and tenacity to take an independent view of the evidence even though the only summing up they hear is the Coroner's interpretation. Some Coroners' summing's up are much more even handed than others. The presence of a jury makes the inquest a more democratic and accountable process than it otherwise would be.

The jury is vitally important for bereaved people but its limited role is often disappointing as is shown by the following comments:

"I had watched the reactions of the majority of the jurors – who I felt were making their own conclusions. However, the Coroner TOLD the jury how to find. The face on some of the jurors was nonplussed – "why are we here then".

"As far as my case is concerned I thought the inquest was a waste of time. After three days of hearing evidence, the Coroner ruled that there could only be one possible verdict – accidental death. The jury didn't give their opinion and the Coroner, whilst sympathetic, wasn't allowed to blame anyone for what happened."

"By 'forcing' an inquiry in front of a jury we were with the co-operation of the Coroner and our own efforts able to get a full and public hearing – but it should be easier (also some help from our MP)."

"I thought it was a waste of time and money as the verdict was decided before the start of the inquest."

"Coroners should not tell the jury what verdict to bring in. As they apologised to me that they could not do more for me."

### The role of the jury in a new system

The ability of juries to formulate longer and more meaningful findings has been questioned by the Coroners review team. We are aware that members of our lawyers group are submitting suggestions about the adoption of the same kind of procedure as that carried out in civil courts. We include some examples of jury's findings and narrative verdicts that demonstrate that they can and will deliver meaningful findings even within the currently narrow and tightly drawn remit. The jury cannot, as it once could, add riders to its verdicts, the only way it can hint at its views is through a carefully worded statement of the circumstances of the death. The following are some examples of where this has been done.

#### **Inquest verdict into the death of Daniel Barry in HMYOI Feltham**

Hammersmith and Fulham Coroners Court.

Before HM Coroner Dr Burton, July 1998.

The jury at the inquest into the death of this young man found that he died:

*"Sometime between midday and 4pm in Cell 29, Osprey Wing, Feltham YOI, on 20 July 1997. He was admitted to Feltham at 4.30pm on 19 July 1997 and received a first reception health screen. His previous health screen form from June 1997 was not consulted: his responses on this occasion were different. There is also a variance in the techniques used for the completion of these forms. On 19 July he recorded a self-harm history, and an attempted suicide in his family. He also expressed a worry regarding his general health – one of withdrawal. A further examination was conducted by a doctor to establish a medical record. The June health screen was not referred to by the doctor. He recorded a history of drug abuse and self harm. Staff on Osprey wing received no record of his custodial history, his drug abuse or his self harm history, nor the reason for his detainment. That weekend there were three prison officers for 62 inmates on the wing. In the 23-hour period from the time of his arrival to the item he was found dead he had one hour and 50 minutes association time. He was found in his cell with a shoelace ligature, which was attached to the window catch."*

**Inquest Verdict into the death Nathan Delahunty in Metropolitan police custody**

Westminster Coroners Court.

Before HM Coroner Dr Knapman, July 1998.

Jury concluded that the cause of death was *'cocaine intoxication, delirious and excited state aggravated by restraint'* describing the death as occurring *'...in circumstances whereby we are not satisfied as to the credibility of the evidence of the police'*. The verdict they returned was *'non-dependent abuse of drugs aggravated by neglect'*.

**Inquest verdict into death of Glenn Howard in Metropolitan Police Custody**

Croydon Crown Court.

Before HM Deputy Coroner, Mr Sampson, May 2000

The Coroner allowed extremely limited questioning of witnesses and forbade Counsel for the family from asking a number of questions relating to the police officers' credibility and recollection of the incident. He rarely asked any questions of the police officers, almost always simply reading out their incident report books and prepared statements. Despite limited responses to questions put to them, on several occasions the Coroner thanked the police officers for answering questions.

At the end of the evidence, the Coroner refused to allow the jury to consider verdicts of 'unlawful killing' or 'accident aggravated by neglect'.

The jury was instructed to consider verdicts of 'accidental death' or an 'open verdict' and was told to make no comment on the circumstances of the death. They ignored his ruling and said that excessive restraint and lack of medical care had contributed to his death.

Their unanimous findings were:

*"On the evening of December 10th 1997 at Sherbourne Court, Cavendish Road, Sutton, Surrey, an incident took place during which Glenn Howard was subjected to excessive restraint followed by an immediate and subsequent neglect of medical care and attention which resulted in a brain injury, as a result of which he later died. Glenn Howard died of an accident."*

As they left the court building, some of the jurors shouted across to the family that they had wanted to return a verdict of 'unlawful killing'. Their verdict based on the evidence available to them, raises real issues about the nature and extent of the force applied in the course of the restraint and the police version of events as provided to the investigation and subsequent inquest. It is clear that the jury comprehensively disbelieved the evidence of the officers.

**Inquest verdict into the death of Wayne Douglas in Metropolitan police custody**

Southwark Crown Court

Before HM Coroner Sir Montague Levine, November 1996

Wayne Douglas was a 25-year-old black man who was found dead in his cell at Brixton police station on 5 December 1995. At the inquest it emerged that he had died from heart failure as a result of a combination of stress, exhaustion, and positional asphyxia resulting from being restrained face down with his hands behind his back. The inquest revealed a failure of the police to act on previous recommendations made after earlier deaths from positional asphyxia. The jury in bringing a verdict of 'accidental death' implied criticism of the police through a carefully worded statement where it found that his death was due to: "stress and exhaustion and positional asphyxia.. following a chase and a series of restraints in the prone position face down as used in current police methods".

**Inquest verdict into the death of Kevin Jacobs HMYOI Feltham**

Hammersmith and Fulham Coroners Court.

Before HM Coroner for West London Alison Thompson September 2002.

The jury returned a verdict of "suicide to which neglect contributed" at the inquest into the death of sixteen-year-old Kevin Jacobs who was found hanging from the bars in his single cell in HM Young Offenders' Institute Feltham in the early hours of 29th September 2001. The jury found that there were "gross deficiencies within the system: lack of co-ordination of

documents; failure to provide consistent and safe accommodation in prison (no ligature hooks); lack of inter-service co-ordination (placement on release)".

The above examples show that some juries, at least, are perfectly capable of drafting narrative findings of fact for themselves. If, however, this is felt to be an unsuitable task for a jury, another way to enable the jury to participate in the formulation of narrative findings might be to follow a procedure similar to that proposed by Lord Justice Auld for criminal trials.<sup>26</sup> The Coroner could draw up, in the light of submissions from the interested persons or their representatives, a written list of questions about those facts that were unclear or disputed. Once the jury had answered the questions, the Coroner could draft a narrative statement and ask the jury to agree to it or amend it. Where appropriate, the Coroner could explain to the jury that certain combinations of answers to the questions would, as a matter of law, lead to a particular verdict.

### 4.3 Legal presentation and representation

We welcome the comments in paragraphs 104 and 105 but would go further than the provision of legal aid.

*104. The Legal Services Commission in England and Wales last autumn somewhat liberalised the availability of legal aid for families at certain categories of inquest. There is currently a similar extra-statutory, ex-gratia scheme in operation in Northern Ireland. We acknowledge the strength and logic of the argument that families, subject to means, should be represented at public expense where other participants are represented. We will be studying the implied effects of last autumn's changes in a wider context.*

*105. We have had a variety of comment from families about their experiences of representation by solicitors or barristers, and will be considering whether to recommend that publicly funded legal aid should be available only when representation is from panels of suitably experienced practitioners.<sup>27</sup>*

As we set out below we believe that in certain categories of cases means testing should be abolished. We also believe the Legal Services Commission needs to incorporate quality assurance for inquest practitioners within its franchising process, that INQUEST should be funded for the specialist advice it gives to practitioners in partnership with leading practitioners and that barristers representing families at the public expense should be members of a panel.

In the cases we focus on in this submission, those held before juries, legal assistance is absolutely vital and necessary. Within the current system the importance of legal preparation and representation cannot be underestimated. If there is to be a new system with judicial Coroners or judges in the role of judicial Coroners we believe that legal representation remains vital to enabling the family to participate fully in the process and in assisting the inquest to establish the truth and identify lessons to be learnt.

In relation to inquest procedures this is a legal process that involved bereaved relatives in a procedure about which they have **no choice**. In many cases there is a statutory duty on a Coroner to hold an inquest.<sup>28</sup>

We are concerned primarily with those cases that are held before a jury, which raise questions of public interest. In this situation the bereaved are not able to decide whether the inquest takes place or not. Following a death in police or prison custody and in other circumstances set out in the Coroner's Act 1988 the Coroner is obliged to hold the inquest with a jury. In cases involving State institutions – police, prison, NHS, local authorities – those institutions will be represented, at public expense. Unrepresented families can find themselves attending an inquest at great disadvantage. This lack of equality of arms perpetuates the view that the system is biased towards the interests of institutions or organisations that may be facing criticism for their handling of a case. It is often the case that the Coroner does not succeed in eliciting the facts where the family is not represented. The public service relies on public funds to represent its interests at a Coroner's inquest but the bereaved have to secure the good will of others if they wish to obtain legal representation.

<sup>26.</sup> *Review of Criminal Courts in England and Wales*, Ch. 11, paras. 50-5.

<sup>27.</sup> Fundamental Review Consultation document *op cit*.

<sup>28.</sup> Under Section 8 (1) of the *Coroners Act 1988* the Coroner is obliged to hold an inquest if there is reasonable cause to suspect the deceased a) has died a violent or unnatural death; b) the cause of death is unknown c) has died in prison or in circumstances requiring an inquest under any other Act.

