

When Things Go Wrong

The response of the justice system

A Report by JUSTICE

Chair of the Committee
Sir Robert Owen



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- We bring people together to discuss critical issues relating to the justice system, and to provide a thoughtful legal framework to inform policy debate.

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EXECUTIVE SUMMARY

When a catastrophic event or systemic failure results in death or injury, the justice system must provide a framework to understand what happened and to prevent recurrence.

This Working Party of JUSTICE was established in recognition that the legal processes designed to fulfil these aims are too often beset with delay and duplication, with insufficient concern for the needs of those affected by disasters. Instead of finding answers through the legal process, bereaved people and survivors are often left feeling confused, betrayed and re-traumatised. The lack of formal implementation and oversight following the end of an inquest or inquiry makes the likelihood of future prevention limited.

Having sat for a year, this report records the 54 recommendations of the Working Party, which seek to ensure that the justice system's response when things go wrong is consistent, open, timely, coherent and readily understandable:

The framework for reform

Inconsistency is a problem for both inquests and inquiries. In the coronial jurisdiction, local authority control with little centralisation means that standards and practices can vary greatly. Meanwhile, the decision to establish a public inquiry is a political one and, at the outset, important practical decisions are made without drawing upon best practice from those with previous experience. The result is a lack of transparency and an unnecessary waste of time and resources. In order to increase coherence, we propose new State and independent bodies to provide oversight and facilitate information-sharing.

Duplication of process can cause anguish, delay and expense. We propose a full-time Chief Coroner role to provide greater oversight and a *special procedure inquest* for investigating mass fatalities as well as single deaths linked by systemic failure, able

to consider closed material and make specific recommendations to prevent recurrence.

Opening investigations

The opening of an investigation can be a disorienting experience for bereaved people and survivors. There is a stark discrepancy between the rights afforded to victims in the criminal justice system and bereaved people and survivors in inquests and inquiries. Further, a lack of coordination between agencies can mean that they can face multiple, repetitious interviews at the evidence-gathering stage. Greater collaboration between agencies is needed to reduce as far as possible the extent to which bereaved people and survivors have to recount traumatic events and to ensure that they are informed throughout the process.

Pre-Hearing Procedure

There is currently insufficient attention paid to the needs of bereaved people and survivors at the establishment of an inquiry. We consider that the processes for appointing inquiry chairs and panels, for establishing the terms of reference and for providing information and relevant documents to core participants need to be more structured and transparent. We build upon other recent JUSTICE working parties in recommending bereaved people and survivors are placed at the heart of the justice system by considering the impact of the physical environment and process on effective participation during the inquiry.

The duty of candour

Institutional defensiveness can impede the effectiveness of an inquiry or inquest, with a detrimental impact on participation and public confidence. We consider that a statutory duty of candour, which includes a rebuttable requirement for position statements, would help to foster a “cards on the table” approach. Directing the inquiry to the most important matters early on in the process could result in earlier findings and reduced costs.

Hearing procedure and practice

Bereaved people and survivors are not provided with adequate information, support and empathy during inquest and inquiry hearings. Drawing again on previous JUSTICE working parties on accessibility, we suggest professionals should attend training on appropriate communication techniques and support services be signposted before and after the hearing.

Other recommendations include modifying inquiry rules to allow core participants to question witnesses directly and for the widespread use of commemorative “pen portraits” as well as considering how inquests and inquiries could better provide therapeutic spaces for bereaved and survivor testimony, without the pressure of legal formalities.

Learning, accountability and systemic change

Effecting systemic change is a complex process. We conclude that an independent body should lead oversight and monitoring of the implementation of inquest and inquiry recommendations, whose review could aid scrutiny by parliamentary committees.

A system cannot provide justice if its processes exacerbate the grief and trauma of its participants. Our recommendations seek to ensure that inquests and inquiries are responsive to the needs of bereaved people and survivors, while minimising the delay and duplication that impede effectiveness and erode public confidence.

I. INTRODUCTION

Because we had never been involved in something like this, the inquiry was all a bit of the unknown. I suppose I had a sense that the aim of it was to get to how things happen and why things happen – but for us there was the fact that more than 70 people died that night, in our view essentially murdered. We were all about people being arrested and we didn't want any inquiry to hinder that. Natasha Elcock (Chair, Grenfell United).¹

- 1.1 An array of legal processes may flow from a single fatal event. The Hillsborough Stadium disaster of 15 April 1989 triggered two sets of inquests; a public inquiry; a non-statutory judicial “scrutiny”; and an independent panel, alongside a number of civil, criminal and regulatory actions.² At the time of writing, the public inquiry into the Grenfell Tower fire of 14 June 2017 is in its second phase,³ with inquests suspended, civil proceedings commenced overseas and pre-charge criminal investigations ongoing.
- 1.2 It is not only mass fatality events that demand a multi-faceted response from the justice system. The death of a new-born baby at HMP Bronzefield in September 2019 gave rise to eleven separate investigations, including an NHS clinical review, an inquest, and two police investigations in addition to an independent review by the Prisons and Probation Ombudsman (PPO).⁴
- 1.3 For those who survive or who are bereaved by fatal events, the encounter with the justice system in all its multiplicity may be overwhelming. They are likely to be faced with a situation wholly outside their experience, and may be bewildered or intimidated by the processes in which they find themselves.

¹ Cited in Tim Adams, “‘It’s a room of lawyers’: what have we learnt from the Grenfell Tower inquiry?” (*The Guardian*, 9 December 2018).

² For a comprehensive account, see Phil Scraton, *Hillsborough: The Truth* (updated edn, Mainstream Publishing 2016).

³ See the [Grenfell Tower Inquiry website](#).

⁴ Hannah Devlin and Diane Taylor, ‘Multiple inquiries ordered into death of baby in UK prison’ (*The Guardian*, 8 October 2019).

They may be deeply distressed and traumatised by the circumstances of the death of a victim, or by their own experience as a survivor. A graphic example was given to us of bereaved people being faced at an inquest into the death of a loved one by a rear view of a phalanx of lawyers debating the applicability of Article 2 of the European Convention on Human Rights (ECHR).

- 1.4 Yet the engagement of the justice system may provide hope: a means of getting to the bottom of what happened and ultimately, achieving justice:

Whenever a major tragedy occurs it engulfs and overwhelms those caught in the trauma of its aftermath. Ordinary people going about their everyday routines are suddenly ‘survivors’ or ‘the bereaved’. The shock of sudden death and the pain of survival are mind-numbing, debilitating... The law, the investigations, the inquiries, seem to operate in another world. As people struggle with bereavement and survival they assume that the investigative and legal process work for them, rather than against; they put their trust in the law.⁵

- 1.5 Too often this trust has been broken. Disaster survivors and those bereaved have been let down by the justice system. Major inquests and inquiries have taken far too long and have cost vast amounts of public money with little gain.

The erosion of public trust

Issue one: duplication and delay

- 1.6 Delays in achieving resolution can be attributed, in part, to separation between proceedings able to determine liability and those, such as inquests and inquiries, prohibited from so doing.⁶
- 1.7 The conventional approach has been that the adversarial process should precede an inquiry,⁷ so that criminal liability in particular can be established

⁵ Scraton, *supra* note 2, p. 176.

⁶ Coroners and Justice Act 2009, s. 10(2); Inquiries Act 2005, s. 2.

⁷ Cabinet Office Proprietary and Ethics Team, *Inquiries Guidance: Guidance for Inquiry Chairs and Sponsoring Departments* (undated), p. 6. See Scraton, *supra* note 2, p. 195: “The naïve assumption is

and the wider fact-finding inquisition may then proceed, unimpeded by questions of prejudice and self-incrimination. Complex cases, however, are rarely this straightforward. Where prosecutions fail, or where the political pressure on government to respond swiftly is overwhelming, the inquest or inquiry process may provide the initial (or possibly the only) means of establishing the full facts. Despite the aim being one of neutral investigation, there are competing interests, “bereaved and survivors will want [the inquiry] to act as a stepping stone for prosecution; just as accused will want to pre-emptively defend their position”.⁸ Yet an inquest or inquiry provides no guarantees as to future liability, even where it may uncover serious wrongdoing or systemic failure.⁹

1.8 The balance between the fair trial rights of the accused and the State’s obligation to conduct an adequate, independent, prompt and transparent investigation¹⁰ means that to some extent, the problem of multiple processes is

that if someone has died through the actions or inactions of another individual, a group or organisation or a dangerous procedure, then the adversarial courts will sort it out... This is a hopeful, but hopeless, counsel of perfection”.

⁸ Danny Friedman QC, ‘Inquests & Inquiries’ (JUSTICE Annual Human Rights Conference, October 2019), para 26.

⁹ The findings of public inquiries and inquests are neither binding, nor admissible, against any person in subsequent proceedings: *R (RJ) v The Director of Legal Aid Casework* [2016] EWHC 645 (Admin) at [26]; *Rogers v Hoyle* [2015] QB 265, 304 at [34]; and *Bird v Keep* [1918] 2 KB 692. However, a decision not to prosecute must be reviewed in the light of subsequent findings by an inquiry/inquest: *R v DPP ex parte Manning and Melbourne* [2001] 1 QB 330 at [33].

