Who Investigates Sudden Deaths?
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"Children have very little voice, and the coroner's inquest is about Luke's voice, and making sure Luke is heard and respected and honoured. I don't want him to have died in vain."
Rosie Batty

In the first lecture in this lecture series, we talked about what happens when the state kills someone.

We talked about what we would want the state to do when it kills someone, and we contrasted that with what the state actually does.

Today we're going to go into more detail about death investigations.
- How would we want deaths to be investigated?
- How are they actually investigated in England and Wales?
- What is our system doing right, and what is it doing wrong?
- How could it be improved?

Setting the Scene

But, given the fact that the system appears to be very old. Let's set the scene by thinking about how we would want a system of death investigations to work. If we knew nothing about the existing system, and were designing a system from scratch, what would we want it to do?

First, we would want it to be independent. We would want to be confident that the people investigating the death are independent from the person or institution that caused the death – whether that is a private individual, a company, or a government agency.

We would also want to be confident that they are independent from the Government of the day and from party politics, so that there is no chance that they will be leaned on to cover up something that is inconvenient or embarrassing. It is important not just that they should be independent but that they should be seen to be independent.

Second, we would want those investigating the death to be competent and qualified.

We would want everyone involved to be properly qualified for their role, to understand their role, and to undertake regular training and keep up to date with the latest developments.

Third, we would want them to have adequate resources.

We would want them to have adequate staff and facilities to carry out a competent investigation. Where necessary, we would want them to bring in outside experts.
Fourth, we would want them to conduct a fair investigation. That means that everyone who has a legitimate interest in the investigation, including the family of the deceased, has a fair opportunity to participate in the proceedings.

We would expect the family to have a chance to put forward their views at each stage of the process. We would expect the process to be carried out according to consistent rules, so that everyone involves knows what to expect and what will happen at each stage.

Fifth, and finally, we would expect transparency. That doesn't mean that everything should be done in public. But it means that justice should be seen to be done, and that – in particular – the family of the deceased, and other people with a legitimate interest, should be told the truth about what is going on and should have the right to see the documents and the evidence.

With this in mind, so how does our system actually work? Is it fit for its purpose?

When a person is killed in England and Wales, the person with the primary responsibility for investigating the death is the coroner. Of course, coroners are not the only people who investigate deaths.

If a person dies in state custody, for instance, the Independent Office for Police Conduct or the Prison and Probation Ombudsman is likely to be involved.

If a suspicious death happens in a hospital, the NHS trust may do its own investigation and produce a Serious Untoward Incident report.

If there is a criminal investigation, the police and the CPS will be involved.

Some deaths are investigated by public inquiries. And so on.

Some death investigations are led by journalists where officials fail. Over the years there have been a number of very good investigative programmes which have taken up the gauntlet where officials have failed such as the World in Action BBC's Panorama and Channel 4 news.

Let us not forget about brave individuals and families who have conducted their own investigation when the state completely lets them down. I can think of many of my clients who would not rest despite the officials telling them there was nothing untoward with a death and they persisted and conducted their own investigation often at great personal costs.

The Sean Rigg family who examined the CCTV themselves which demonstrated that the official version that Sean Rigg had been looked at by the custody sergeant out in the police yard was patently and demonstrably false.

But coroners are the officials who have the primary responsibility for investigating sudden and unexplained deaths, and this lecture is going to focus mainly on them.

The History of the Office of Coroner

So, let's start by asking who actually investigates. I originally had the provocative title originally for this talk

"You're kidding me, we really use a judge who has been around for nearly 900 years to investigate sudden death?"

Is that true? Well yes, it actually is. The office of Coroner is so old even Chaucer makes reference to it:

"*lord and sire,*
Full often time was knight of the shire,
A schreve had been, and a Coronour:"

John Jervis on Coroners 1st edition 1829

So what exactly is a coroner? The office of coroner is the oldest judicial office in England and Wales, dating back to at least the 12th century. The office is mentioned as early as 1194.

Chaucer's coroner was a knight of the shire. The office of coroner was historically reserved for the landed gentry. Even in the 19th century, a coroner was expected to be a substantial landowner in the county. Like the rest of the English legal system, the office of coroner was created by and for the ruling class.