**29.** *The Stephen Lawrence Inquiry Report* TSO 1999, Cm 4262.

**30.** *Stephen Lawrence Inquiry - Home Secretary's Action Plan* Home Office, March 1999.

**31.** The Home Office has been revising the leaflet *'The Work of the Coroner's Court'* for a number of years. This is supposed to be given to all those bereaved families attending an inquest but in our experience this rarely happens.

**32.** Claim 10 assistance is available to those on income support for preparation. Our clients are overwhelmingly from the low income bracket and in the most controversial deaths in custody cases disproportionately from the black community which is over represented amongst those on low incomes.

**33.** *INQUEST's Parliamentary Briefing on the Access to Justice Bill*, June 1999.

**34.** We mean both funding for solicitors preparatory work and for barristers representation at the hearing.

**35.** Coles and Ward, *op.cit* p 114.

The MacPherson inquiry into the death of Stephen Lawrence recommended that consideration be given to 'the provision of legal aid to victims or the families of victims to cover representation at an inquest in appropriate cases'.<sup>29</sup> The government has made means tested public funding available for representation of families of victims at hearings in 'exceptional cases' and automatically now in deaths in custody cases.<sup>30</sup> However we believe that this still creates inequality, as the State is not similarly means tested and because families have no choice in being involved in this legal process they should have equal access to funding.

In working with bereaved families we are concerned about access to quality assured legal assistance because of:

- poor quality information about their rights from the Coroner's Court;<sup>31</sup>
- poor information and advice about inquests from generalist advice agencies;
- lack of knowledge about appropriate agencies or specialist practitioners to refer to by generalist advice agencies;
- inadequate training of lawyers in inquest law leading to poor or inaccurate advice and overcharging by lawyers;
- lack of public funding for legal advice and representation;<sup>32</sup>
- inability, unwillingness or lack of solicitors who are adequately qualified in the area of inquests to take on pro bono work.

We have argued for legal services to be re-orientated to prioritise those cases that raise important questions of public interest<sup>33</sup> and impact disproportionately on the lives of the most disadvantaged. Many of those who contact INQUEST for assistance are living in or on the margins of poverty and publicly funded legal services can offer an important counterbalance to the inequalities of power that inevitably arise from wealth, social position, gender, race or otherwise.

The Legal Services Commission including inquests in its franchising process should assure the quality of legal assistance. We have had too many families come to us after they have paid considerable sums, sometimes life savings, to solicitors and barristers who do not have the knowledge and skills to properly represent them. Indeed in a small number of cases the original inquest has been quashed in the High Court despite the family having legal representation.

### Questions of public interest

Many of the categories of cases, which INQUEST believes, merit the availability of public funding for legal representation<sup>34</sup>, raise issues of public concern. In these categories the inquest is frequently the *only* public forum where such issues can be addressed.

There has been widespread public disquiet expressed following inquests into controversial deaths – in police custody, in prison, in psychiatric institutions and following major disasters such as the Marchioness, Hillsborough and Herald of Free Enterprise. Many of the issues looked into at such inquests have been matters of wide public interest and have been thoroughly explored within the limits of the inquest system because of the quality of representation of the families. The inquest provides a forum in which the case constructed by the official investigation (police/prison/HSE etc.) can be challenged both by the family of the deceased and any other party including those who might be subject to criticism. Where the inquest works at all effectively to investigate complex and contentious events it relies on the questioning of witnesses on behalf of those with the strongest interest in challenging what they say. "It is very rare indeed for a Coroner, in the absence of legal representation to conduct the kind of searching questions that occurs when interested parties are represented."<sup>35</sup>

The inquest hearing is often the first forum in which highly controversial scientific and medical theories are put to the test. For example, cannabis-induced psychosis and positional asphyxia. These issues may have implications for both civil claims and criminal prosecutions. The need for adequate funding to ensure expert reports can be obtained to question, challenge or rebut the often sole – expert called by the Coroner. Very commonly the Coroner will call an expert who gives highly controversial or complex evidence with no opportunity for informed questioning, because the family's lawyers do not have the funds to instruct their own expert advisor to assist in questioning the witness.

## The MacPherson Inquiry into the death of Stephen Lawrence – questions of race equality

The MacPherson Inquiry recommended<sup>36</sup>

*43. That consideration be given to the provision of Legal Aid to victims or the families of victims to cover representation at an Inquest in appropriate cases.*

The Inquiry report noted <sup>37</sup>

*45.21 ...“Deaths In Custody”. We are clear that this issue is outside our terms of reference. But we cannot fail to record the depth of the feelings expressed. There is a need to address the perceptions and concerns of the minority ethnic communities in this regard. Such an issue if not addressed helps only to damage the relationship between police and public, and in its wake there is an atmosphere which hinders the investigation of racist incidents and crimes.*

In our submission to the Inquiry<sup>38</sup> we argued that we have major concerns about the suitability of the inquest system in providing the families of those who have died with a proper explanation of the circumstances of a death. Often, the intervention of INQUEST, local campaigners and lawyers with experience of Coroner’s Courts has been the deciding factor in ensuring the evidence is fully explored at the inquest; that the truth is established and that in some cases verdicts of unlawful killing or neglect have been returned by juries. Without that intervention the family is dependent on the Coroner whose inquiries are shaped by the official investigation.

## Representation and preparation

The failure of the State to ensure equality of arms at inquest hearings is one of the major problems with the inquest system that perpetuates a view that the system is biased towards the interests of institutions or organisations that may be criticised. Currently unrepresented families can face barristers for the Home Office, Police Authority or Health Authority whose lawyers are always paid at full commercial rates out of the public purse.

## Which kinds of inquests?

In our view, the categories of inquests where non means tested public funding is most needed are those set out in Section 8 (3) of the Coroners Act 1988 where the Coroner is obliged to hold the inquest with a jury including:

- 1. Any death in custody, whether police, prison or immigration detention centre.*

INQUEST’s high public profile results in more and more families of those who have died in custody asking for our assistance. In these cases we can assist but are in the position of calling on barristers who belong to our lawyers group to carry out the representation in cases which often involve complex issues of law; controversial and difficult questions of forensic science, sometimes being raised for the first time; and quite commonly are the only legal forum for exploring the issues raised, since in many cases there are no claimants eligible to pursue a civil action for damages of any kind. This assistance is provided with the benefit of public resources only if the family meets the financial eligibility criteria. The numbers of deaths in such circumstances is approximately 160 per year.<sup>39</sup>

- 2. Any death in a psychiatric institution, whether special hospital, psychiatric hospital or psychiatric wing of a general hospital; and whether or not the deceased was detained under the Mental Health Act at the time of his or her death.*

In reality many voluntary patients are de facto detained, and would be detained if they attempted to leave. The boundaries between the categories of patients is therefore blurred and the issues after a death are exactly the same: the person was in the care of the institution, the same questions – of medication, supervision, etc. – will arise, and the family are equally disadvantaged at the inquest by technicalities in the evidence and procedure. The hospital or institution will almost invariably be represented whether the patient was detained or not.

<sup>36.</sup> *The Stephen Lawrence Inquiry Report* of an Inquiry by Sir William Macpherson of Cluny 1999, p 332.

<sup>37.</sup> *Ibid.* p 314.

<sup>38.</sup> INQUEST Submission to the Stephen Lawrence Inquiry 1998.

<sup>39.</sup> G Glasscock, ‘Coping with Grief’, Chapter 11, in H Selby (ed.), *The Aftermath of Death* (1992), Sydney, The Federation Press, p 187.

3. *Any death at work.*

4. *Any death which could have resulted from the act or omission of a corporate body.*

5. *Any death which could have resulted from the act or omission of medical, para-medical or social services personnel.*

All these categories involve an institution or organisation with the funds to be represented, and where the family is at the greatest comparative disadvantage in the proceedings.

### Why families cannot represent themselves

The suggestion has been made by the review team that in a reformed inquest system a family would not need legal representation and could represent themselves. Since the early 1990s it is highly unusual to attend an inquest where the police and prison service are not represented by a team of lawyers. A bereaved family could attend an inquest without any understanding of the court nor with any understanding of prison guidelines, duty of care etc and what questions should be asked. Across the court they face a professional barrister or barristers representing other parties who are as prepared and experienced as they are not. Most families would not or could not face the trauma of representing themselves and would choose to be represented.

Indeed it is often said that inquest hearings are so informal that families do not need representation and can ask their own questions. Many families are assured that the Coroner is 'on their side' and that there is no need for a lawyer to represent their concerns. In our substantial experience of working with bereaved families, as documented in this submission, it is often the case that the Coroner does not succeed in eliciting the facts where the family is not represented. The inquest is the only opportunity for the family to find out what happened to a loved one and plays an essential part in coming to terms with the bereavement.

In theory, the inquest is an inquisitorial tribunal, with no 'parties', and with a common aim of assisting the Coroner to establish the facts. However, the reality of many inquests is that the institution or organisation involved appears to be defending itself using a team of lawyers against the concerns of the – family – concerns which, whether ultimately borne out or not, are legitimate after a death.

In our submission **representation is necessary in the public interest** to ensure the thorough investigation and scrutiny of deaths which may have important issues of wider public concern and access to justice for the bereaved.

It is our experience that many solicitors and other advice agencies although willing to assist are not sufficiently skilled or knowledgeable to give good quality assistance. There are currently no specific franchise standards relating to inquests. Aside from those cases where exceptional legal aid is granted, pro bono legal assistance is often the only option.