¹⁰ The “enhanced investigative duty” under Article 2 ECHR is engaged where death or life-threatening injuries occur in “suspicious circumstances”, namely where the State is or may be in breach of one of its substantive duties or where death occurs as a result of the criminal act of a non-State agent. Whatever form it takes, the case law has determined that the investigation must be “effective”, necessitating the following minimum procedural requirements:

- the initiative to begin the investigation must be taken by the State, not the individual;
- the investigation must be “adequate”, i.e. the authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident;
- the investigation must be carried out by an independent body or individual;
- it must be carried out with exemplary diligence and promptness;
- there must be a sufficient element of public scrutiny of the investigation or its results;
- the investigation must enable effective involvement of next-of-kin; and

intractable. Further, our consultation with bereaved people suggests that lengthy investigations are on occasion welcomed where length is perceived to correlate with thoroughness.¹¹

- 1.9 However, unnecessary delay and further anguish is caused by wasteful duplication. Multiple investigators may ask the same questions of the same witnesses. Public inquiries may follow inquests established to investigate the very same matters. Coroners may issue a series of Prevention of Future Death (PFD) reports, each making identical findings aimed at preventing recurrence. Inspired by the challenges facing the bereaved people and survivors of the Grenfell Tower fire, this project was originally conceived as a means of identifying how such duplication (and associated delay) might be avoided.

Issue two: barriers to effective participation

- 1.10 The erosion of public trust is not merely a product of multiple legal processes, and the duplication and delay that may result. The legal processes may *themselves* be retraumatising and alienating. Nominally inquisitorial processes pitch bereaved people and survivors into an unequal battle against State and corporate interested persons with vastly greater financial resources and knowledge of the process:¹² “an adversarial wolf in inquisitorial sheep’s clothing, to which the bereaved have to turn”.¹³

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- the investigation must be capable of imputing responsibility for the death; and (where appropriate) the identification and punishment of those responsible; and the identification of any shortcomings in the operation of the regulatory system.

¹¹ See INQUEST, ‘Family reflections on Grenfell: No voice left unheard (INQUEST report of the Grenfell Family Consultation Day)’, May 2019, p. 27 “[F]or all the frustrations the consensus from the groups was that a thorough and meticulous inquiry would best serve the families and future generations living in tower blocks”.

¹² Adams, *supra* note 1. Adams writes of a tacit assumption amongst officials that “when very bad things happen, those directly involved would sit somewhere like this, 18 months or two years down the line, in front of a polite QC and a retired judge and a bank of lawyers with box files... That understanding – that the horrific tragedy would lead inevitably, in the first instance, to a public inquiry – was not immediately grasped by the survivors of the Grenfell fire, or by the bereaved, whose mothers and fathers and sons and daughters and brothers and sisters were among the 72 who died”.

¹³ Scraton, *supra* note 2, p. 198.

- 1.11 In a 2018 submission, INQUEST – the leading charity on State-related deaths and their investigation – described the barriers bereaved families face in securing effective participation:

*Bereaved relatives’ trauma is often compounded by a systematic disregard for their needs and concerns, and the lack of information they are given about their legal rights in these processes. Families with whom we work, describe their shock at the adversarial, unsympathetic and defensive approaches deployed by corporate and state bodies.*¹⁴

- 1.12 This finding chimes with two reports published in 2017: the Right Honourable Dame Elish Angiolini DBE QC’s *Report of the Independent Review of Deaths and Serious Incidents in Police Custody*¹⁵ and the Right Reverend Bishop James Jones KBE’s *‘The patronising disposition of unaccountable power’: A report to ensure the pain and suffering of the Hillsborough families is not repeated* (“*Patronising Disposition*”).¹⁶ Both reports highlighted the difficulties faced by families in securing specialist advice on their rights; in gaining access to full and frank disclosure; in accessing public funding for legal representation at inquests; and in exposure to inappropriate, aggressive questioning during hearings.¹⁷
- 1.13 The barriers to effective participation identified by Dame Elish Angiolini and Bishop James Jones were reiterated by the bereaved people and survivors to whom we spoke at the scoping stage of our work. Institutional defensiveness was raised consistently: one consultee described the public sector response to the Grenfell Tower fire as an “impenetrable wall”. Yet this criticism was levelled not just at the behaviour of State core participants, but at the very architecture of the justice system. The lack of diversity in the Inquiry panel;

¹⁴ INQUEST, ‘INQUEST response to the Ministry of Justice Consultation on establishing an Independent Public Advocate’, December 2018, p. 3.

¹⁵ The Rt Hon Dame Elish Angiolini DBE QC, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (2017).

¹⁶ The Rt Rev Bishop James Jones KBE, *‘The patronising disposition of unaccountable power’: A report to ensure the pain and suffering of the Hillsborough families is not repeated* (HC 511, 2017).

¹⁷ We are indebted to the authors of both reports for providing such helpful material to draw upon and for their constructive engagement with this project.

the inability of bereaved and survivor core participants to ask questions of witnesses through their own lawyers; and the unsuitability of the Phase I hearings venue were invariably cited as threats to the legitimacy of the process and its ability to establish the truth.¹⁸

- 1.14 Recognising these concerns, the scope of this project expanded beyond the issue of duplication and delay. Recent JUSTICE working party reports have considered how users of the justice system experience its processes, recommending system-wide reforms to promote the effective participation of lay users.¹⁹ We were keen to apply this approach in the context of inquiries, in a renewed attempt to place bereaved people and survivors at the heart of the process.

Issue three: effecting change

- 1.15 The effective participation of lay users should serve as a primary objective in all jurisdictions. But inquests and inquiries play a unique function: they “offer to victims of suspected human rights abuse the promise of civil, criminal and broader social justice, which could not otherwise be readily achievable through ordinary litigation and/or parliamentary oversight”.²⁰ Inherent in this promise is the formulation of recommendations, directed at ensuring that a similar fatal event will never happen again.

- 1.16 However, as identified by the Institute for Government’s 2017 report *How public inquiries can lead to change*:

The formal checks and procedures we have in place to ensure that public inquiries lead to change are inadequate. There is no routine procedure

¹⁸ Concerns as to whether a State-led inquiry can serve the interests of bereaved people are not a recent phenomenon. In the very first intended inquiry under the Inquiries Act 2005, the family of Pat Finucane declined to take part due to concerns about the inherent lack of independence of the Chair. See Peter Watkin-Jones and Nicholas Griffin QC, ‘Public Inquiries: Getting at the Truth’ (*Law Gazette*, 22 June 2015), p. 22.

¹⁹ See in particular, JUSTICE Working Party report, *Understanding Courts* (2019). See also JUSTICE Working Party report, *Mental Health and Fair Trial* (2017); and JUSTICE Working Party report, *What is a Court?* (2016).

²⁰ Friedman QC, *supra* note 8, para 2.

*for holding the Government to account for promises made in the aftermath of inquiries, the implementation of recommendations is patchy, in some cases repeat incidents have occurred and there is no system for allowing inquiries to build on the learning of their predecessors.*²¹

- 1.17 Our evidence gathering suggested that this is of great concern to bereaved people and survivors. The hope that others will not have to endure near-death experiences, or the deaths of loved ones in similar circumstances, is consistently dashed when PFD reports and inquiry recommendations are not implemented.
- 1.18 JUSTICE’s expertise as a law reform and human rights organisation dictated that our principal focus would be the justice system’s response to catastrophic death. However, thorough interrogation of this concern obliged us to consider the outcome of the “legal” process, especially the framework for implementation.

Methodology and scope

- 1.19 The Working Party set out to consider the three overarching issues outlined above. We aimed to arrive at practical recommendations to ensure that inquiries into fatal events are more efficient, more humane and more likely to precipitate lasting change.
- 1.20 Following the scoping phase, the Working Party was convened in June 2019. Its work was initially supported by three sub-groups, engaging collectively with the first two issues explored above:
- i. *Conceptual framework and investigative coherence* (chaired by Sir John Goldring);
 - ii. *Public engagement* (chaired by Deborah Coles); and
 - iii. *Practice reform* (chaired by Martin Smith).

²¹ Emma Norris and Marcus Shephard, *How public inquiries can lead to change* (Institute for Government, 2017), pp. 3-4.

In order to address the issue of how inquiries can lead to change, a final sub-group was convened in April 2020:

iv. *Learning, accountability and systemic change* (chaired by Ken Sutton).

1.21 We were committed by our terms of reference to consider institutional processes in other jurisdictions. We are grateful to our corporate partner Morrison & Foerster LLP, whose lawyers prepared a comparison of the inquiry structures and processes in 21 countries across five continents. This research helped to contextualise and set the agenda for the Working Party’s discussions.

1.22 The Working Party was faced with the initial, and taxing, task of addressing a fundamental question: what class of case fell within its scope? Some 30,000 inquests are established each year.²² The issues explored above do not affect the great majority of these. Equally, we were conscious of the breadth of the subject matter of public inquiries, capable of investigating a range of concerns “from the actions of Harold Shipman in murdering his patients, to the management of foot and mouth outbreaks in agriculture”.²³

1.23 Conscious of our initial commitment to explore duplication between *inquests and inquiries*, we limited our consideration to **the justice system’s response to multiple fatalities and to single deaths arising from a systemic pattern of failure**. This is reflected in the ambit of our proposed *special procedure inquest* (see **paras 2.40-2.85** and **Annexe**).

1.24 However, we are conscious that many of the barriers to participation identified above apply to inquiries into serious non-fatal harms such as near-death; sexual abuse²⁴, human trafficking and most recently harmful side effects from

²² Ministry of Justice, ‘[Coroners Statistics Annual 2019 England and Wales](#)’ (14 May 2020).

²³ Dr Karl Mackie CBE, ‘Public Inquiries: Proposals for a design rethink’ (Centre for Effective Dispute Resolution, 2012).