Originally the coroner had many duties, but over the centuries these were whittled away. In modern times, the coroner ended up with two main duties. First, to carry out inquests into sudden and unexplained deaths, and second, to inquire into cases of treasure that is found. The first of these is the one we are interested in for the purposes of this lecture.

Coroners have always been <u>local</u> officials. For centuries they were elected by the freeholders of a county. In the late nineteenth century, this was replaced with election by the county council. Coroners are still appointed and paid by local authorities today.

Coroners are judges, and they have judicial independence. But they are unlike most other English judges, because their role is inquisitorial rather than adversarial. They carry out investigations into sudden or unexplained deaths. They are assisted in their work by coroner's officers, who are normally either police officers or local authority staff on secondment. In some cases a coroner is required to carry out a formal proceeding in court, which is called an inquest, to decide how the deceased came by their death.

Inquests only happen in a minority of cases. The majority of deaths are never investigated by the coroner at all, and are simply certified by the doctor who was treating the deceased. Later in this lecture we will look at when a death has to be investigated by the coroner and when an inquest has to be held.

<u>The Personalities of Coroners</u>

I want to look at an important factor that shouldn't be underestimated: the personality of the individual coroner. Coroners have a lot of discretionary power over how the investigation is conducted.

Whether the coroner is caring and compassionate, or rude and hostile, has a huge impact on the bereaved family's experience. This is especially so when emotions run high in the courtroom. You can't be a good coroner unless you understand the trauma of bereavement. I want to give a couple of examples, both good and bad.

First a bad example. I was doing an inquest involving a death in custody, where the jury verdict came back with a result that was a big disappointment to my clients, the family. One member of the family got very upset, shouted and stormed out of the courtroom – a reaction we can all understand when we feel that our loved one's death has not been fairly investigated. The coroner promptly lost her temper and shouted at me. She blamed me for failing to "control" my client. She even threatened me, saying that I was going to be appearing before her in a few weeks on another inquest, and saying "I hope you control your clients, not like on this occasion." She shouted me down when I tried to respond to her. How do you think that made me – and more importantly, my clients – feel?

Compare and contrast that with the reaction of a different coroner when a mother, whose son had died of a drug overdose, got angry and started shouting during the evidence of a witness. The coroner allowed her to vent. Then he calmly said "Mrs X, I'm terribly sorry for your loss, I understand your frustration. Would you like a break now and we can resume in 10 minutes, or when you feel ready to come back into court?" That calmed her right down and she apologised. At the end of the inquest she felt that she was satisfied with the inquest process and had received a fair crack at justice.

The 21st Century and the Luce Report

Around the turn of the twenty-first century, there was a lot of criticism of the coronial system for a variety of reasons. The system was viewed as inefficient, outdated and fragmented. And there was a scandal arising from the failure to detect the activities of the GP and serial killer Harold Shipman in the 1990s, who killed over 200 patients before he was detected.

So, the Government commissioned two reports. It commissioned a report into the coronial system generally, which was known as the Luce Report after its chair Tom Luce. It also commissioned a separate inquiry into the Shipman case led by Dame Janet Smith.

The Luce Report was published in 2003. It identified a number of deficiencies in the coronial system. It commented on many deficiencies in the system, including:

- the lack of any supervision or national leadership for the coronial service;
- the lack of clear participation rights for bereaved families and the lack of standards for their treatment and support; and
- the lack of training for coroners and coroners' officers.

The Luce Report made six main recommendations. These were the following:

- First, there should be a national coronial service made up of full-time, legally qualified professionals. The report called for the creation of a Chief Coroner to lead the service. It called for coroners to be appointed by the Lord Chancellor, like other judges, rather than by local authorities. It also called for the introduction of an appeals process against coroners' decisions.
- Second, there should be a Family Charter that would set out the rights of families in the inquest process.
- Third, each coroner area should have both a legally qualified coroner and a doctor working as Statutory Medical Assessor, who would support the coroner in death investigations and would oversee death certifications by doctors in the area.
- Fourth, there should be a single process of death certification irrespective of whether the body is buried or cremated.
- Fifth, there should be more informative and accessible outcomes for inquests. The recommendations here included more flexibility over the scope of the inquest process, more involvement of the senior judiciary in exceptionally complex inquests, fuller conclusions from

inquests with a stronger bias towards narrative and preventive findings, and fairer and more consistent rules on disclosure.
- Sixth, a proper recognition of the work of coroners' officers and the provision of training for them.