There is now provision within the Access to Justice Act 1999 for the Lord Chancellor to grant funding for representation in 'exceptional cases' and deaths in custody cases have been brought into scope but solicitors continue to prepare for inquests under the limited legal help provision. This limited assistance makes it even more important that solicitors are able to access authoritative advice to avoid unnecessary or simply uninformed courses of action. This is particularly important now that the Prison Service, police and Coroners have formulated procedures relating to the advance disclosure of material, which depend largely on the material being requested. It is now possible for a properly advised family to have material that is useful and necessary in terms of what they might find out at an inquest.



## 5. The impact of an inquest and sudden death

40. Comment from INQUEST survey.

41. Glasscock, *ibid.*, also states: "It is usually some kind of unexpected and traumatic death that requires people to be involved in the coronial system. The survivors or victim's family/friends have to be understood from that perspective", p 186.

42. In relation to those families having completed an inquest (i.e. excluding those cases where inquests did not or had not at the time of the survey occurred), the proportion suffering negative effects was consistently higher. However, as the margin of increase was small (as was sample of respondents not proceeding to an inquest) and because these deaths may have been more traumatic for other reasons, it is not possible from this survey to draw any firm conclusion as to whether inquest proceedings in general are actually responsible for exacerbating grief effects. Although see Barraclough and Shepherd study referred to above note 27 for evidence of inquest hearings causing worse grief effects in case of suicide.

*"For most people the normal expectations are that they will live the allotted three-score-years-and-ten...that parents will predecease their children...[and] that dying persons will be able to deal with any unfinished business and breathe their last breath surrounded by their loved ones. Whilst the death will of course create a major loss for the family and friends, the death is natural, peaceful and, for the majority of people, pain-free."*<sup>40</sup>

*"This has affected my family in lots of ways. Our relationships have suffered, some unable to cope at work and have lost their job. You are expected to carry on as normal but one cannot. We've been blaming each other, ourselves. It's always there in the back of your mind. We will never get over this."*<sup>41</sup>

An inquest invariably follows a death that was sudden or unnatural – and therefore an event that was remote in the expectations of the bereaved. This contrasts with a natural death, for which relatives may often have some opportunity to prepare themselves, psychologically and emotionally – and also to consider the various practical matters needing to be addressed after death.

In marked contrast to the scenario described is the "unexpected death of a loved one" through violent means such as murder, suicide, or following a struggle. The "mode of death has major implications for the resolution of grief".

For families subsequently involved in inquest proceedings, that the bereavement has been entirely unanticipated has various consequences firstly, that it is more intensely traumatic in the period immediately after death; and, secondly, that it has more serious long-term effects<sup>42</sup>. This is especially so where the death was in some way violent, and in the case of loss of a child.

This difference in bereavement has become medically recognised, leading to the development of different approaches to assistance offered to the bereaved. In particular, there is strong evidence that early intervention (for those who wish it) can preclude the most severe health effects, both physical and mental, of grief following sudden death.

Those bereaved by unnatural death resulting in an inquest will always be, as a group, at higher risk of suffering severe grief trauma than persons' bereaved by "expected" death. Therefore official agencies with which bereaved families come into contact are under a particular obligation to ensure that all possible steps are taken to provide the information, resources and assistance.

Our survey and work indicates that the majority of bereaved families facing inquests lack access to appropriate information and assistance. Furthermore – and which is likely to be a related result – most 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 the national level – which, to date, has escaped both public notice and government decision-makers' attention almost entirely. Although not all sudden deaths involve an inquest, and grief trauma can also follow a "natural" death, the significance in this context of the Coroner's court – as a point of contact with public services for most "at risk" families, regardless of how and where their loved one's death occurred – is at once clear. *Its potential role in guaranteeing informed and effective access to appropriate bereavement intervention options for bereaved families must therefore be a central concern in the development of a new system.*

### INQUEST survey: impact on bereaved families in the Coroner's court

The impact on the bereaved of sudden death followed by an inquest is and has always been immediately apparent to INQUEST's staff. This was underlined when analysing the responses to our questionnaires. Over 100 families replied to our request to share their perceptions of the Coroners system.

We asked respondents whether their physical health had "*improved, deteriorated or stayed the same*" since the death. Almost two-thirds (64%) identified a deterioration, while a 25% described unchanged physical health, and no respondent indicated an improvement in physical health since the inquest.

Asked the same question in relation to their "*state of mind*", again two-thirds (66%) felt this had deteriorated, while approximately one-fifth (21%) indicated no change, and only 2% felt there had been an improvement.

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).

Returning to other aspects of "*quality of life*", the survey results highlight a widespread negative impact of sudden death bereavement on respondents' personal relationships. Family relationships in general (44%) partner-relationships (37%); other friendships (34%); and workplace relationships (25%) were all found to suffer extensively.

Of little surprise, given the above, "*enjoyment of life*" was identified as having deteriorated by the overwhelming majority of respondents (74%, while 14% indicated no change, and only 2% an improvement in this respect).

Questioned as to whether they had gone through various categories of "*major life change*" since the inquest, of respondents over two-fifths (43%) indicated a house-move from the area where they lived previously; approximately one in five (21%) had suffered further bereavement; one in five (21%) the end of a relationship; and one in five the loss of employment (which was distinguished from "*change a job*", to which 14% responded affirmatively).

When asked if they felt that any of these major life changes had resulted from the experience of the death/inquest, the vast majority of respondents experiencing such changes (80%) felt this had been the case (20% held other factors responsible).

Some of the specific comments made were as follows:

"My health. I can't come to terms with it all death left me emotionally depleted to deal with loss of position."

"Suffered severe depression which according to GP has exacerbated problems connected with a previous head injury (from a car accident)."

"Suffer from high blood pressure and depression."

"Because of our anger and frustration about the death and prison service, how we have been treated, some of the family have developed health problems (all related to stress – heart attack, depression, self harm, suicidal) and the other mistakes – have mental health problems."

"Physical and mental health has deteriorated."

"Relationship breakdown – physical health – employment."

"Still suffering severe guilt and deep depression."

"Me and my wife have not been the same since our son died, we were in ill health before our son died, we have been a lot worse since the whole experience began."

"End of relationship – moved out of area became even more depressed. Lost custody of son due to drink. Lost self respect – still on medication two years later."

"Physical and mental health problem – depression, can't face people, general weakness, on medication."

"My life and that of my family has gone downhill. I am bringing up my late daughters children (age 10 and 13 at the time of her death). We are not doing very well. My life is on hold and I have been under a psychiatrist and on medication. I feel suicidal but have to keep going for the children and the rest of the family. We miss my daughter, so much, it still hurts after three years. I just want to be with her."

"My wife is still unwell and on medication."

"Loss of employment."

"Serious physical health problems."

"Serious mental health problems."

"Change of job as daughter also worked there."

"I have had about three jobs since I lost my brother. I find it hard to be happy and sometimes don't even want to get out of bed."

"Loss of my employment and relationship. My partner of 16 years felt I should accept and not fight events. This was a major source of disappointment at his lack of support for me and my family and served to further estrange us."

"Moving. Health."

"Loss of employment. Mental Health. Physical health."

"I do suffer with my nerves, but it's made me worse."

"Feeling very depressed but now gradually coming to terms with things."

"I could no longer help other people who were going through bereavement. Could not bear to be anywhere near the area where our son died."

"Both – one cannot lose someone they have loved and lived with for 32 years, and for them to die in the way they did, and never to find out the true circumstances of their death to ever be the same again."

"...I put my son in the hands of other who say they understand his sort of illness and within four days my son met his death. Remember I, his father, put him there. Believe me I am here only because my wife need me in her illness."

"I know I will never be the person I was before (my) son's death, carry on for the sake of other children. Will never be truly happy again."

"I have never come to terms with the loss of my son which became worse as I feel that who was responsible was never held responsible."

"There is very little in life that equips you to deal with the tragedy of a son hanging himself in

prison and knowing that better practises and behaviour by the Prison Authorities could have avoided this.”

“My partner who died was also my unpaid carer.”

“Not knowing the truth has left us all in limbo.”

These results of INQUEST’S survey appear consistent with the common conclusion of other relevant studies to date – that sudden death bereavement exposes survivors to high risks of subsequently developing physical and mental health problems, and of continuing disruption to relationships and social function.<sup>43</sup>

It is therefore of acute concern that the survey also indicates a very low level of effective access to post-bereavement health and social services across England and Wales. This represents both, i) a failure to provide appropriate services to a group ‘at-risk’; and ii) a possible causative factor in the enduring health and personal problems experienced by survivors of bereavement.

### Bereavement counselling and other therapeutic intervention

Less than one-fifth (19%) of the bereaved knew at the time of the death how to access advice and information about bereavement counselling, which represents a significantly lower level of awareness than in respect of both legal assistance (28%) and funeral arrangements (48%).

Correspondingly, less than one-third (27%) of respondents later obtained bereavement counselling. Where counselling was obtained, this largely appears to have been arranged by families privately, and therefore independently of public health or social services. Of those who did access help that was arranged by others it was primarily through their GP.

For three-fifths (63%) of respondents counselling lasted for a period of one to 12 months, and for one-fifth of respondents for over 12 months, which could suggest prevalence of symptoms of Post Traumatic Stress Disorder amongst the survey population. Of those who succeeded in obtaining bereavement counselling, over two-thirds (67%) felt that it had been helpful in coping since the death, while of the two-thirds who did not receive it, the majority (58%) indicated that they would have liked to do so, if they had been offered this facility.