²⁴ A number of our members are involved in the Independent Inquiry into Child Sexual Abuse (IICSA). With hearings ongoing, this large-scale inquiry provided us with a useful point of comparison and is referenced throughout this report.

medicines and medical devices.²⁵ Recognising that the State's enhanced investigative duties arising under Articles 3 and 4 ECHR are of a very similar nature to those arising under Article 2,²⁶ we consider that a number of our recommendations will have broad application beyond investigations into fatalities.

²⁵ Baroness Cumberlege, *First Do No Harm – The report of the Independent Medicines and Medical Devices Safety Review*, (July 2020): *We have found that the healthcare system...is disjointed, siloed, unresponsive and defensive. It does not adequately recognise that patients are its raison d'être. It has failed to listen to their concerns and when, belatedly, it has decided to act it has too often moved glacially. Indeed, over these two years we have found ourselves in the position of recommending, encouraging and urging the system to take action that should have been taken long ago*, at p. ii.

²⁶ On the State's investigative obligations under Article 3 ECHR, see *Commissioner of Police of the Metropolis v DSD and another* [2018] UKSC 11.

II. THE FRAMEWORK FOR REFORM

*The suggestion of a single Disaster Court to find the facts, make recommendations and establish civil and criminal liability would be unworkable...Lord Justice Clarke.*²⁷

*The hole in the heart of these proceedings, the question about the British legal system looming over every miserable day for the families, was why it allows and requires this: established truths, determined by a jury on comprehensive evidence given on oath in front of a senior judge, erased and up for grabs again. David Conn.*²⁸

- 2.1 Many of the problems outlined in **Chapter I** are products of inconsistency. In coroners' courts, which are funded and administered by local authorities, standards and practices vary greatly.²⁹ Meanwhile, those tasked with establishing and managing public inquiries have adopted markedly varied approaches to important practical tasks such as sourcing venues, procuring the necessary infrastructure and appointing chairs.³⁰ Although the Working Party accepts that public inquiries require a degree of flexibility in order to address the wide range of events that have caused (or are capable of causing) "public concern",³¹ failure to capture and emulate best practice clearly comes at the expense of both time and the public purse.
- 2.2 Further, whether a public inquiry is established to investigate a fatal event is something of a political lottery, entirely dependent on the "very broad" discretion enjoyed by a Minister.³² Yet the type of investigation opened has a

²⁷ Department of the Environment, Transport and the Regions, *Thames Safety Inquiry: Final Report by Lord Justice Clarke* (Cm 4558, 2000), para 13.25.

²⁸ David Conn, 'How David Duckenfield's trial left Hillsborough families distraught again' (*The Guardian*, 28 November 2019).

²⁹ HHJ Mark Lucraft QC, *Report of the Chief Coroner to the Lord Chancellor, Fifth Annual Report: 2017-2018* (2018), see paras 15-16.

³⁰ Select Committee on the Inquiries Act 2005, *The Inquiries Act 2005: post-legislative scrutiny* (HL 2013-14, 143), see paras 113-193.

³¹ Inquiries Act 2005, s. 1.

³² *R (Marina Litvinenko) v Secretary of State for the Home Department* [2014] EWHC 194 (Admin) [75] (Richards LJ).

significant effect on participation,³³ with inquests and inquiries each holding perceived advantages and drawbacks. An inquest provides the opportunity for questioning of witnesses by one's own legal representative.³⁴ In some circumstances it will give rise to a duty or discretion to empanel a jury,³⁵ an element of the inquest process viewed favourably by all the bereaved people we consulted. It also may be perceived as an investigation wholly independent of Government. However, a public inquiry allows for broader scope, opening and closing addresses (where core participant status is granted)³⁶ and, perhaps most significantly, statutory funding for legal representation.³⁷

- 2.3 In order to maximise consistency (both in standards and in the type of investigation established), enhance participation and reduce duplication, this chapter explores how inquiries are established and managed and the effective operation of the coronial system.

Establishing public inquiries

- 2.4 Public inquiries are established to investigate some of the most traumatic events to which the public is subjected. However, until recently, there has been no central source of information that inquiry chairs and teams, alongside the general public, might turn to in order to find out how such an inquiry should be established and managed.³⁸ Previous experience has not been routinely captured. When the House of Lords Select Committee on the Inquiries Act 2005 “asked the Ministry of Justice for copies of the lessons learned papers for

³³ See Clive Coleman, ‘London fire: Inquest versus inquiry’ (BBC, 2017) and INQUEST, ‘INQUEST Statement on the Grenfell Tower Fire’ (16 June 2017).

³⁴ The Coroners (Inquests) Rules 2013, r. 19.

³⁵ Coroners and Justice Act 2009, s. 7.

³⁶ The Inquiry Rules 2016, r. 11.

³⁷ Inquiries Act 2005, s. 40.

³⁸ Norris and Shephard, *supra* note 21, p. 5.

inquiries under the 2005 Act [they] were astonished to be told that the Cabinet Office held only one, [that] for the Baha Mousa Inquiry”.³⁹

- 2.5 Without a formal mechanism for capturing past learning, inquiry chairs and secretaries have largely had to depend on word-of-mouth advice. We agree that to “start from scratch ... is ultimately a waste of both financial and non-financial resources, and causes delay to the progress of the Inquiry and possibly to the effectiveness of some Inquiries”.⁴⁰
- 2.6 The Cabinet Office has in the past issued ‘Inquiries Guidance’,⁴¹ intended as a guide for inquiry chairs and secretaries. However, this document is difficult to find, undated (although it is thought to have been published in 2012),⁴² and remains watermarked as a draft. Its utility was questioned by the Lords Select Committee, finding that the section of the Guidance aimed at inquiry teams contained “much about what needs to be done, but very little about how to do it”.⁴³ It is not clear when the Guidance was last updated.
- 2.7 We understand that work is underway within the Cabinet Office to review the Inquiries Guidance and to ensure that effective advice and support on best practice is provided both to Departments considering the announcement of an inquiry and to inquiry teams. We encourage the Cabinet Office to be ambitious and give effect to the various calls made over the years **to establish a dedicated Central Inquiries Unit**. Below we outline our recommendations for the location, composition and functions of such a unit.

³⁹ Select Committee on the Inquiries Act 2005, *supra* note 30, para 162.

⁴⁰ Dr Karl Mackie CBE and Frederick Way, *Setting Up and Running a Public Inquiry: Guidance for Chairs and Commissioning Bodies* (Centre for Effective Dispute Resolution, 2015), p. 72.

⁴¹ Cabinet Office Proprietary and Ethics Team, *supra* note 7.

⁴² Select Committee on the Inquiries Act 2005, *supra* note 30, para 157.

⁴³ *Ibid*, para 159.

A Central Inquiries Unit

Location and independence

- 2.8 A fundamental question relating to the establishment of any inquiries unit is whether it should be located within Government. The legitimacy of any office or role advising on the opening and management of an inquiry will depend on the degree of independence from the Government Department sponsoring or giving evidence in that investigation.
- 2.9 The Institute for Government told us that, when formulating its recommendation as to an appropriate host for the inquiries unit, initially a non-departmental public body (NDPB) such as the Equality and Human Rights Commission (EHRC) was considered. Another viable alternative suggested to us includes the part-time appointment of a retired individual with requisite experience and seniority to advise on the management of new inquiries.
- 2.10 The need for independence, however, must be balanced with the requirement for sufficient influence, funds and administrative capacity. If an inquiries unit is housed outside the executive in a NDPB, NGO or similar, Government may choose to ignore its advice with little consequence. The part-time appointment of a retired individual may formalise the existing system of word-of-mouth advice, but in the view of the Working Party could not provide a comprehensive repository of information, nor the up-to-date practice experience required to formulate and update relevant guidance.
- 2.11 Most proposals for an inquiries unit therefore envisage a small team positioned within Government, distanced from sponsoring Departments but with sufficient “pull” to exert influence. In its report *Government by Inquiry*, the Public Administration Select Committee (PASC) suggested a “central government department such as the Cabinet Office or the Department for Constitutional Affairs”⁴⁴ while the Lords Select Committee recommended that basing the unit within Her Majesty’s Courts and Tribunals Service (HMCTS)

⁴⁴ Public Administration Select Committee, *Government by Inquiry* (HC 2003-4, 51-I), para 161.

would “give it access to all the necessary expertise and at the same time give it the necessary degree of independence”.⁴⁵

- 2.12 The Institute for Government recommend that the unit should be housed within the Cabinet Office.⁴⁶ This recommendation was partially premised on the fact that the Cabinet Office is less vulnerable to change or dissolution than other Departments. The Cabinet Office, with its largely inward-looking remit, is also ostensibly less likely to be implicated in the course of an inquiry.⁴⁷ The Working Party agrees that the Cabinet Office is an appropriate location for these responsibilities and will provide the right balance of influence and insulation.
- 2.13 However, in order to enhance independence and the quality of decision-making, we recommend that **a Central Inquiries Unit is supported by an Independent Advisory Board.** The Ministerial Council on Deaths in Custody, with its multi-tiered structure, provides an instructive model.⁴⁸ **The Board should include representation from bereaved people and survivors of catastrophic events. Membership of the Independent Advisory Board should be published.**
- 2.14 Appointments to the Independent Advisory Board should be determined through open competition, administered by the relevant team in the Cabinet Office. As with appointments to the Judicial Appointments Commission, there should be a set quota for the number of seats allocated to each professional grouping. Groups represented on the Board should include former inquiry chairs; retired civil servants/public officials; NGO or frontline representatives; legal practitioners; academics; and “lay” members, with appropriate representation of race and gender.