One observation I want to expand on was that bereaved families have often had very limited opportunities to participate and have often been treated poorly.

A stark example is the inquest into the 1989 Marchioness disaster, where a riverboat sank on the River Thames. The coroner, famously, described the families of the victims as "mentally unwell" and "unhinged". He then refused to recuse himself, as a result of which the families brought a claim for judicial review, which ultimately succeeded.

This was not an isolated incident. Families have sometimes been treated with thinly disguised contempt throughout the death investigation process, from the beginning to the end.

As my late colleague Ian Macdonald QC said in 2001,

> *"I note the insensitivity and rudeness with which people are given news of their relative's death which is utterly inexcusable. There are not many social skills required to do something more with dignity."*

In more recent times, the European Court of Human Rights case law has guaranteed the bereaved family's right to participate in an Article 2 inquest. But there are still often huge barriers to meaningful participation by the family, which I will be expanding on later.

The then Labour Government did commit to acting on the Luce report. Harriet Harman delivered a blistering critique in the House of Commons in 2006. She said

> *"Under the current coroner service, families frequently get overlooked during the inquest process. There is nowhere for them to turn when they think that something is going wrong; there is no complaints system. The system is fragmented, with no national leadership, and it is not accountable. We have no overview of the system as a whole, or of individual cases. Moreover, the system is not properly accountable to this House, which it should be. Standards are not uniformly good; everything rests too much on the personal qualities and abilities of individuals within the system. The legal framework is downright archaic."*

But to cut a long story short, these proposals ended up being significantly watered down. The Labour Government brought forward a reform bill which became the Coroners and Justice Act 2009.

This Act went some way towards professionalising the coronial service, but not nearly as far as the Luce Report had advocated. It created an office of Chief Coroner as the Luce Report had recommended. But it did not create a national coronial service. Coroners are still appointed and paid by local authorities. And as we will see, many of the problems identified by Harriet Harman persist today.

How the Coronial System Works Today

So now we are going to talk about how the coronial system works today, under the 2009 Act.

Under the 2009 Act, there are three basic circumstances in which the coroner is required to investigate a death, which are very similar to those which applied before the 2009 Act. They are:

- If the deceased died a violent or unnatural death;
- If the cause of death is unknown; or
- If the deceased died in custody or state detention.

In some cases, a coroner has to hold an inquest, which is a formal judicial proceeding in court. Until the 2009 Act came into force in 2013, an inquest had to be held in every case where the criteria were satisfied.

Since 2013, the coroner now has power to discontinue the investigation without holding an inquest if the post-mortem examination has shown the cause of death and the coroner thinks that it is not necessary to continue the investigation.

However, the coroner still needs to hold an inquest in every case if the deceased died a violent or unnatural death or if they died in custody or state detention.

It's an incredibly important role because the coroner is essentially the state's investigator in sudden and unexpected deaths. A position that can be very sensitive, with organisations and also politically.

At first blush, an inquest looks a lot like a trial. It takes place in a courtroom, and witnesses are called to answer questions. But the difference is that a criminal or civil trial is adversarial, while an inquest is inquisitorial.

In a criminal or civil trial, the parties decide what witnesses to call and what evidence to put forward, while the judge is meant to be a neutral arbiter.

In an inquest, by contrast, it is the coroner who decides what witnesses to call and what evidence to consider.

An inquest is also unlike a trial in that, in theory, there are no "wins or victories" or "loses or defeats". Instead, the coroner, or the jury if there is one, decides on who the deceased was and how, when and where they came by their death. This is known as their "determination". As we discussed in the first lecture, the scope of the inquest varies according to whether the case is one that engages Article 2 of the European Convention on Human Rights. In a normal inquest, the task of the coroner is limited to deciding "by what means" the deceased came by their death, and it is not their role to apportion fault or blame. By contrast, in an Article 2 inquest, such as one where a person has died in state custody or at the hands of state agents, the House of Lords case of Middleton established in 2005 that the task of the coroner is now wider – they have to decide "in what circumstances" the deceased came by their death. That can include criticisms of state agents where the death could and should have been avoided.