Some of those surveyed found the experience positive:

“I didn’t think it would be any good, but it really helps.”

“It was a necessity to share the WHOLE trauma of the situation which stretched over six months – accident-hospital-death”

“Because the time of the inquest was postponed from five to seven months, and now because we have registered a complaint against the Police, I have found counselling extremely helpful.”

“The counselling given by CRUSE was excellent and I would recommend it to anyone in a similar, unfortunate situation.”

“I had counselling two years after my son died. I did not think I needed it at the time but eventually agreed that I needed help to come to terms with what happened.”

Others felt that it was not counselling they needed to resolve the issues arising from the death:

“Though the counsellor himself was extremely kind and understanding gentleman, he wasn’t in a position to do much in the way of alleviating the kind of deep hurt inflicted on my family... a hurt arising from the fact that it was unnatural death.”

“No Because it wasn’t so much counselling I needed, as an adequate investigation into the real circumstances of my son’s death.”

**43.** In relation to those families having completed an inquest (i.e. excluding those cases where inquests did not or had not at the time of the survey occurred), the proportion suffering negative effects was consistently higher. However, as the margin of increase was small (as was sample of respondents not proceeding to an inquest) and because these deaths may have been more traumatic for other reasons, it is not possible from this survey to draw any firm conclusion as to whether inquest proceedings in general are actually responsible for exacerbating grief effects. Although see Barraclough and Shepherd study referred to above note 27 for evidence of inquest hearings causing worse grief effects in case of suicide.

Access to counselling at the most appropriate moment was also not always available:

“Although the counselling was extremely helpful it took over 12 months to get on the waiting list by the GP.”

“Got to wait for appointment.”

“I did not go to counselling the first year after my husband death. But I had nine session the following year. I found it too painful to continue.”

Some of those surveyed also expressed scepticism about its value:

“Still ongoing. Not sure, willing to try anything in the hope that it will help.”

“Yes in that I want to talk to the counsellor, BUT I am not sure about the good in the long term.”

“I don't think it would help.”

“Bereavement counselling was very difficult to receive. I found it came at the wrong time, months after my daughter's death and did not find it helpful, due to the counsellor being a second year trainee.”

“My young grandson seemed content with his counsellor. My granddaughter and myself were not satisfied due to her (same counsellor) being inexperienced.”

In the absence of widespread access to bereavement counselling services, respondents turned elsewhere for advice, assistance and support. Most frequently, respondents sought assistance from GPs; almost half of respondents (44%) indicated they had received GP support (regardless of whether they had received counselling or not).

“My doctor came to visit me at home and rang my home daily to find out if I was OK.”

“My doctor put me on medication and sent me for counselling. Someone told my ex-boyfriend to get Cruise for me.”

“Our main support at home was from our family doctor... who came straight out to assist my wife at a very sad time. He made regular visits.”

“Doctor visited my stepfather to describe the results of post-mortem.”

“My GP was very understanding and listened to me in great detail talk about how I felt. He reassured me that my feelings were normal.”

“Treated us with sympathy, care and understanding. We could call on him night or day.”

“Wonderful doctor words cannot describe just how good & helpful he was”

Two other principle sources of support were identified: places of worship, where almost one-third (28%) of respondents turned for help, and the workplace (16%). Approximately one-quarter of respondents (26%) indicated receipt of support from “other sources”; in most such cases, respondents later identified their friends and relatives as providing support in this category. Also identified were specialist non-statutory advice and support organisations – Death On Remand, INQUEST, RoadPeace, Compassionate Friends.

### Places of worship:

“Spiritual, emotional and material help from the church. Although the church was supportive, there are reasons to suggest that this support is soporific rather than truly constructive.”

“The vicar, who knew our son, visited us many times.”

“Spiritual guidance from minister (I work at hospital where my son was brought) Minister there at time gave great comfort, colleagues/friends supported us.”

“Church and Dr. offered practical help – eg domestic chores, walking dog, bereavement counselling.”

“I am attached to a very supportive but small Christian church and also have a Christian GP. If it had not been for this support I would have received nothing.”

“Priest – spiritual visits.”

“The church was of enormous support and assistance as was our local GP. They gave counselling phone numbers.”

### Work, Trade Union and friends:

“We did receive plenty of support from work colleagues and friends but no professional bodies.”

“Via friends and colleagues.”

“The Union offered bereavement counselling/therapy.”

“The Inspector who broke the news of the death is a colleague of mine and kept in touch and offered to put me in touch with bereavement counselling.”

“Friends and family ADHD National Support Group.”

“Friends and family helped in practical ways, by answering telephone calls, housekeeping etc, they also supported us emotionally. The church offered comfort and help arranging the funeral etc. GP etc offered advice and help eg medication to help with grief.”

### Voluntary Sector:

“Compassionate Friends’ organisation for bereaved parents.”

“Death on Remand – understood how I felt, helped me to understand the secrecy, procedures, how the inquest works and what would happen. Most importantly they kept me sane when all you want to do is go with your son who is dead.”

“The lady from DOR helped me greatly. She told me things to do, and what to expect at the inquest. She was very kind.”

“Needed more specialist help and advice! Solicitor told us about INQUEST. But never rang back with number. We visited the CAB and they found the number after half hour.”

“Victim Support (This was not much help and even this HAD NOT been suggested by Police).”

“Coroner’s Officer was thorough, sympathetic and supportive while remaining neutral. C.A.B gave advice about inquest and inquest procedures.”

“Gulf veterans group and INQUEST.”

“RoadPeace.”

“CHC – The NHS complaints procedure is a very hard road to travel. I think I would have gone out of my mind without their help as I have had trouble with the Coroner’s Officer, and the police, to deal with also.”

The picture that emerges can therefore be described as one of erratic and inadequate public bereavement service-provision in England and Wales, with a major discrepancy between the levels of contact and intervention actually achieved by health and social services, and the level of unmet demand (as judged by the size of the relevant at-risk population and the high proportion of our survey respondents’ indicating their receptivity to bereavement interventions, if these were available).

What we have found in our casework and this survey is that the whole experience affects the ability to recover from the trauma of sudden death. Where the experience of the Coroners’ service and inquest has been bad, counselling does not appear to assist in moving on. Where the counsellors do not understand the particular difficulties experienced by some families at some inquests this itself can have a negative impact.

“My doctor put me on medication and sent me for counselling. Someone told my ex-boyfriend to get Cruse for me. It was no good. All he did was talk about other people who had committed suicide and he kept telling me my son did commit suicide.”

The only other comparable survey to have been conducted in the UK to address the “psychological and physiological consequences” of sudden death bereavement made similar findings. In its [1995] survey, the European Federation of Road Traffic Victims (FEVR) discovered that in terms of “psychological help to relatives of dead victims” during the first three years after bereavement, only one in twenty (5%) had access to group therapy and one in five (23%) access to professional counsellors; whereas two-fifths (40%) relied on family doctors, one-fifth (22%) on religious groups and a clear majority on family and friends (87% and 86% respectively).

FEVR observed that in general, “most victims and affected families need considerable emotional, practical and legal support” and that failure to provide such support causes “psychological suffering by the victims and their relatives [which] is often extreme and long-lasting,” adding that “this suffering often increases with time and is frequently the cause of serious illness which may even lead to death.”

There is a small body of research and literature that deals with the psychological and physical impact of sudden and unnatural death and we are including detail about this in our forthcoming project funded by the Nuffield Foundation. However we situate the following comments within the context of academically recognised processes.

Rynearson comments in (1987) “Psychological Adjustment to Unnatural Dying” comments “The rituals associated with natural death frequently seem inappropriate where unnatural death occurs. People...find they are uncertain about how to give support in a case of unnatural death. Many survivors talk of themselves feeling like the victims, becoming isolated and even feeling like others are avoiding them. An additional problem...is that if the media becomes involved then their privacy is invaded. Private grief becomes public...At times the judicial system...creates stress for the survivor.”

“I was absolutely devastated. I gained nothing from it. Just totally humiliating.”

This is commonly described by INQUEST caseworkers, and was/is particularly damaging when there is no pre inquest disclosure of evidence and families hear for the first time distressing details about their relative’s life and death in open court.

“The inquest was worse than anything I’ve been through was. Brings everything to the surface in the most humiliating manner. Such a cheap way to hear details of your loved one’s last few hours on earth or how they died. I was devastated. I came out with nothing.”

In particular a lack of accurate information given at the time of being informed of the death has in INQUEST’s experience led to further distress and suspicion about the whole process. Attempts to understand grief following violent death has often overlooked the legitimate anger caused by the system of investigation of deaths and the experience of the inquest system. Whilst there may be circles of symptoms that need to be interrupted in order to foster the work of grieving for many families it is only when they have answers to their questions about the circumstances of the death that they can begin to grieve. In some cases that has required attendance at numerous court hearings and even obtaining a second inquest in order for the process to move on. For others who did not have access to appropriate advice and support their ability to move on is greatly hampered, as they have not only been victimised by the death but also by the inquest system itself.

Our case work has demonstrated that many families are comforted when they realise they are not the only people to be suffering such symptoms nor are they alone with their experience. It has often helped bereaved families to talk to others in the same circumstances. In the immediate-to-short term, health and social services professionals should therefore aim to identify individuals and/or families most “at risk” – “some people and some individuals have better coping skills than others...possibly because of their own psychological well-being, previous history of mental illness, or previous exposure to trauma” – and to assisting access to support services, information, and referral to external support groups in this phase.