⁴⁵ Select Committee on the Inquiries Act, *supra* note 30, para 172.

⁴⁶ Norris and Shephard, *supra* note 21, p. 33.

⁴⁷ This may not always follow. Having replaced the Department of Health and Social Care as the sponsoring department for the Infected Blood Inquiry precisely because of the perceived conflict of interest, the Cabinet Office was obliged to issue a formal apology in October 2018 for its failure to ensure that other Government Departments did not destroy material relevant to the inquiry. See Brian Williams, [Letter to Brian Stanton](#) (18 October 2018).

⁴⁸ The Ministerial Council on Deaths in Custody consists of three tiers: a Ministerial Board on Deaths in Custody; an Independent Advisory Panel (IAP); and a Practitioner and Stakeholder Group.

Staffing

- 2.15 Staffing the unit with full-time officers would enable it to accrue institutional memory and secure a degree of permanence. We consider that a complement of five full-time staff members is sufficient to counteract the effect of civil service “churn”.⁴⁹
- 2.16 PASC recommended that the staff in a Central Inquiries Unit include “secondees from bodies versed in investigatory processes such as the NAO, the Ombudsmen community and Select Committee staff”.⁵⁰ Previous investigatory experience may well be a desirable quality for those recruited to the office.
- 2.17 As an advance on PASC’s recommendation, the Working Party recommends that **at the close of a public inquiry or special procedure inquest** (see paras 2.40-2.85 and Annexe), **members of the inquiry/inquest team should be seconded to the Central Inquiries Unit for between six and twelve months in order to share recent experience.** This would allow Government to learn iteratively from the successes and failures of recent inquiry processes. Secondees should be drawn from members of the inquiry/inquest team who are sufficiently senior to have exercised broad oversight of the process.
- 2.18 This recommendation would serve to address a collateral issue. One consultee considered that Government has “not been great at understanding the strength of [inquiry team members’] experience and finding them ‘normal’ jobs” at the close of an inquiry”. This dynamic may be exacerbated by perceived conflicts of loyalty. In evidence to *Government by Inquiry*, Dr Tim Baxter noted that where “you move to be secretary to a judicial inquiry, your primary loyalty is to the chairman of that inquiry [but] there are tensions because one is dealing from time to time with colleagues back in one’s own department and you have

⁴⁹ The term used in Whitehall to describe frequent movement within or between Departments. See Tom Sasse and Emma Norris, *Moving On: The costs of high staff turnover in the civil service* (Institute for Government, 2019), p. 8.

⁵⁰ Public Administration Select Committee, *supra* note 44, para 161.

to remember where your primary loyalty is”.⁵¹ We anticipate that building in a “buffer period” of secondment immediately following a public inquiry could provide members of the inquiry team with some certainty of destination and lessen the chances of them finding themselves in an invidious position on return to their “home” Government Department(s).

- 2.19 We recommend that **Civil Service Human Resources works to ensure that such a period is recognised as a valuable element of civil service career progression.**

Functions

- 2.20 While the Working Party does not consider that the Cabinet Office’s responsibilities in this area could or should eclipse the role of individual inquiry teams, we think that the **Central Inquiries Unit should advise inquiry secretariats on best practice** in the set up for both public inquiries and our recommended *special procedure inquest* (see **paras 2.40-2.85** and **Annexe**). This will involve **updating and maintaining publicly available ‘Inquiries Guidance’** for use by sponsoring Departments, chairs and inquiry teams.
- 2.21 We consider that the Central Inquiries Unit should also have a role in **ensuring that “lessons learned” papers are completed by inquiries secretaries and that it should analyse and disseminate core findings from completed lessons learned papers.**
- 2.22 We also consider that the Central Inquiries Unit would be particularly well-placed to **conduct standardised procurement exercises**, obtaining a set of contracts covering, *inter alia*, electronic systems for document management and transcription of live evidence before the establishment of any particular inquiry. This would help avoid the inconsistency of approach that has beleaguered previous inquiries, with some having “bought new custom-made

⁵¹ Public Administration Select Committee, *supra* note 44, para 160.

IT systems costing millions of pounds more than the systems used by other inquiries of comparable length”.⁵²

2.23 Along with the ‘Inquiries Guidance’, **the Central Inquiries Unit should provide a repository of chairs’ reports, lessons learned papers, statements of values and procedural protocols from previous inquiries, as well as retaining a database of previous secretaries and solicitors.**

2.24 The storage and provision of information should benefit not only those tasked with establishing and managing inquiries. CEDR’s report envisaged an “Independent Inquiries Office could be a go-to resource for members of the media, researchers and the public to find out about past Inquiries”. We agree that **the Central Inquiries Unit should have a public-facing role, taking questions from the media and ensuring that the information it compiles is held on a publicly accessible, clearly structured website.** The House of Commons Library, an independent research and information unit providing impartial information for MPs and their staff, serves as an instructive comparator.⁵³

Coroners and the Office of the Chief Coroner

Local authority administration

2.25 Coroners and their officers provide a service that is operated and administered at a local level. While coroners’ services nationally are underpinned by a statutory framework under the Coroners and Justice Act 2009 (“the 2009 Act”), each coroner is appointed, paid and their service funded by the relevant local authority.⁵⁴

⁵² The Lords Select Committee likewise recommended that beyond the storage of archival material, the unit should be “responsible for all the practical details of setting up an inquiry, whether statutory or non-statutory, including but not limited to assistance with premises, infrastructure, IT, procurement and staffing”. See Select Committee on the Inquiries Act, *supra* note 30, para 174.

⁵³ See the [House of Commons Library website](#).

⁵⁴ HHJ Peter Thornton QC, ‘[The Coroner System in the 21st Century](#)’ (Howard League for Penal Reform Parmoor Lecture, 25 October 2012).

- 2.26 There are 88 coroner areas in England and Wales, roughly mirroring the boundaries established by local authority districts.⁵⁵ Section 24 of the 2009 Act requires the relevant authority to provide “whatever officers and other staff are needed by the coroners for that area to carry out their functions” and to provide accommodation that is “appropriate to the needs of those coroners” (although these requirements apply only where the relevant police authority does not provide such officers and staff).⁵⁶
- 2.27 There are advantages associated with the local authority-administered structure. One practical benefit is that unlike public inquiries, coroners’ investigations and inquests are not seen as “an expensive anachronism in the eyes of a cost-conscious central government”.⁵⁷ Adherence to tight local authority budgets and sharing of facilities with police forces has meant that local coroner services have evolved organically, without recourse to central funds. Coroners may also acquire considerable local knowledge and understanding.⁵⁸ Our consultees confirmed our experience of local coroners bringing to bear their knowledge of previous, similar cases from within the local area.
- 2.28 The 2009 Act marked a significant restructuring of the system. Adopting many of the recommendations in the Luce and Third Report of the Shipman Inquiry⁵⁹ reports, it instituted the Chief Coroner as a new national head of the system,⁶⁰ introduced the new concept of “investigations” into deaths;⁶¹ reduced the

⁵⁵ Ministry of Justice, ‘Coroners Statistics Annual 2019 England and Wales’ (14 May 2020).

⁵⁶ See also Explanatory Notes to CJA 2009, para 221.

⁵⁷ Stephen Sedley QC, ‘Public Inquiries: a Cure or a Disease?’ (1989) 52 MLR 469, 472.

⁵⁸ See *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* chaired by Tom Luce (Cm 5831, 2003), p. 180, para 15.

⁵⁹ Dame Janet Smith DBE, *The Shipman Inquiry Third Report: Death Certification and the Investigation of Deaths by Coroners* (Cm 5854, 2003), pp. 21-22.

⁶⁰ Coroners and Justice Act 2009, s. 35 and sch 8.

⁶¹ *Ibid*, s. 1.

number of coroner areas;⁶² and moved towards a system of full-time and legally qualified coroners.⁶³

2.29 The Chief Coroner provides judicial oversight of the coroner system, with responsibilities including the provision of support, leadership and guidance for coroners; setting national standards, developing training; approving all future coroner appointments; keeping a register of coroner investigations lasting more than 12 months and taking steps to reduce unnecessary delays; directing coroners to conduct investigations; providing an annual report on the coroner system to the Lord Chancellor; and collating, publishing and monitoring PFD reports.⁶⁴ To date, the two Chief Coroners in post have issued 39 detailed Guidance documents and five ‘Law Sheets’,⁶⁵ a significant body of work to standardise practice across the system.

2.30 However, in her 2017 Independent Review of Deaths and Serious Incidents in Police Custody, Dame Elish Angiolini found that “while the introduction of the role of Chief Coroner is a significant advance for the system... inconsistencies in approach are inevitable while the system remains fragmented”.⁶⁶ Dame Elish found significant variation in the standard of coroners’ decision-making;⁶⁷ a lack of uniformity in the ways that coroners are resourced and supported;⁶⁸ and that the service is “largely dependent on a ‘grace and favour’ relationship with other agencies (some Coroners report even relying on other agencies to help with photocopying for disclosure at inquests).”⁶⁹

⁶² *Ibid*, s. 22 and sch 2.

⁶³ *Ibid*, s. 23 and sch 3.

⁶⁴ Chief Coroner of England & Wales, ‘The Chief Coroner’s Guide to the Coroners and Justice Act 2009’, 2013, para 8.

⁶⁵ See ‘Chief Coroner’s Guidance, Advice and Law Sheets’, Courts and Tribunal Judiciary.