There are a number of standard conclusions that coroners and juries normally use. These include death by misadventure (i.e. accident), suicide, lawful killing, unlawful killing, natural causes, and industrial disease.

In past centuries, all inquests took place with a jury. Most inquests now take place in front of a coroner without a jury, indeed there is a presumption against sitting with juries. But a few inquests still take place with a jury. A jury inquest is still required when a person dies in custody or state detention, and their death was violent or unnatural or the cause was unknown. It is also required where the death resulted from the acts or omissions of police officers in the purported execution of

their duty, and for notifiable accidents and diseases. A jury is not required for an Article 2 inquest if it doesn't involve a death in custody or at the hands of the police.

The 2009 Act as enacted by Parliament created a right of appeal to the Chief Coroner against decisions of coroners, as the Luce Report had recommended. But this provision was subsequently repealed under the coalition government, which came to power in 2010, without ever being brought into force.

So there is still no appeals process. Both before and after the 2009 Act, the only way to challenge judicial decisions of the Coroner during the course of an investigation or inquest is to apply for judicial review, which is cumbersome, difficult and expensive.

Has the 2009 Act Worked?

So, let's talk about whether the 2009 Act worked. From my perspective as an inquest practitioner, the 2009 Act did make some concrete improvements on the ground. The coronial service is now more professional and better trained. The Chief Coroner has a very important leadership role.

But there are still a lot of problems arising from the fragmentation and localisation of the coronial system. These include the following:

- First, there is a lot of variation between different local authorities as regards the quality of the coronial service. Some coroners have poor facilities and minimal staff. As "Unlocking the Truth", the report by INQUEST, explained, Coroners' Courts are frequently in particularly remote or badly served areas. Many have no refreshment facilities. One family member of a person who died said
  'The police had lunch laid on while we had to take ours with us or walk into town.'

  Many courts have no private waiting areas, so the family have to have private conversations in the corridor. INQUEST said that the lack of private space has been particularly distressing for families where they have had to wait or discuss their case in close proximity to people who they believe may have been responsible for the death. Unlocking the Truth was published before the 2009 Act, but this continues to be a problem in my experience after the 2009 Act.

- Second, in cases involving deaths at the hands of the state, families often feel that the coroner and the authorities are closing ranks against them. I will give you an example. I did a horrible case in the early 2000s where a child died in a police station. The family were understandably suspicious about the police's account of events. This of all cases was one which called for sympathy with the family. But when we got to court on the first day of the inquest, there were two rows of police officers outside the coroner's court, ostensibly providing security. The family had to walk into the court surrounded by these two rows of police officers. As you can imagine, that created a strong feeling that the system was closing ranks against them. That feeling was confirmed for them when the coroner was implacably hostile. Sometimes the very cases where the bereaved family is most traumatised are the cases where they are treated most poorly. And at times, the race of the deceased and the family can be seen to play a role in this.

- Another factor that contributes to this is that coroners' officers are usually police officers or local authority staff on secondment. This means that coroners do not have their own, independent investigators. It can create an appearance of lack of independence, particularly when the police or local authority were involved in the death that is being investigated.

- Third, there is a lack of consistency between different coroners as to how inquests are conducted. The law gives the coroner a wide discretion as to how to conduct the inquest. As Sir Thomas Bingham said in the case of Ex parte Jamieson in 1995, *'It is the duty of the coroner… to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedure to be followed.'*

- From my experience working with bereaved families, some coroners are very good and the family is very happy with them, while other coroners can be rude, hostile and downright unjust.

- Fourth, the appointment system lacks transparency. Coroners are appointed by local authorities, rather than centrally. It isn't as bad as it used to be, since coronial offices are now advertised. But there is still a perception that coroners are recruited from within a small circle. In Cornwall, for instance, a succession of members of the Carlyon family have held the office of coroner, going back to Victorian times. The current coroner is the daughter of the former coroner. This is not a criticism of the current or former coroner – but in the modern world the existence of a de facto hereditary office may well give rise to public concern. People may ask whether it is really likely that the best qualified person for the job happens to be the near relative of the last person to have the job.