In the second phase, survivors “may become quite proactive”; as a result their principle intermediate need will be for assistance in preparing themselves psychologically for the inquiry, which can bring about fear of facing the accused; coping with media attention; and post-traumatic stress reactions, exacerbated by repeated exposure to trauma sources and painful memories.

“It should be treated as a proper court case. Maybe if this was the way it was I would not wake up every morning and throughout the day wonder what happened to the man I loved. The anger I felt at listening to people lying while giving evidence. Just to save their own neck. Left me frustrated and angry. I am crying now as I do most days in my life. That’s what his death and the useless thing called (an) inquest has done to me.”

Assistance from official agencies should therefore continue in this period, when support available from family and friends may naturally diminish given the demands of everyday life, and the need for those more remote from the death ‘to move on’.

### Future alternatives: best practice and recommendations

In recent years a number of major inquiries have concluded that survivors of sudden death bereavement in Britain faced a resource deficit in terms of post-bereavement support, and that official procedures, while failing positively to address survivors’ grief reaction, at the same time can often exacerbate it by failing to take account of the perspectives of the bereaved – the needs and feelings of whom, as those most seriously and enduringly affected by the death, should be the starting point of any investigation of the death.

It has been INQUEST’s experience that access to and information about support organisations has been denied. This leads to the possibility that there is an understandable reluctance by those who may be criticised about the death to pass on information to the bereaved about where they might obtain independent and competent advice and legal representation. It is therefore even more incumbent upon the Coroner service to ensure families are furnished with that information that they can access if they want. It also raises the need for greater separation of the Coroner service from those institutions be they the police or the local hospital. Our survey results demonstrated the high esteem in which the supportive specialist voluntary sector organisations are held by the majority of bereaved

families. But it is also the case that those organisations are often under resourced and viewed as an irritant by officialdom.

The Health Select Committee, in its *Report on Procedures Related to Adverse Clinical Incidents and Outcomes in Medical Care* observed in October 1999 that for families bereaved by unexpected death in the clinical context:

*“Initial needs are likely to be for accurate and honest information. Families will need to know in detail what has happened, what steps are being taken to investigate the outcome or incident and the implications. They need to have an accessible, identified person with whom they can communicate regularly their feelings and emotions. They may also need support through any longer term investigations and enquiries. The person chosen to offer immediate information needs to be a senior member of the medical team involved in the incident. However, for continuing support someone with experience in bereavement counselling should be identified where appropriate”.*

It was also observed that:

*“Relatives and carers of patients who have died, especially in unexpected circumstances, need particular assistance and to be dealt with sensitively, ideally by staff trained in bereavement counselling. Some hospitals employ a “patients affairs officer” who is designated to help bereaved relatives. Arguably, all staff need some training with regular up dating in dealing with bereaved relatives. The work of staff especially skilled in bereavement counselling needs to be integrated with other staff.”*

The Committee however concluded that support for patients or their relatives in the circumstances outlined “*varied between trusts and was often inadequate.*” The report refers to evidence

*“...from patients, relatives and carers who felt they did not receive enough support. Certainly, they felt they were alone against the trust or health authority in trying to obtain information...they had resorted to litigation because they felt it was the only way they could get an explanation. The GMC commented that sometimes at the end of a case...[in] their professional conduct committee, the complainant pointed out that it was the first time they had “heard what really happened.”*

The Committee’s recommendations – which include that the bereaved should be provided “*at minimum with...information on local bereavement services*”, and that arrangements should be put in place between trusts and local voluntary agencies on agreements on support for the bereaved – reflect the gaps in basic service provision in many areas. The government response was slow and work only really started on this issue following the Alder Hey scandal.

Two questions immediately arise. First, what are the root causes of these problems? And secondly, how should user-centred service systems be designed appropriately to cater for the needs of the bereaved?

In relation to the first of these, and as reflected elsewhere in this response, diffused governmental responsibility for the Coroners’ jurisdiction is likely to be principally to blame. Along with the consequent relative autonomy of Coroners within the judicial system, the location of the coronial service outside the mainstream of public administration has also resulted in its isolation from contemporary developments in governance, and particularly in standards of training, administration, and service. This too must have been partly to blame for the service’s historic failure to recognise and respond to the evolving needs of service users.

As to the second question, finding an answer here must primarily be a task for the Government following the fundamental review of the inquest system. New proposals must be linked to the work currently being done by the Department of Health following up the Chief Medical Officers recommendations in the wake of the Alder Hey scandal. It is therefore welcome that the terms of reference refer to the need for ‘coherence of bereavement services’. However, pointers already exist as to the broad features of a new integrated coronial court and bereavement support system.

All the bereaved people who responded to our survey had contact with the Coroner’s court, most often very soon after the death, and well in advance of inquest hearing. The Coroner service would therefore appear to be the most appropriate partner for an integrated

local bereavement service, in terms of location and service-users, particularly where Coroner's courts are housed in dedicated premises.

There are also already useful pointers, and good practice models as to the kind of resources that a new integrated coronial and bereavement service must, at minimum, provide.

Bereaved people should be entitled to:

- Information on their rights – beyond a single leaflet and an opportunity to ask questions;
- Referrals to legal, social and health service providers, including voluntary sector providers. This should strive to deliver face to face contact, not just telephone, and will provide reassurance from independent person not part of Coroner's court or police service;
- Mental health professionals should be a recognised part of the coronial system. Where on-site assistance is not available, the court should have an index of suitable counsellors/psychologists/social workers who have the skills to deal with this kind of complicated grief.

Intermediate needs:

- Adequate and accessible information must be provided about the inquest process – it is more difficult to resolve grief if people have missed elements of the legal process
- An understanding by those working in the court process of the fear of facing those perceived to be responsible for the death and that this can be overwhelming.
- Training of counsellors/psychologists/social workers on the inquest system and the complex responses of bereaved people to a sudden death and an inquest.

Around the hearing:

- There are times when bereaved people can feel their rights have been disregarded. The legal system...may appear to be so preoccupied with the processes of law in regard to the case that the survivors feel overlooked. Society has developed appropriate services for people who die from natural causes but where the death is unnatural support services have been less than adequate. The new system must address these concerns and also understand that because legal processes are slow, grief is frequently reactivated by the inquest.

After the hearing:

- Appropriate ongoing support must be available and follow-up communication about action being taken where the death has occurred in an institution must be made available.

## 6. Comments from bereaved people on inquest system and suggestions for reform

Bereaved people have a number of suggestions for reform. The comments below reflect a selection of the views of the families who responded to our survey. We have tried to divide them into:

- a) General comments on the system;
- b) Suggestions for reform

Inevitably there is some overlap.

### a) The Investigation And Inquest System

“Although we knew how to obtain legal advice we were under the impression that an inquest was an impartial investigation – not a game of advocacy/opposition.”

“Primarily, the problems associated with the death relate to two specific areas:

1. Lack of explanation of all the circumstances; 2. The complete disregard of rights by the Coroner.

The Prison Service were not called to give evidence and therefore could not be questioned. The Prison Service investigation was done by itself, with no independent outsider. The Prison Service investigation remains secret – why?

The Coroner appeared almost to dismiss my questioning as a teacher would a child. He completely disregarded my questions as an insignificance.”

“I really felt very threatened and intimidated by the behaviour and actions of the Coroner’s Office. Because the police were involved in the death they were adamant that I was in the wrong. I do not think this was fair as I was trying to do what I thought was right.”

“I cannot believe that such official and important people that I trusted before Jamie’s death, to do their jobs properly and be honest, turn out to be: Liars; Deceitful people; Obstructive; Economical with the truth; Unsympathetic; Unprofessional; Anything goes to save their hide; Anything goes to cover up the truth. And downright horrible people. I will never get over the death of my son. I will never get over the lies and cover up of my son’s death. I will never trust prison staff, police, Coroner’s Office staff again.”

“At the time of my son’s death we had to fight to know where he was and what was happening. He had been dead three weeks before we could see him. I just could not understand why I was not allowed access to him. Whomever we phoned we got no answers. As far as they were concerned we just didn’t matter. I would like the system to change why was I not allowed access it would have made no difference to any-thing. And there should be somebody to liaison with family’s my oldest son sorted everything but he was as devastated as myself. We had no help only from my solicitor.”

“There were and still are many questions left unanswered. The police (complaints?) authority although pleasant were always evasive, I feel that because my son’s death occurred in police custody it should have been investigated by people (not members of police force) – people who would be unbiased. Evidence we would have wanted to see ‘actual custody record etc’ withheld – procedures do not help us in our quest for the truth. Also if it was not for the fact the son’s partner obtained legal aid we would not have had the funds to bring a civil action – if Police can be represented without cost then we should have that facility. If we do ‘win’ the civil action (first

hearing in March 2001) then it is not the monetary value that brings comfort but the fact that the police will admit they were negligent. – I fight on to find the truth for my son I would like to thank you for the help and advice INQUEST gave me.”