⁶⁶ Angiolini, *supra* note 15, para 16.68. The report renewed the recommendation for a National Coroner Service, see para 16.78.

⁶⁷ *Ibid*, para 16.72.

⁶⁸ *Ibid*, para 16.12.

⁶⁹ *Ibid*, para 16.14.

- 2.31 Our consultees confirmed this impression of the system. Some concerns were practical: we were told that the Gwent Coroner Service does not have an email system for the receipt of documents. Other concerns related to sufficient expertise, with particular anxiety in relation to local coroners without requisite experience presiding over complex Article 2 ECHR inquests involving issues of systemic failure. We note, in contrast, the convention in the criminal jurisdiction, where judges are authorised (“ticketed”) to hear cases of escalating seriousness.⁷⁰
- 2.32 We heard further concerns regarding open justice. PFD reports have only been published online since 2013. Further, narrative conclusions are not compiled or published in an accessible form, despite the fact that a majority of inquests do not produce PFD reports and so narrative conclusions play an important role in highlighting systemic failures.⁷¹

Oversight of the coroner system

- 2.33 The Working Party recognises that the introduction of a national coroner service may have significant benefits for allocation of resourcing and consistency of standards. We note that even the current Chief Coroner is of the view that “there remain some problems with a local as opposed to a national coroner system”,⁷² despite moves toward a more judicial service.
- 2.34 A recommendation to create a national service capable of accommodating all deaths reported to coroners and all inquests (in 2018, 210,900 and 30,000 respectively)⁷³ lies beyond our scope (see **Chapter I, paras 1.19-1.24**). We suggest that the issue of centralisation should be kept on the agenda and note that the Government is yet to publish its response to post-legislative

⁷⁰ Criminal Practice Directions 2015 Division XIII Listing, D: Authorisation of Judges.

⁷¹ As a consequence, INQUEST maintains its own record of narrative conclusions from the cases it is involved in.

⁷² HHJ Mark Lucraft QC, *supra* note 29, para 20.

⁷³ Ministry of Justice (2020), *supra* note 22.

consultation, due in “early 2016”.⁷⁴ However, recognising the concerns raised in previous reviews and by our consultees around inconsistency of service and practice, we make three recommendations aimed at oversight and transparency of the coronial system.

2.35 First, we recommend that the position of **Chief Coroner be made a full-time appointment**, as envisaged by Luce in 2003.⁷⁵ The current Chief Coroner has combined this role with sitting as a Senior Circuit Judge at the Central Criminal Court and has recently been appointed Recorder of London.⁷⁶ The Working Party appreciates that combining the role with sitting duties may make the appointment attractive to a number of able candidates. However, given the decision-making, oversight and advisory role we envisage for the Chief Coroner in the *special procedure inquest*, we consider that a full-time appointment is highly desirable so that the Chief Coroner’s duties are not compromised. The role has been universally recognised by our consultees as valuable in giving leadership to the jurisdiction, driving up standards and providing public information through annual reporting. Moreover, the Chief Coroner presides over inquests at least as serious and complex as murder cases tried in the Old Bailey.

2.36 Second, in the light of the Working Party’s concern regarding considerable variation in standards, we recommend the **establishment of a small Coroner Service Inspectorate**. This recommendation once again develops a proposal in Luce’s 2003 *Fundamental Review*:

⁷⁴ Ministry of Justice, ‘Post-implementation review of the coroner reforms in the Coroners and Justice Act 2009’, 2015.

⁷⁵ *Death Certification and Investigation in England, Wales and Northern Ireland*, *supra* note 61, p. 186 para 51.

⁷⁶ See Lord Chief Justice of England and Wales, ‘Recorder of London appointed’, (Courts and Tribunals Judiciary, 8 April 2020). The Lord Chief’s announcement confirms that “Judge Lucraft QC will take on some of the responsibilities of leadership at the Old Bailey with immediate effect. However, in the light of pressures on the coronial system as a result of the current pandemic, Judge Lucraft QC will remain in post as the Chief Coroner. He has agreed to do so over the coming months and this dual role will be kept under review”.

Its concern would be with timeliness of process, standards and suitability of the physical environment and the provision of prompt and clear information to families. The inspectorate could also examine complaints made by members of the public and could deal with those complaints which cannot be resolved by the area coroner.⁷⁷

The Working Party considers this to be a workable proposal. It would also strengthen implementation of our recommendations as to early communication with bereaved people (see **Chapter III, paras 3.31-3.37**), their ability to make administrative complaints (see **Chapter III, para 3.5**) and suitability of hearing venues (see **Chapter IV, paras 4.23-4.28**).

2.37 Luce recommended that such an Inspectorate would require only six people. Given the moves toward fewer coroner areas and the work already undertaken by the Chief Coroner in producing annual reports for the Lord Chief Justice, the Working Party considers that this number is sufficient.

2.38 Although we recognise that implementation of this recommendation would necessitate some expenditure of central funds, we note that such an inspectorate function was to be discharged by HM Inspectorate of Court Administration (HMICA).⁷⁸ On the abolition of HMICA in 2011, the Government stated its commitment to “joint inspection of the criminal justice system”.⁷⁹ No such commitment was made to the coronial system. Implementation of this recommendation would fill a sorely needed gap in quality control.

2.39 Third, the Working Party recommends that **the Office of the Chief Coroner should explore how best to compile and publish narrative conclusions online where those conclusions highlight systemic failings**. We appreciate that this task will involve providing some context for each conclusion and so may be more resource-intensive than simply uploading text.

⁷⁷ *Death Certification and Investigation in England, Wales and Northern Ireland*, supra note 58, p. 176.

⁷⁸ Coroners and Justice Act 2009 (as enacted), s. 39.

⁷⁹ Ministry of Justice, ‘[Impact Assessment: Abolition of HM Inspectorate of Court Administration, IA No: MoJ 118](#)’, 2011, p. 4, para 7.

Special Procedure Inquest

- 2.40 Our recommendations for a Central Inquiries Unit and the expansion of the Office of the Chief Coroner will contribute to improving the establishment and management of inquests and inquiries. However, neither will address the duplication of process across inquests and inquiries, nor the inability of inquests to investigate multiple asynchronous deaths, causatively linked by systemic failure.
- 2.41 As such, **the Working Party recommends the establishment of a new *special procedure inquest***, in order to investigate both mass fatalities and single deaths causatively linked through systemic failure. It is a “fused” model, combining what we consider to be the most successful features for effective participation of inquests and public inquiries.
- 2.42 We are grateful to Sir Peter Thornton QC for leading development and adaption of the model over the life of our work.

Duplication of process

- 2.43 Under Schedule 1 of the 2009 Act, a coroner must suspend an inquest when requested by a prosecuting agency on the grounds of a potential criminal charge;⁸⁰ where they become aware that a person has been charged with a homicide offence involving the death of the deceased;⁸¹ and where the Lord Chancellor requests the coroner to do so on the ground that the cause of death is likely to be adequately investigated by a current or future statutory inquiry.⁸² The coroner also has a general power to suspend an investigation into a person’s death in any case if it appears to the coroner that it would be appropriate to do so.⁸³ However, despite the operation of these provisions, most of our consultees felt that there is no practical benefit in opening two

⁸⁰ Coroners and Justice Act 2009, sch 1, para 1(2).

⁸¹ *Ibid*, para 2 (2).

⁸² *Ibid*, para 3.

⁸³ *Ibid*, para 5.

“inquisitorial” investigations both directed at establishing the facts of a fatal incident.

- 2.44 Professor Phil Scraton highlights one of many injustices arising from the multiple legal processes involved in investigating the Hillsborough disaster. The original, quashed inquest was structured so that the opening hearings served as “a kind of Taylor [Inquiry] rerun”⁸⁴: “given that the coroner had debarred evidence taken by Taylor from the inquest, it was inconsistent that [South Yorkshire police superintendent Roger] Marshall was allowed to criticise the inquiry and its findings”.⁸⁵
- 2.45 The Grenfell Inquiry has also demonstrated the potential for duplication. In a ruling following the Inquiry’s second procedural hearing, The Chair expressed the hope that he could “minimise as far as possible the need for [the coroner] to re-open any of the inquests and thereby to spare the relatives of those who died the need to endure further proceedings in relation to the deaths of their family members”.⁸⁶ However, the four statutory questions (who the deceased was, and how, when and where the deceased came by his or her death), which must be answered in every inquest, are not expressly set out in the Inquiry’s Terms of Reference.⁸⁷ Further, the Chair noted that he could “foresee some potential difficulty in making extensive and detailed findings about the movements of each of the deceased in the period leading up to his or her death”. “Evidence relating to the deceased” serves as the eighth and final module of the Inquiry’s Phase II; at time of writing there is still no guarantee that this module will enable the Coroner for London Inner West to close the inquests.

⁸⁴ Scraton, *supra* note 2, p. 199.

⁸⁵ *Ibid*, p. 214.

⁸⁶ Sir Martin Moore-Bick, ‘Chairman’s Response to Submissions made on 21 March 2018’ (Grenfell Tower Inquiry, 28 March 2018), para 4. In the previous paragraph, the Chair noted submissions made by bereaved and survivor core participants stressing “the importance...of making findings of fact sufficient to meet the requirements of an inquest which satisfies the state’s obligation under article 2 of the European Convention on Human Rights, thereby making it unnecessary for the coroner to continue the inquests which she has suspended” – submissions contested at the hearing by Counsel to the Inquiry.