- Fifth, the post-mortem process can be upsetting for families. Families are often provided little information about the post-mortem, and in some cases the use of invasive procedures may be contrary to the family's religious or cultural beliefs. One bereaved family member, quoted in INQUEST's report Unlocking the Truth, said
  'Sixteen months after he died I was informed that my son's organs (his brain, heart, lung etc) were sitting on a shelf somewhere. We were absolutely devastated, I kept my son's ashes at home so he was with us always but now I could no longer keep him at home because he wouldn't be complete. No ashes would come from his organs. So I had to arrange for him to be in a cemetery for his organs to be buried with his ashes. So all you go through with the first funeral, you have to go through it all with the second.'

I'm now going to talk about how we could improve the inquest process. And I'm going to start with a caveat. As we heard earlier, the office of coroner, like the rest of the English legal system, was created by and for the ruling class. It was historically filled by members of the landed gentry. Our legal system's main function for hundreds of years has been to protect the powerful and privileged, and it has done so very effectively. So when we try to reform and improve it, are we just putting lipstick on a pig? Are we wasting our time?

My answer is both yes and no. Reforming the office of coroner will not bring the fundamental social change we need. But it will make things better in the present moment for some bereaved families during the most terrible time of their lives.

So, what should we do? My view is that we should implement the Luce Report's recommendation and create a single, unified, independent national coronial service. The leadership role of the Chief Coroner should be strengthened, and a Deputy Chief Coroner should be created. Within the national coronial service, we should create a cadre of experienced senior coroners who deal with state-related deaths and other high-profile and difficult cases. And we should create a right of appeal to

the Chief Coroner against decisions of coroners during the course of an inquest or an investigation. The national coronial service should be supported by a permanent staff of coroners' officers who work directly for the coronial service, not for the police or local authorities.

And, perhaps most importantly, we need to centre the bereaved families in the inquest process.

Legal Aid

Any investigation of death and who conducts it cannot ignore the elephant in the room namely funding. The proper lack of legal aid funding is one of the most important problems in this area of law. In high-profile and controversial inquests, the institution responsible for the death – whether it is the police, the prison service, an NHS trust or a private company – is going to be represented by an expensive team of lawyers, usually headed by a Queen's Counsel.

Even though an inquest is theoretically inquisitorial rather than adversarial, powerful institutions frequently fight hard in the courtroom to absolve themselves of blame. Yet the family of the deceased does not have an automatic right to legal aid. Legal aid is normally means-tested, so they have to disclose information about their financial circumstances. Often, we have to fight hard for the family to get legal aid.

And there is a further problem which sometimes arises. In an inquest that engages Article 2 of the European Convention on Human Rights, such as an inquest where someone has been killed in state custody or by state agents, the family of the deceased may be able to get legal aid and, in some circumstances, the means test can be waived. But what if the family is dissatisfied with a decision the coroner has made, and wants to challenge it? In general, the only way to do that is to apply to the High Court for judicial review. And while there is legal aid for judicial review claims, there is no discretion to waive the means test.

So if the family is earning slightly too much to be eligible for legal aid, but not enough to pay for the litigation themselves, then they simply can't bring a challenge. Especially as, if they lose and they don't have legal aid, they could be ordered to pay the opposing party's costs, which may be substantial.

The charity INQUEST, which does great work with bereaved families, has been campaigning for years to have automatic, non-means-tested legal aid for families in all Article 2 inquests. I fully endorse that campaign. We need equality of arms and fairness for families, and the only way to achieve that is to ensure that families can have high-quality legal representation. And we also need to implement the Luce Report's recommendation for a right of appeal to the Chief Coroner, so that families can challenge decisions of coroners quickly and cheaply without having to go to the High Court.

Appointment of Coroners

We also need to look at the appointment of coroners. We need an open, transparent appointments system for coroners. This is not to say that the centralised appointments system for judges is working well.

I have frequently pointed out that appointments to the senior judiciary are still disproportionately white, male, privately educated, and from a narrow range of professional backgrounds.

We will be returning to that subject in a later lecture.

But while we need to reform judicial appointments generally, the appointment of coroners by local authorities is particularly unsatisfactory.