“On 15.02.99 at our first opportunity to meet with representatives of the Oxfordshire County Coroner’s Office and the Oxford Police, we gave them our statement demanding that the person responsible for our son’s death be found, since we are convinced that he was murdered. We did not receive any answer for our statement up to now. The Pathologist from J R Hospital assumed for purposes of his investigation that our son committed suicide and the efforts of Oxford Police were, in our opinion, devoted exclusively to finding any possible evidence, cause or motive for suicide. The Police claimed (to media as well) that there was no question of foul play and ignored all the circumstantial evidence (and) other indications that our son’s death was in fact murder. During the hearing the Police inquiry, toxicological analysis test etc could not demonstrate any evidence of our son’s suicide. And therefore the ‘open verdict’ was submitted by the Coroner. In the same time the Coroner ignored all unclear questions which we addressed to him before and during the hearing. The circumstance in which our son was found (on the floor in blood etc) also make it impossible for us ever to accept the interpretations of his death as suicide. The investigation of our tragedy by the Coroner and the Oxford Police had been based exclusively on the assumption that no murder could ever possibly be committed in residence of Oxford University... it appears that if the murderer is not discovered at the scene of the crime and has failed to leave any obvious direct clues, then nothing can be done but to classify a case as suicide or accident (or ‘Open Verdict’). The ‘Open Verdict’ allowed the Oxford Police to stop the inquest and not to open a criminal case.”

“The hospital not giving, although requested many times, until mentioned at first part of inquest (and this was three months after the suicide) the hospital notes. Left questions that we would have liked to ask the psychiatrist and thus have his response on record unanswered.”

“I felt shamed by the fact that I could not get legal aid to bring a negligence case against the hospital even though my partner’s husband was prepared to swear an affidavit confirming the relationship and relinquishing any award that might have been made.”

“As you can see from some of my answers we were not pleased with the outcome. I did write to the Coroner and subsequently told her of the distressing and distasteful way it was heard. The people that were witnesses were allowed to leave before she brought in the verdict, which I thought was wrong as they all had a part in his death. She brought in a verdict of accidental death on probabilities. They all left with contempt and total disregard for my brother’s life.”

“Please inform the Home Office that £800 is an exorbitant price for the cost of the full notes of the inquest. I would not expect the proceedings to be little different in a totalitarian state! The inquest firmly cemented the ‘Cover up’ of serious malpractice. It has undermined my credibility as a primary carer and the well being of my son. No one could say death was inevitable and that had my daughter needed treatment she would have lived longer. The Coroner based her judgement on carefully orchestrated statements by doctors that provided her with the statement she wanted to make – in order to protect the doctors. Her judgement was not rooted in rationale or in scientific fact. This has implications for the care of my son. The Coroner used the inquest to discredit me as I am vociferously complaining about the doctor’s conduct. She chose to ask questions of peripheral importance that resulted in implied criticism of me and yet refused the barrister to question the doctor who had deliberately denied treatment.

“1. The inquest was a complete shock. I just thought it would be a summing up of what was found in court, prior pathology evidence, police etc.

2. I did not expect more witnesses to be called than at the court case.

3. I did not realise I should have been legally represented at the inquest.

4. I was annoyed that the prior court finding, ie guilty verdict, was never mentioned at the inquest as “his actions” caused the death and injuries etc.”

“Without the help of INQUEST we could not have been represented at the inquest on Andrews death. We could not have legal aid for this but the prison service could-we feel this is totally UNFAIR. The family did not get answers to the question as to why Andrew was left alone and locked in for most of the day of his death. And will never forgive staff of Glen Parva for this. Or the remarks by the Coroner on Andrew's death certificate. The registrar phoned before it was sent to me because she was so concerned for me.”

“This was not typical of INQUEST's concerns. Our daughter's crash was held to have been a single-vehicle incident and, according to the police, was due to her driving beyond her limited experience. There was no evidence for this.”

“The police held that the road was ‘of a good standard’ – we contested this. There was evidence that another vehicle may have been involved. Privately the police were critical of the condition of the road but this was not disclosed at inquest. We discovered this over a year later. Since then much else has come to light, but two investigation reports remain secret. PCA adjudication exonerated the officers concerned in May 1999.”

“As I explained earlier, the Coroner was very kind and understanding. I wrote him a letter afterwards to thank him for being so sensitive towards me and my family. He later rang me to tell me how much he appreciated my letter.”

“The pathologist wrote in his report that he had read the hospital notes before doing the post mortem. How can he have done an impartial investigation if he knew what the hospital staff had written?”

“In his report he included the hospital nursing notes version of the ‘fall’ – thus perpetuating the myth that my mother fell off the toilet. He ignored the nursing notes that said she had been dropped; and the notes, which said, she was found in the corridor.”

“His report said the fall did not contribute to her death. On the phone he told me the shock of the fall may well have contributed to her death.”

“Felt as though my daughter was being blamed for the accident. The Coroner's attitude and police insensitivity to us during and after the inquest. Having to sit next to the man who killed my daughter was painful (driver of overtaking car). Felt my daughter was just another statistic and not a person in her own right. My faith in British justice is almost vanished.”

“As far as my case is concerned I thought the inquest was a waste of time. After three days of hearing evidence, the Coroner ruled that there could only be one possible verdict – accidental death. The jury didn't give their opinion and the Coroner, whilst sympathetic, wasn't allowed to blame anyone for what happened.”

“It is an experience that changes your life. Obviously it is a very traumatic time and the persons concerned should be treated with more compassion. In my son's case I was told that it was my son's fault and all through the funeral very angry toward my son. Later at the inquest it proved that it was not my son's fault.”

“It was then too late to reverse the way I felt at my son's funeral. We received no help or advice from the police or Coroner from the death to the inquest. The person responsible for my son's death was not interviewed for 84 days after the accident; I do not feel that was acceptable. We also saw Jack Straw's assistant in Westminster who promised that all the points mentioned would be looked into. We are still waiting!”

“Was offered the opportunity for an independent post mortem, but decided at the time this was not needed. Looking back – now feel it may have been a better idea to gain independent post mortem. Inquest held over 18 months ago, so difficult to remember some facts.”

“Firstly I was LIED to by prison personnel that inquest should have been able to MAKE RECOMMENDATIONS and Parliament should make SURE they are brought about. Our daughter’s death has left us with a child to care for which is a daunting prospect at approaching retirement. Without INQUEST’s help we would have been totally in the dark about where to ever begin. It has only been by their recommended solicitor and barrister’s diligent investigations that the many shortcomings and obvious neglect within the prison service has been brought to light.”

“I don’t think I have been much help to you as my complaint is still being investigated by the ‘Parliamentary Medical Ombudsman’. Therefore we haven’t gone through legal proceedings yet. The Coroner’s Office report that I received was incoherent and left too many questions unanswered. I wrote to them four times and they have never sent a reply.”

“We feel badly let down by the whole system. You’re passed form pillar to post, and everyone doesn’t want to know. They profess sympathy and express regret, but it means nothing. You cannot get Legal Aid, Coroners are untouchable, no one to complain to!”

“The system is geared to protect the Police, Prison Service, Prison Officers etc. When will we get justice?”

“We were advised not to go and view our son’s body. We were never given any reason for this, but we took the advice, as we didn’t know what to expect. We often wonder if some of his organs had been removed.”

“The whole experience as you will see from the above has left us very wary, not trusting the Police, Prison Service, Coroners etc. We should like to see the Coroners held responsible for their verdicts and for people like ourselves having a body to turn to to complain, and for thy and the Prison staff etc. brought to account. We feel very strongly that this is legalised murder.”

### b) Suggestions for Change and Reform

“The impact of the experience we have suffered at the hands of the Coroner, is utter disbelief. These people are supposedly there to aid tragic families like ourselves. How can people in public office get away with their lies and mistakes and have no one to answer to. *I feel that the Coroner or his assistant should have contacted me or a member of my family to inform us when and where the post mortem would be carried out. Also we should have been informed who would be carrying out the PM, which they are obliged to do.* We would not be suffering as much as we are now if they were to stick to this tiny rule. I feel it would improve the system. I have not given up on my search for the truth in the passing away of our beloved son and one day I hope to expose the profession misconduct of this Coroner’s Office.”

1. I have proof of their lies in letters and on tape
2. They did not keep records of our son’s case. Everything they told us was from memory
3. We did not know the time the PM was carried out and much much more

The Coroner still knows how I feel about this. One day I will expose him and hope this leads to changes in this corrupt system and I do not care who finds out. I am sorry if I sound angry but no one should have to go through this nightmare after losing someone so precious.”

“The police should be allowed to see the officers involved and interview them straight away. Or better still an independent group should be interviewing the people involved, as I believe the Police and Prison officer are the same. All information relating to the person who died should be given to the relative straight away. Witnesses should not be allowed to sit in the court while everyone give their evidence. Every witness should be cross-examined as in a proper court of law. It should be treated as a proper court case. Maybe if this was the way it was I would not wake up every morning and throughout the day wonder what happened to the man I loved. The anger I felt at listening to people lying while giving evidence. Just to save their own neck. Left me frustrated and angry. I am crying now as I do most days in my life. That’s what his death and the useless thing called (an) inquest has done to me.”

“The whole system requires a full overhaul. The families should be treated with respect; we were made to feel that we had committed crimes ourselves. All information including the prison’s own internal investigation should be made available to the families, and the Coroner should not be allowed to act in the way they do. He alone could have made a real difference, but he totally betrayed our hopes.”

“A brochure made available immediately after death, by the Coroner’s Office setting out in clear language – procedures; rights; support groups; options.

By ‘forcing’ an inquiry in front of a jury we were with the co-operation of the Coroner and our own efforts able to get a full and public hearing – but it should be easier (also some help from our MP).”

The verdicts available should be fully explained; more options.

The Coroner should give recommendations and follow up actions and follow up monitoring arranged or if not, give a written explanation, why not?

The inquest should be recorded in a report – the copy we were given just gave the verdict.”