⁸⁷ Coroners and Justice Act 2009, s. 5. In an Article 2 ECHR inquest, the question of “how, when and where” is to be read as including the purpose of ascertaining *in what circumstances* the deceased came by his or her death. The Grenfell Tower Inquiry terms of reference do commit to examine the “circumstances” surrounding the fire at Grenfell Tower on 14 June 2017, but the 72 deaths are not referenced explicitly.

2.46 A further issue arises in relation to cases where the coroner decides that they are unable to discharge their investigative obligations because of a claim for public interest immunity (PII), and the coroner asks the relevant Minister to convert the inquest into a public inquiry. There is no statutory process for such a request and it can lead to considerable delays. Neil Sheldon QC writes:

*The request in Grainger was made in November 2015 and the decision to establish the inquiry was taken in March 2016. In Litvinenko the delay was even longer, not least because of the intervening judicial review [...]. The lesson provided by these cases, and the Manchester Arena Inquest in which the potential problem of delay is anticipated, is that the PII nettle should be grasped sooner rather than later.*⁸⁸

2.47 We have designed our proposed Special Procedure Inquest (SPI) such that it could consider closed evidence (see **paras 2.69, 2.74 and Annexe**), therefore avoiding conversion altogether.⁸⁹ However, in cases where – in any event – a public inquiry is established to investigate one or more deaths, the Working Party recommends that **the inquiry, where possible, should be required to answer the four statutory questions.**⁹⁰

Investigating deaths linked systemically

2.48 A Senior Coroner who is made aware that the body of a deceased person is within their area must as soon as practicable conduct an investigation into the person’s death if they have reason to suspect that the deceased died a violent

⁸⁸ Neil Sheldon QC, ‘Conversion of the Inquest to a Public Inquiry’ (1 Crown Office Row conference, ‘Is this too sensitive? Dealing with difficult issues in inquests and inquiries’, October 2019). Sheldon also cites the inquest into the death of Jermaine Baker, awaiting conversion at the time the conference paper was delivered. Conversion was announced on 13 February 2020, some eleven months after HHJ Goldstone QC was appointed to hold the inquest. Baker was killed by armed police in December 2015.

⁸⁹ See Ministry of Justice, *Justice and Security Green Paper* (Cm 8194, 2011), pp. 15-16.

⁹⁰ We accept that this is already the case for inquiries suspended under Coroners and Justice Act, sch 1 para 3. However, this accommodates only the narrow subset of cases where the Lord Chancellor requests the coroner to suspend the inquest on the ground that the cause of death is likely to be adequately investigated by a *statutory* inquiry and a “senior judge” has been appointed as chair.

or unnatural death; the cause of death is unknown; or the deceased died while in custody or otherwise in State detention.⁹¹ However, the duty to investigate does not extend to those cases which do not give rise to such suspicion, but which form part of a series of deaths that when looked at longitudinally is suggestive of systemic failure.

- 2.49 Examples of such a series cited to us in the course of our work include the (at least) 69 suicides over a six year period linked to the handling of benefit claims by the Department for Work and Pensions⁹² and the 63 deaths across six care homes in South Wales investigated for abusive practice in the early 2000s.⁹³ There are further examples where individual inquests were opened into deaths in custody or otherwise in State detention, but a single inquest might have been beneficial in exploring the commonality of issues. A graphic example is the series of fatalities at HMP & YOI Styal, where six women died in the 12 months between August 2002 and August 2003.⁹⁴
- 2.50 None of the examples in the above paragraph have led to the establishment of a public inquiry. As outlined at **para 2.2**, this is a political decision entirely within the discretion of the relevant Minister. However, it is unsatisfactory that in the absence of sufficient political pressure, deaths such as these are not investigated in context, and without scrutiny of underlying systemic causes.

Jurisdiction and scope

- 2.51 In order that systemic failures causative of death are investigated in context and are investigated as efficiently and humanely as possible, we recommend

⁹¹ Coroners and Justice Act 2009, s. 1.

⁹² National Audit Office, *Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants* (HC 79, Session 2019-20).

⁹³ See Margaret Flynn, *In Search of Accountability: A review of the neglect of older people living in care homes investigated as Operation Jasmine – Executive Summary* (2015).

⁹⁴ See INQUEST, *Learning from Death in Custody Inquests: A New Framework for Action and Accountability* (2012), p. 11. The report notes that “at the conclusion of an inquest into a previous death in Styal prison in 2001 the coroner made a rule 43 report about the need to set up a detoxification regime for women withdrawing from drugs. This was not implemented until after the sixth death had occurred, which was over two years after his report was issued”.

that the SPI is adopted for “specified deaths”. The specified deaths to be investigated are:

- i. multiple fatalities, i.e. two or more deaths occurring in circumstances giving rise to serious public concern or for other good reason (“type I”);⁹⁵ and
- ii. any death which a coroner has reason to suspect requires investigation and which, by reference to another death or deaths, may give rise to issues of systemic failure (“type II”). The issues may arise either:
 - a. from an inquest or inquests already held or;
 - b. from a death or deaths (including deaths in other coroner jurisdictions) in which no inquest has yet been held.⁹⁶

2.52 The SPI would not be able to overturn any findings of facts, answers to the four statutory questions or conclusion of any other completed inquest. The SPI could only consider evidence in relation to a death forming the subject of another completed inquest if a potential issue of a similar systematic failure arose, and evidence from the earlier inquest were considered by the SPI judge or Senior Coroner to be relevant to the issues addressed by the SPI.

2.53 The SPI could not ask the High Court to overturn the conclusions of another completed inquest. If, as a result of the SPI, it was thought that the previous inquest should be revisited by the High Court, the Attorney General could apply to have the inquest quashed in the normal way.⁹⁷

2.54 The scope of the SPI would be a matter for the judge or Senior Coroner when setting its terms of reference.⁹⁸

⁹⁵ Obvious examples of type I multiple fatality cases include deaths from an aircraft, helicopter or train crash, deaths of children in a school bus incident, and multiple deaths from a single terrorism incident.

⁹⁶ One or more transfers would take place under existing provisions in Coroners and Justice Act 2009 ss. 2-3 so that the inquests may be held together.

⁹⁷ Coroners Act 1988, s. 13.

⁹⁸ See *Coroner for the Birmingham Inquests (1974) v Hambleton & Ors* [2018] EWCA Civ 2081 [48].

Procedure

2.55 Our recommended procedure for the SPI is set out in the **Annexe**. There should be a special and recognised focus on the needs of families throughout the process, and from a very early stage. Bereaved people and survivors with interested person status should be entitled to full disclosure of relevant (but not closed) material.

Immediate action

2.56 The SPI should follow a report of the death(s) to the local Senior Coroner. The Senior Coroner would commence their investigation immediately in the usual way, ordering a post-mortem where necessary.⁹⁹ The Senior Coroner should immediately inform the Chief Coroner of any “specified deaths”.

2.57 The family or families of the deceased (where identity known) should be contacted immediately following the report to the Chief Coroner and they should be provided with information on the actions already taken, in addition to the provision of information as outlined at **paras 3.33-3.37**, below.

2.58 The Senior Coroner should consider the release of the body for burial or cremation. They should then open inquests to receive evidence on identity (if possible) and to explain the future procedural steps. The inquests should then be adjourned.

Special procedure

2.59 The Chief Coroner would decide on the available information whether the SPI is required, making further inquiries as necessary to inform the decision. The Chief Coroner should inform Government that a decision has been made or is pending.

2.60 Alternatively, Government may recommend that the Chief Coroner establishes an SPI. **This should not prejudice Government’s ability to establish a public inquiry under Section 1 of Inquiries Act 2005.** Some matters, such

⁹⁹ Coroners and Justice Act, ss. 1, 14.

as infected blood, involving over a thousand deaths and wide-ranging socio-economic and cultural issues may remain better suited to a public inquiry.¹⁰⁰

- 2.61 The establishment and conduct of the SPI should be guided by a clear and publicly accessible *Protocol*. The *Protocol* would include standard terms of reference, to be adapted according to the circumstances of the case.**
- 2.62 If the SPI is not invoked, the local Senior Coroner will continue the investigation and inquest as standard. The local Senior Coroner and family should be notified and reasons given within seven days (to enable any judicial review to be considered).
- 2.63 If the SPI is invoked, the Chief Coroner should within seven days of the fatal event appoint a judge or Senior Coroner (local or other) to conduct the new procedure. Appointments should be taken from a pool of judges and Senior Coroners trained in advance and ticketed to conduct SPI hearings.
- 2.64 The SPI would permit judges and Senior Coroners to hear and, if appropriate, rely upon “closed” evidence, i.e. evidence heard in the absence of the public.¹⁰¹ Where a decision is made that evidence must be heard in closed proceedings, this must be explained clearly to interested parties.¹⁰²

Hearings

- 2.65 The appointed judge or Senior Coroner should announce the date and venue of the first preliminary hearing, to be held within 14 days of the event and at a local venue. The date and venue of the hearing should be published on the coroner’s page of the Local Authority website and on the Office of the Chief

¹⁰⁰ See ‘Contaminated Blood Scandal Statistics’, Factor 8.

¹⁰¹ See Coroners (Inquests) Rules 2013, r. 11.

¹⁰² See Sheldon QC, *supra* note 88: “...it is important to remember, particularly for those representing families of the deceased, that the replacement of an Inquest by a Public Inquiry can be something of a double-edged sword. On the one hand it will be a relief that a ‘full and fearless’ investigation can be conducted, with consideration of all the relevant evidence, including that which would otherwise have been excluded by PII. On the other, that consideration will take place, to a significant extent, in the absence of the families or their representatives”.