The Relationship Between Inquests and Inquiries

Another benefit of a national coronial service would be that it could take over the role currently performed by public inquiries. At present, where there is a particularly high-profile and/or large-scale death event, the Government will sometimes commission a public inquiry rather than having it investigated through the normal inquest process. In my experience, having been involved in a number of inquiries, there are some major problems with them.

- First, the chairman of the inquiry is appointed ad hoc by the Government. This can give rise to a perceived lack of independence.
- Second, the chairman largely makes their own rules as to how the inquiry will proceed. There is little consistency between different inquiries.
- Third, the family's opportunity to participate is often limited. The family's lawyers usually aren't allowed to question witnesses directly and the role of the family's lawyers is often more limited than in an inquest.

With a new national coronial service, and an expanded and improved inquest process, coroners would be able to handle even the most high-profile, complex and difficult cases.

A key advantage of this process over a public inquiry would be that the national coronial service would be completely independent from the Government, and the coroner who conducted the inquest would be nominated by the Chief Coroner and not by the Government.

In my view, this would be a better process than the current inquiry process.

Juries as Part of the Investigation Process at Inquests

> *"It takes courage to sit on a jury. How many of us want to decide the fate of another person's life or freedom? How many of us want to hold that kind of power in our hands?"*
>
> Regina Brett

Next, I want to talk about juries because in certain inquests ordinary people take a big role in death investigations. As discussed earlier, not every Article 2 inquest is held with a jury under the current system, although a jury inquest is held where someone dies in custody or at the hands of the police.

I would say that juries are an under-acknowledged strength of our justice system. My experience of juries is that they are better than you might expect at getting their heads around complicated facts. And they are also fairer than professional judges. I have appeared before many juries, in inquests, criminal trials and civil trials. My experience is that, in a case where the cards are stacked against you – for example, because you are going up against the might of the state – you are generally better off with a jury than with a judge.

There is some empirical evidence to support this. The Lammy Review, which investigated racial inequality in the criminal justice system, crunched the numbers and made the interesting finding that juries were not systematically biased against black and minority ethnic defendants. There was no

evidence of a racial disparity in juries' decisions to convict or acquit. This contrasted with sentencing, where there was a racial disparity in who got sentenced to prison, particularly for drug offences.

Obviously, this data relates to criminal trials rather than inquests. But my anecdotal experience suggests that the same is true in inquests. During my career I have appeared before some juries who were unafraid to make fearless criticisms of those in power. My view is that a jury inquest should be the norm in every Article 2 case.

Conclusion

So, let's sum up. Our coronial system has many strong points – it is better than the systems that many countries around the world have for investigating deaths. The role of the coroner as an independent judge is an important and valuable one. But it could be improved.

We need a national coronial service, led by the Chief Coroner. Coroners should be centrally appointed and paid and should be supported by a permanent professional staff. We need a right of appeal against decisions of coroners. We need to expand the role of juries. And most importantly of all, we need automatic, non-means-tested legal aid for every Article 2 inquest. If we can make these improvements, we will have a system of death investigations that is truly fit for the 21st century.

So, I am now coming to the end of this lecture. So, let me tell you an uplifting story.

It's a story about one of the best experiences in court I have ever had. I shall name and praise the coroner, his name is Mr Geraint Williams, and he was conducting an inquest in Worcester into the death of Mr Martin Green.

It was a horrible case where Mr Green had literally starved to death while in prison, and the prison staff ignored his condition.

Mr Green's young child, who was brought to court one day. At the end of the day the coroner invited the child into the court room after proceedings and sat the child on his lap.

This was in front of all the lawyers in court, representing eight or nine different interested parties. The child said, "Are you going to help find out what happened to my daddy?" The coroner said yes. He said, "all these people here are here to help find out how your daddy died."

The people in the courtroom couldn't keep themselves from crying. There wasn't a dry eye in court. That is an example of real compassion and human understanding.

Unfortunately, coroners do not always show this level of care, understanding compassion and human decency.

This is not an easy job. Although the following has been said of the US coroner, who is a bit like a pathologist in the UK, that:

"The easiest job in the world has to be coroner. Surgery on dead people. What's the worst thing that could happen? If everything went wrong, maybe you'd get a pulse."

Dennis Miller