“I appreciate your concern regarding inquest courts. And on behalf of the likes of me and many, many others who have not had the right to put their case in full. Or because the Coroner has rules what one must follow which was very wrong. It would be better if all witnesses are to give evidence on oath, in hearing at Coroner Courts they don’t need to answer questions if they don’t want to. That seems very wrong, because some one like me and the questions I myself needed some answers which was avoided. This is very wrong, one’s at a disadvantage before one starts his lines of ones questions. That’s what was wrong in my hearing. And for the jury, I think all jury members who are call(ed) need to be mature in age around 28 to 35 years of age whether a Law Court or a Coroner Court. The reason I say this is because the first thing I noticed when I looked at the jury was that they were all in the age bracket 18 to 22 years old. You could almost feel what my hearing was about, just another nut case under a train. I knew before they came back what the verdict was. Your good self will probably be thinking I am angry because I got a bad deal. That would be far from the truth, let me ask you yourself who are doing their very best to change the system. If the Mental Health NHS Trust are blameless and Legal Aid area office tell me in a nice way they can’t afford to waste good money after bad. Then I take a good stock myself in bringing about my dear son’s life to its end in a most appalling manner then that responsibility must be mine. That’s what I am left with each new day. So I hope you understand my writing.”

“The death of my son has had an enormous impact on me, his brother and the rest of our family. Nothing can ever be the same again and I still feel a slow burn of anger and an overwhelming sense of injustice that will not go away. The inquest gave us some more information but did not fulfil our expectations. In many ways it led to more uncertainty and after it was over I felt as if there was no one else left to listen.”

“Apart from keeping families fully informed, giving free access to documents and treating them with respect, there are only a couple of things which could have made the experience easier for me.

1. The jury should be encouraged to look at the evidence and ask questions. They should be made aware of how important this role is.
2. Witnesses should be kept apart. We had to endure a dozen or more prison witnesses talking amongst themselves during evidence, smirking at each other on leaving the stand and taking up almost all the seating.”

“Family members of the deceased need to be given their rights at the time of death (not when [the] inquest opens). I realise if this advice is just given verbally at the time of death there is the possibility this information will not be retained. However if such information is printed (as it is when inquest opens) and given by Police to the family, then this could be very helpful. Also families need to know that they can be legally represented at this time too. Not left to find legal representation for themselves. In my case, I found the experience of finding my son dead and being asked to identify him as he sat slumped in a chair, and the insensitivity and prejudice of Police and

Coroner's Officer devastating. It is traumatic enough to find one's perfectly healthy son alive one minute and dead the next, without having to walk through the nightmare of unbelievable treatment by Police and Coroner's Officer. Their treatment has left me scarred for life."

"Since the death of my son, I have always felt that the GPs should not be allowed to prescribe drugs such as Methadone because it is clear to me that if he had had to go to a special clinic for this, he would have had tests to see the amounts of Methadone he needed. Instead of this he was given a large amount of the drug + Valium which resulted in his death. My son was due to go into detox three days after his death and I believe he was given four days' supply in one go. I also believe that if an inquest is to be held I think that I, as his mother, should have been allowed to call the witnesses who I consider may have been able to provide some of the answers to my questions."

"The major problems with the inquest system lie in the restrictive scope in which it has to operate and which are described above. There is a real need to explore liability and accountability, especially where government institutions are concerned, in order that preventive action can be taken to avoid similar events in future. In cases such as my son's there is a very clear need for open inquiries with wide-ranging remits, not hampered in any way by the restrictions of the Inquest system. One last point – I went very much my own way on the legal side, using my own solicitor and barrister for the inquest. I very much regret that I was not made more aware of the INQUEST organisation at the critical time when they could no doubt have pointed me in the right direction for legal expertise and help on these specialist areas."

"Thank you for giving me the opportunity for airing my grievances against a system that should be dragged kicking and screaming into the 21st Century.

The Coroner should be made accountable to the parents and family of the deceased.

Our son, Scott, was the driver of a car, which crashed at a notorious black spot, killing him and three of his friends.

We always felt the Police were fair and sympathetic, and kept us informed at every step. We were told, quite rightly, that Scott had zero alcohol in his blood, but 33 nanogrammes of cannabis, which was less than a third of a recreational amount, and therefore had no bearing on the accident, and therefore was irrelevant.

The Coroner's assistant said that it wouldn't be mentioned at the inquest, so we more or less forgot about it. Taking everything into account we decided that, in no way, did we need legal representation at the inquest, and I decided that I could not face it. My husband went, and just as he was about to enter the courtroom, one of the Police Officers pulled him to one side and told him that the Coroner was going to make an issue out of the cannabis.

We were told that we could get legal representation, but taking everything into consideration we decided there was no need. However had we known just how the Coroner, Mr Johnson, was going to crucify our son, we would certainly have hired a solicitor.

Even though there were people with Scott that night who were prepared to go into court to swear that he did not smoke cannabis that night, the Coroner stated that he had smoked cannabis one hour before driving home. Obviously the media got hold of that part of the story and it was in the newspaper and on Meridian News.

My husband rang Mr Johnson the following day to ask why he did it and he told my husband to ignore the media, because that's what he does, then he said that he feels that cannabis is far less harmful than normal tobacco. What sort of man is he?

I wrote to him, with copies to various people, but we were told in no uncertain terms that a Coroner is answerable to no one.

We would do anything in our power to get the facts put right in this case, because it still causes us so much unhappiness on top of our immeasurable grief."

"Because I can't work due to ill health I had to borrow money for [the] Barrister as I am on basic income I still today feel the pressure of borrowing £550 for [the] Barrister. Definitely should not have to pay the very high bills for Barristers as this had to be paid before he acted on my behalf."

“The Coroners have too much power that is abused. There should be a national procedure for Coroners to operate under; it should not vary from county to county. Coroners should be accountable to the public, not immune from prosecution as they are currently. The law needs to be changed so that the Coroner does not have sole power over the body. They should not have the right to remove organs without the families consent.”

“The Coroner’s system proved to be anxious to help and assist my voice to be heard. However they did not seem to be able to consider failures of an overall system – my mother fell into the cracks of the system. Also the medical profession closed ranks and hid behind defensive posture. More information about the system more readily offered would have helped. An advocacy system as of right for the bereaved – to ensure their views and questions and voice are heard – would be massively helpful.”

“THIS PAGE IS NOT BIG ENOUGH. From the moment my son died there was a closing of ranks and wall of silence compounded with a total lack of information. The inquest itself was a farce conducted by a person with pre-conceived views and opinions, which were instructed on the jury. The Coroner gave licence to the authorities, HM Prison etc but denied us the same. People hope for truth at the inquest, how the person died is already known, what they need to know is WHY and if anyone is responsible. But the present system prevents any investigation into WHY. What is needed is a legal inquiry before the inquest with a wider parameter and the opportunity for all concerned to ask and be asked questions concerning the death, along with full disclosure of official reports etc. The constraints of an inquest prevent this and leave most questions unanswered – Let the inquest decide HOW, let justice decide WHY.”

“Both my husband and myself felt totally at a loss at a time when we needed answers to a lot of questions, but because of red tape we felt we were excluded from all but the fact our son was dead. We had lost our son in a police station cell and we just wanted to be sure of all the facts surrounding that night, but were given just a brief outline of what took place. Although there was an investigation by the Police Complaints Authority, they too would not release any statements before the inquest hearing. Our solicitor did try but only certain documents were released just a week before. Even now we both feel let down by the authorities because we needed to know as much information as we could to try and understand how and why our son died. We feel bereaved families should be allowed all information as it becomes available, so that they too can have time to study and get to grips with all that happened before the inquest, then maybe they would be more prepared for all that is said and brought up at the inquest.”

- “1) To allow the cross-examination of witnesses.
- 2) To be able to speak of the deceased so the jury could have the human side of the person, not just prison record.
- 3) To clarify certain points that are confusing and then are forgotten and not used in the Coroners summing up.
- 4) Witnesses should be made to answer incriminating questions so the Coroner and jury get the whole picture not half of it.”

“I feel the inquest system is a complete farce. In my case the officer with whom I met was very nice but the Coroner himself, although he let a lot of questions be asked, directed the jury to their decision. I feel not enough of the witnesses I asked to be spoken to were taken seriously, also they were being interviewed in the prison where my brother had also been, nobody considered their feelings and I feel they couldn’t say what they wanted to say as prison officers were standing around. The worst feeling is that recommendations were made but I feel the Coroner should make sure, especially if deaths are re-occurring at the same establishment, that these recommendations are implemented. I feel very let down by the system.”

“The WHOLE system needs to be restructured/overhauled. It has no co-ordination (except when buck passing, at which all elements seem to be very proficient!) with most involved trying their

hardest to do very little. When I did find fresh leads re: the deceased's family's whereabouts, it would take at least a fortnight to get any action taken at all and only after constant, daily pestering contact. Even then I felt they didn't bother to follow up the leads, but simply lied to get me to stop calling. (Which I didn't).

I mean, if the police, Coroner's etc can harass us with CIB investigations etc al directly post death BUT cannot locate relatives who live only a borough away to inform them or their son's death, it is obvious what the priorities are...Isn't it!?"

"I would like to see in future Inquest a free legal service and all documents provided free of charge. As the people who have to pay to find out what has occurred to a loved one is scandalous to say the least. These persons are grieving and should be allowed to grieve without the worry of trying to finance their own inquiry as to what has occurred.