Coroner web page, as well as notified to the families and media. The judge or Senior Coroner should follow the *Protocol* for notifications.

- 2.66 The judge or Senior Coroner should notify the relevant investigating agencies (as appropriate) to attend for directions. The judge or Senior Coroner, exercising their power of investigation under Section 1 of the 2009 Act, would have the option to request agencies to conduct specific inquiries. Without impinging on operational independence, the judge or Senior Coroner may ask the agencies whether and how they are working with one another, and what they are doing to minimise delays (see **Chapter III paras 3.6-3.10** on coordination of investigations generally).¹⁰³
- 2.67 A draft agenda should be drawn up ahead of the first preliminary hearing (with reference to the *Protocol*), to cover necessary case management.¹⁰⁴ Families and agencies should be notified of the draft agenda and invited to raise issues and concerns (either in advance of or at the first preliminary hearing).
- 2.68 The first preliminary hearing should cover the topics on the draft agenda and should take place in public (preferably in a local coroner's court). Further preliminary hearings should take place in public and should cover any remaining matters, including: progress of investigations; further investigation; scope; the list of witnesses; disclosure; the jury bundle (if a jury is to be empanelled); and the date and venue for the final hearing. Provision should be made for bereaved people and survivors to attend and participate in the first and subsequent preliminary hearings.
- 2.69 The final hearing should be conducted in public (except where it is necessary to consider closed evidence). Interested persons should be able to ask questions of witnesses. The hearings should be completed within 12 months, unless there is good reason for a longer timeframe.

¹⁰³ As a comparator, see also Crime and Courts Act 2013 s. 5 and sch. 3, which provide the Director of the National Crime Agency with the power to request or direct another police force to fulfil a task.

¹⁰⁴ Items might include: terms of reference; a provisional timetable; directions to agencies to provide a progress report (within 21 days); the identity of interested persons; representation; whether Article 2 ECHR is arguably engaged; whether a jury or assessors are required; whether closed evidence is likely; and preliminary issues of scope (including potential systemic issues).

- 2.70 The SPI should determine answers to the four statutory questions,¹⁰⁵ the medical cause of death and a conclusion as to the death. In a type II SPI, scope may well include evidence on other deaths, and on episodes of near-death.¹⁰⁶
- 2.71 Findings of fact should be neutral (conferring no civil nor criminal liability)¹⁰⁷ but where appropriate, “judgmental”, as in Article 2 ECHR inquests.¹⁰⁸ In a departure from the current position,¹⁰⁹ findings would be admissible (although not binding) in civil proceedings.¹¹⁰
- 2.72 In addition, the SPI should formulate recommendations to prevent future deaths,¹¹¹ hearing further evidence if necessary. Recommendations could be wider than permitted under the current regime, extending to specific actions to be taken by addressees.¹¹² Formulation of recommendations would be for the judge or Senior Coroner alone, although they may draw on narrative conclusions from the jury.

Composition of tribunal

- 2.73 Final hearings should be conducted by the judge or Senior Coroner, either alone, with a jury or with two lay assessors (at the discretion of the judge or Senior Coroner). The mandatory and discretionary provisions on empanelling a jury under Section 7 of the 2009 Act would apply.
- 2.74 A jury would be the usual option; but assessors could be used, for example, where the judge or Senior Coroner is of the opinion that the SPI requires a

¹⁰⁵ Coroners and Justice Act 2009, s. 5.

¹⁰⁶ See *R (L) v Secretary of State for Justice* [2009] 1 A.C. 588.

¹⁰⁷ Coroners and Justice Act 2009, s. 10(2).

¹⁰⁸ See ‘Chief Coroner’s Guidance No.17: Conclusions’, 2016, paras 34, 51-52.

¹⁰⁹ i.e. an exception to the rule in *Hollington v Hewthorn* (1943) K.B. 587.

¹¹⁰ The Working Party agrees that the findings of all inquests should be admissible in civil proceedings. This proposal, however, lies beyond our terms of reference.

¹¹¹ Coroners and Justice Act 2009, sch 5 para 7.

¹¹² See ‘Chief Coroner’s Guidance No. 5: Reports to Prevent Future Deaths’, 2016, para 24.

prolonged examination of documents or accounts or any scientific or local investigation which cannot conveniently be undertaken with a jury.¹¹³ Neither jury nor assessors would be used in cases where closed evidence may be called and relied on.

Oversight and administration

- 2.75 The Chief Coroner could invoke the SPI in the course of a standard inquest should further information come to light (for example, of other cases involving similar systemic issues).
- 2.76 The Chief Coroner would maintain an oversight and advisory role throughout the process, including during the preliminary hearings in order to monitor the timetable and to ensure family participation, without encroaching on the independence of the judge or Senior Coroner.
- 2.77 The cost of the investigation and inquest(s) should be paid from central funds (see paras 2.81-2.83 below). The Chief Coroner, or following the decision to establish an SPI, the judge or Senior Coroner appointed to conduct it, could draw upon the advice of the Central Inquiries Unit as to its management.

Related criminal investigations

- 2.78 The not guilty verdict in the 2019 criminal trial of Chief Superintendent David Duckenfield, coming after a conclusion of unlawful killing in the 2014-16 Hillsborough inquests, highlighted the injustice felt when criminal investigations follow (and diverge from) inquest conclusions. In an article reflecting on that case, David Conn argued that “the perverse and wasteful separation between public inquiry, criminal prosecution and inquests should

¹¹³ See Senior Courts Act 1981 s. 69. The Working Party considered whether the SPI should include the option for panellists to sit alongside the judge or Senior Coroner, as in the Inquiries Act 2005 s. 3. The benefits of panellists in respect of representation were noted. However, given that the coroner holds a judicial office which must be discharged without consultation, panellists could only perform a limited advisory role under the SPI. It is hoped that sufficient representation and diversity of the tribunal could be secured through (in the majority of cases) the use of a jury, and through a transparent and rigorous appointments process.

end, and established facts should carry over, not be repeatedly subject to revision”.¹¹⁴

2.79 However, the Working Party (and all of its consultees) are of the view that, given the lack of criminal evidential and procedural safeguards, there is no possibility of an inquest or inquiry binding a criminal trial without prejudicing the Article 6 ECHR defence rights of the accused. This would be the case even where an unlawful killing conclusion is found to the criminal standard. We therefore consider that **there should be a presumption that criminal proceedings, if commenced or expected, will precede the SPI. The Working Party recommends that this presumption should also apply in the establishment of public inquiries.**

2.80 However, we recognise that there will be cases of serious public concern, where the complexity of criminal investigations (involving forensic evidence and large numbers of witness statements) when set against the urgent need to address issues of public safety, will dictate that the fact-finding process should proceed alongside or in advance of criminal proceedings. Therefore, departing from the mandatory Schedule 1 suspension provisions in the 2009 Act, the **judge or Senior Coroner should retain discretion as to whether the investigation should be opened notwithstanding any ongoing prosecution, where delay is likely to be inordinate and/or where the fair trial rights of potential suspects are unlikely to be prejudiced by concurrent investigations.**

Volume and cost

2.81 It would be for the Chief Coroner or Government to determine whether an SPI is required (see **para 2.59** above). However, we would predict that an SPI would be established infrequently – perhaps up to six times a year and some years not at all. It is not designed to replace the jury inquests heard every day across the system (527 in 2019).¹¹⁵ An instructive comparator might be the

¹¹⁴ David Conn, ‘Once again, our legal system has failed the victims of Hillsborough’ (*The Guardian*, 6 December 2019).

¹¹⁵ Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, s. 4.

system of Fatal Accident Inquiries (FAIs) in Scotland: there were a total of 131 FAIs held in the two years 2016/17 and 2018/19, but only 12 of these were established under the discretionary provision where the Lord Advocate considers that the death occurred in circumstances giving rise to serious public concern *or* was sudden, suspicious or unexplained. The test for establishing the SPI is narrower, although covering a considerably more populous jurisdiction.

2.82 Non-means tested publicly funded legal representation of families should be provided where State bodies are represented (see **Chapter V** paras **5.20-5.23**). We also appreciate that the introduction of the SPI may necessitate some expansion of the Office of the Chief Coroner.¹¹⁶ The current team comprises only six members of staff despite the complement of over 20 originally envisaged. We understand that the spate of mass fatality terrorist attacks in recent years has at times stretched the Office to capacity.

2.83 However, the Working Party considers that the introduction of the SPI could reduce numbers of (and calls for) public inquiries, representing a significant cost saving for Government.¹¹⁷ Further, the Working Party is confident that the SPI, designed to promote meaningful participation and the making of recommendations to prevent future deaths, could reduce the considerable long-term costs associated with traumatic bereavement.¹¹⁸

¹¹⁶ Additional capacity would be particularly important in the event that a decision not to open a type II SPI were subject to legal challenge.

¹¹⁷ See Norris and Shephard, *supra* note 21, p. 6, note **: “Thirty inquiries have been called or converted from another form of investigation since 2005, eight of which are ongoing. Of the 30 inquiries, 24 have reported final or interim costs that we were able to identify, totalling at least £263.2m (2017 inflation-adjusted values)... In total, we were able to identify expenses for 43 inquiries since 1990, which have the combined inflation-adjusted cost of £638.9m; this includes the estimated £201.6m spent on the Saville Inquiry (£191.5m reported in 2010)”.