We are told an inquest's job is to find how, where and when a person has died in the case of a police car pursuit. This is already known i.e. car crash (how), place (where), and a time (when). Events leading up to this are not taken into account. Even when statements made by police could not have been possible. And we the grieving parents have to fight the system for justice to be done.

A totally independent body should be formed. NOT the Police Complaints Authority."

"The impression I have gained in the involvement into the circumstances surrounding my brothers death have much wider implications and issues relating to the agencies involved namely the Prison Service, Probation Service, Legal Profession that serve all criteria's defence prosecution and judges.

I strongly feel that the Coroner's court does not go far enough in answering relevant questions and it's remit should be extended to make further investigations into circumstances relating to a persons death, certainly where Government agencies are involved and the legal profession, when facts have been given and produced.

What you come up against is a wall of silence, bureaucratic systems that prevent the ordinary person gaining bone fide questions answered certainly where the above are concerned and I should know working for local government social services, it is difficult for anyone to break down barriers put there to protect the very people whom should be brought to account for their decisions and actions."

"Recently I have had the unfortunate experience to attend my adopted son's funeral and inquest the events surrounding his suicide where of a dual nature came into play, one was of personal circumstances, the other was involvement of the C.S.A.

It was clearly noted at the inquest by the Coroner that government agencies should be sensitive to situations relating to mothers of children and absent parents, again I have witnessed an injustice to someone whom did not need punitive measures placed upon him by our so called elected peers, but help and compassion in dealing with complex personal situations.

What I came up against was again a wall of silence and bureaucratic distancing of accountability, as my M.P replied not enough evidence to make a complaint.

I am sure there are many people that have been in my position where they have witnessed what my brother and adopted son went through, I have spent many hours going over how I could have done more to help them, I have found some answers not to console but to justify my anger at the hypocritical nature of this country's portrayal of a fair, civilised society, the inadequate government agencies, legal profession and the individual's rights portrayed that we seem to have in this country.

These life experiences have left me very bitter toward officialdom of any kind. It has led me to trust no one connected with it, I have always lived my life on the principles that you should treat everyone fairly and with compassion until you know otherwise. I am sorry to say those principles have been eroded to hate and distrust, and yes I do hold those accountable for the deaths of my brother and adopted son because I firmly believe they could have been prevented.

So in closing I hope that your research, that is to be presented to the Home Secretary, impresses upon him that there is at least one person whom feels strongly the system needs to change in tangible effective way and to listen to the people whom have experience it first hand, not to pay lip service to change. We do not need spin but fair and realistic legislation."

“The entire system should undergo a radical overhaul whereby Coroners especially should be made accountable for their conduct. There should be clear complaints procedures and an independent body responsible for investigating and disciplining incompetent Coroners. Coroners and their officers should receive training to bring them into the same century as the rest of us.

There should be major changes wrought to improve communication between families and the subjects of inquests and those working at the Coroner's Office. It should be illegal to proceed with an inquest if the Coroner has failed to inform the family of the time/date of the inquest. The families of those deceased should be included far more (if they wish) in the entire procedure and should automatically have access to legal aid to cover solicitor's fees if they are on a low income, should they feel they require a solicitor. I will never forget nor forgive that Coroner in Lancaster for denying me and my family and John's partner of 16 years the opportunity to ask questions of some very unreliable witnesses or even simply to BE THERE!!”

“It has been a long fight, but the solicitor who is helping me so far free of charge has asked the Coroner to sit with a jury, and he has now agreed, he has also applied for Legal Aid but we still do not know when the inquest will be held

I feel that the Coroner's Officers are given a free reign to do as they please. If the Officers in my son's case had their way the inquest would have been over as quickly as possible. It has been a very hard fight to get as far as we have. I cannot help wondering how many wrong verdicts have been recorded due to the Coroner's Officers incompetence and the Police withholding evidence.

The pathologist gave the INQUEST telephone number to me, and INQUEST in turn gave me the telephone number of my solicitor. I am extremely grateful for his help and hopefully when we finally have the hearing I will get some answers.

It seems that even the Home Office has no control over a Coroner's court. My suggestions would be that some of the power is removed from them, and that legal Aid should be made available to all those who need it and that an organisation should be set up to help families through this awful ordeal.”

“I wrote to yourselves earlier this year regarding my son Robert; you will perhaps remember the case.

The most immediate changes are information of rights given to the involved at the time.

Information not withheld just because it's not the way things are done.

Finding the cause of death before being treated like a criminal.

Experienced police officers to handle cases especially of children who die at home, not walking in like the KGB.

The Coroner's Officer giving decisions of importance without proper information.”

“We don't understand how a non-medical Coroner can decide an inquest is not necessary. He just accepted the post-mortem reports findings – because he did not know any better. An independent NHS review found that the hospital did not look after my grandmother properly – she was seen by four consultants who misdiagnosed her in four days in the hospital. This however took two years to do. An inquest may have speeded the process up.”

“Getting the inquest heard ASAP after the death. The sword of Damocles seems to hang over one – it is debilitating.”

“When we came out of the inquest we were shocked/devastated and angry. We felt our son's death had NOT been properly investigated. That the probable cause of death was contrived by the Coroner for convenient expedience of the case.

It appeared as though our son's life began, existed and ended with his fiancée and her family. That we his parents & sister, let alone the extended family, had not played an integral part in his life. This is NOT so!!! We were/are one for all and all for one – very close. No one asked us anything – WHY???

People must be informed of their rights re information & legal representation prior to and during post mortem/inquest.

Police should be more accountable to next-of-kin in sudden death. Nothing should be taken at face value!!”

“Nothing will bring our son back, sadly! But we have a God-given right to know how he died!! No stone should be left unturned.”

“My comments here are about the first inquest, which I thought, was a joke. Ordinary people are kept completely in the dark; they don’t know where they stand. The police were of no help whatsoever. Until I went and sought advice my brother’s death would have remained an open verdict. It took nearly three years for a second inquest where we had legal representation in front of a jury, which brought back a verdict of unlawful killing. Until people are informed of their rights regarding inquests a lot of them are not going to get the justice they deserve. My family and myself were extremely distressed about the whole situation. The Coroner’s Office was unhelpful the police were atrocious and everyone else was almost useless. It is only through having a strong family that we actually got through the loss. Something needs to change in the whole system.”

“The aborted inquest came as a future cruel blow after the shattering cataclysmic tragedy of my youngest son. The reason being that such an abortion could have no other interpretation by the bereaved parent or person than being a deliberate intent of the ‘system’ via the Coroner to cover up yet another scandalous incident – by the NHS medics in this case – which has been my impression and view so far. Such a state of affairs drives any sane, law-abiding citizen to lose hope and trust in the establishment. I, for one, have now lost almost all confidence in the NHS as it stands. As to the inquest system it definitely requires a radical overhaul. To the extent of my own limited experience in this matter I strongly feel the need for a change of attitude whereby any citizen should be allowed personal access to meet a Coroner, even with the presence of one of his office clerks/assistants to eliminate any possibility of ‘bribery’ or influence of any kind being used to affect the Coroner’s upright course of action in the case. Secondly, whatever “independent” expert opinion the Coroner may obtain should be open to questioning and challenge. In my case this wasn’t so! As you will immediately see, my family has received a deadly blow, quite unduly and undeservedly, through the tragic loss of the youngest son then further blows from the harsh, unfair and in many ways archaic ‘system’ of justice. Particularly so it was when I tried to get the Coroner involved in examining my child’s death.”

“The case was held off until the CPS decided not to prosecute for involuntary manslaughter. A health & Safety prosecution is now underway.

1. Post mortems/organ retention:

No one said they would do or had retained the brain.

– Found out by accident when reading official notes of hearing later, saw in pm report.

– Can’t see why needed to retain when head injuries obvious.

– Can’t see why further pm tests not carried out for several months, some AFTER the hearing, and no results passed to Coroner anyway. Shows was all unnecessary – in any case, family should have been informed.

2. Juries:

Although there is a health and safety prosecution underway, because the death was on the highway (but not a motor accident) then the incident was not reportable to the health and safety authority. Since it was not reportable to the HSE, a jury was not compulsory. It feels therefore that the Coroner avoided a jury on a technicality. Seems a gap in the law, which should be plugged.”

“I experienced delay in receiving copy notes of evidence from Deputy Coroner. He withheld the documents that interested me most. On second application he again withheld documents. On third application he said that the police had them. I was compelled to ring the police who said they had to be cleared by their legal department. After some delay I did receive copies. (I have letters from Mr. A which admit the brevity of notification, that he would not allow me to speak.)

I was advised by the Citizen’s Advice Bureau to approach the University of Northumbria and two final year law students, under their supervising solicitor, did an excellent job but their findings

were that, in theory there was a good cause but in practice there are too many obstacles to get any redress. Although they have concluded the investigation into the Coroner, they are now investigating my complaint against Northumbria police.

I feel very strongly that it appears that Coroners are, in reality, unassailable and no matter how incompetent their actions there is no redress. From my own experience the way I was treated was appalling, there ought to be some sort of ombudsman appointed to monitor the performance of Coroners with the power to take them to task and, if possible, rectify the wrong doings. At present there seems to be those who are fully aware that they are immune from any redress and behave accordingly. In my case I wonder whether it was gross incompetence or a cover-up for the police.”

# INQUEST

United Campaigns for Justice

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ISBN 0 9468 5813 5 ● Registered charity No.1046650 ● Cover design: Andy Smith ([andymss@aol.com](mailto:andymss@aol.com)) ● Printed by Oldacres, London EC1

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