¹¹⁸ See Scraton, *supra* note 2, p. 386: “As more bereaved relatives and survivors suffered physical and psychological illness, many forced into early retirement through trauma-related stress, it was clear that the destructive impact of Hillsborough extended beyond the deaths of the 96”. See also New Economics Foundation, ‘[Stress and anxiety related hospital admission costing taxpayer £71.1m](#)’ (18 May 2018).

Advantages

- 2.84** We consider that introduction of the SPI would be a considerable advance on the current framework for inquests and public inquiries:
- i. Points of overlap between inquests and public inquiries or other independent inquiries would be avoided, as the SPI would obviate the need for two processes. In particular, the new process would permit judges and coroners to hear and if appropriate rely upon “closed” evidence, avoiding the cumbersome process of conversion.
 - ii. The scope of the inquest could be expanded beyond present limitations to include (proportionately) consideration of issues of wider importance relating to obvious aspects of “serious public concern” or “systemic failure”. This should reduce the number of calls for public inquiries, whilst leaving open the possibility that Government might establish one where appropriate.
 - iii. There would be a special and recognised focus on the needs of families throughout the process, and from a very early stage.
 - iv. The procedure would be published and available at all times. It would be expressed in clear and simple language.
 - v. The use of juries in the majority of cases would promote public trust and confidence.
 - vi. The process of investigation would become more structured, particularly in coordinating different investigations and avoiding delay.
 - vii. The process would also lead to a more significant exploration (than at present) of factors which could save future lives and to more specific recommendations. For example, the recognition that certain deaths in different prisons are linked by a specific systemic failure could lead to a marked reduction in deaths in custody.
- 2.85** Catastrophic events involving preventable deaths will by their very nature give rise to anguish and lasting trauma. The Working Party considers that the introduction of the SPI would serve to reduce duplication and delay, foster certainty, ensure inclusion of bereaved people and survivors and ultimately promote public trust in the system.

III. OPENING INVESTIGATIONS

My whole perception of justice, of public service, stuff I thought I could rely on – turned out to be a paper tiger. The culture of these institutions is to obfuscate, and no one guides you through the process. We were still shell-shocked. We didn't know about different types of inquest...we didn't know that we could be represented. Evidence of a bereaved brother.

- 3.1 For those already dealing with bereavement, confrontation with the complex legal processes triggered by a fatal event can serve to prolong and intensify trauma. Multiple concurrent investigations may require grieving families to tell their stories several times, often without the equivalent care or safeguards afforded to victims of crime, despite the wrongs they may have suffered.
- 3.2 Concurrently, bereaved people often receive insufficient information as to their legal rights and only sporadic communication as to the progress of investigations. This affects participation. In her 2017 Review, Dame Elish Angiolini highlighted the State's responsibilities to bereaved people in the investigative phase, stressing that their involvement "should not be seen as a matter of being sympathetic or benevolent ... under Article 2 of the European Convention on Human Rights families of the deceased must be allowed to be involved in the investigation in a meaningful way".¹¹⁹

Status of bereaved people

- 3.3 Interested person and core participant bereaved people and survivors in inquests and inquiries will have suffered serious harm, often at the hands of State or corporate bodies. However, families do not receive the same practical support as those recognised as 'victims' in the criminal justice system. INQUEST in written submissions to the Angiolini Review noted that "as soon as police officers were charged with criminal offences the families of Azelle Rodney and Thomas Orchard were assisted by Victim Support with transportation and accommodation around the trial. This is in sharp contrast to

¹¹⁹ Angiolini, *supra* note 15, Executive Summary, para 30.

how families in death in custody cases are generally treated”.¹²⁰ A further example cited by INQUEST related to a custody suicide. In the week before the death, the mother of the bereaved had had her car stolen; within 24 hours she had received a telephone call and been provided with a leaflet from Victim Support. She received no such support the following week from the coronial system. We do not see any principled reason for the difference in treatment.

- 3.4 The Code of Practice for Victims of Crime (the “Victims Code”) is the statutory code that sets out the minimum level of service that victims should receive from the criminal justice system.¹²¹ Where a victim of crime has died, close relatives of the deceased are entitled to receive services under the Code as victims of the most serious crime.¹²² There are, of course, elements of the Victims Code that do not translate to death investigations. For example, victims in the criminal jurisdiction are not interested persons and will not have legal representation.
- 3.5 However, we would suggest that investigators, coroners’ offices and inquiry teams should reconsider their Protocols in line with the Victims Code, to ensure that bereaved people are treated in a manner that is dignified and promotes participation. **Bereaved people and survivors in investigations into contentious deaths should be afforded the relevant entitlements outlined in the Victims Code.** These may include conducting a needs assessment to identify what support is required; interviewing without unjustified delay and limiting the number of interviews to those that are strictly necessary (see **para 3.14** below); arranging court familiarisation visits; providing expenses for travel to inquests, subsistence and counselling; and affording a route for administrative complaints, with a full response to any complaints made.

¹²⁰ *Ibid.*

¹²¹ Ministry of Justice, *Code of Practice for Victims of Crime* (2015).

¹²² *Ibid.*, Introduction, para 23.

Coordination of investigations and evidence gathering

Delay

- 3.6 An unexpected death may trigger investigation by a wide range of investigators, such as: the police; coroners and their officers; the Health and Safety Executive (HSE); the Independent Office for Police Complaints (IOPC); the Care Quality Commission; the Air Accident Investigation Branch (AAIB); the Marine Accident Investigation Branch (MAIB); the Rail Accident Investigation Branch; and the Prisons and Probation Ombudsman (PPO), alongside agencies conducting internal institutional reviews.
- 3.7 The Angiolini Review found inadequate coordination between investigating agencies to be a significant cause of delay in death in custody cases. Citing submissions from INQUEST, the Review highlighted the case of Olaseni Lewis who died in 2010 following prolonged restraint by police officers whilst in psychiatric detention:

The HSE did not extend its investigation to the police force because of the IPCC¹²³ investigation. In 2015 it emerged that since 2012 the HSE had been in communication with the MPS, IPCC and CPS regarding corporate manslaughter by the NHS Trust, without any single agency taking responsibility for that matter. Later that year Devon and Cornwall Police began to undertake such an investigation. In the meantime the IPCC referred their investigation to the CPS in relation to the actions of individual officers, but not the MPS as a corporate body. The inquest has now been scheduled to commence in January 2017, over six years on from the death.¹²⁴

- 3.8 We have heard conflicting accounts as to the effectiveness of existing arrangements between the police and other investigators. One consultee suggested that the situation is improving: while there has been tension between agencies historically, the number of terrorist attacks in the United Kingdom in

¹²³ The Independent Police Complaints Commission, the predecessor of the Independent Office for Police Conduct until January 2018.

¹²⁴ Angiolini, *supra* note 15, para 14.43.

recent years has demanded greater understanding and coordination between investigators. In several contexts, coordination does take place and is formalised through Memoranda of Understanding (“MoU”).¹²⁵ One of our consultees suggested that in most death in custody cases, relationships between police, IOPC and coroners’ offices are well-established and lengthy delays such as in the Lewis case are atypical. This would be a welcome position. Unfortunately, however, some of us do not recognise it as the reality. Nonetheless, that consultee drew attention to the delays caused in investigations into deaths where the specialist accident branches are involved and the principle of “just culture”¹²⁶ weighs against evidence sharing between agencies.¹²⁷ Another consultee noted the further complexity caused where a statutory review of the investigative framework runs concurrently with the investigations themselves.¹²⁸

- 3.9 We appreciate that a push for rationalisation may come into tension with operational independence. The proposal that a political office could take on a coordinating or directorial role over investigating agencies in England and Wales, as performed by the Scottish Lord Advocate,¹²⁹ were not well received

¹²⁵ See Grenfell Tower Inquiry and Metropolitan Police Service, Memorandum of Understanding (27 September 2017).

¹²⁶ Promoting “a non-punitive environment facilitating the spontaneous reporting of occurrences”. See EU Parliament and Council Regulation 996/2010 of 20 October 2010 on the investigation and prevention of accidents and incidents in civil aviation and repealing Directive 94/56/EC [2010] OJ L 295/35, Recital 24. Recital 25 stipulates that “the information provided by a person in the framework of a safety investigation should not be used against that person, in full respect of constitutional principles and national law”.

¹²⁷ The issue of disclosure of materials from an Air Accident Investigation Branch (AAIB) investigation to a coroner was considered in *R (on the application of Secretary of State for Transport) v HM Senior Coroner for Norfolk* [2016] EWHC 2279 (Admin). The inquest was into the deaths of four men in a helicopter accident in March 2014. The Court found that the effect of Reg 996/2010 (see *ibid*) and Civil Aviation (Investigation of Air Accident and Incidents) Regulation 1996 (SI 1996 No 2798) was that the coroner had no power to order the AAIB and its Chief Inspector to disclose the cockpit voice and flight data recorder and/or a transcript of the recording. See Singh J (as he then was) at [49]: “it is important to emphasise that there is no public interest in having unnecessary duplication of investigations or inquiries”.

¹²⁸ For example, see the Independent Review of the statutory multi-agency public protection arrangements (MAPPA).

¹²⁹ In Scotland, criminal cases are prosecuted and conducted by the Crown Office and Procurator Fiscal Service (“COPFS”) with the Lord Advocate’s oversight. However, COPFS also receives reports from

by consultees. Equally, we are aware that different cases may necessitate different lead agencies. This may depend, for instance, on whether the police are implicated in the fatal event or an agency has specialist expertise.

- 3.10 However, we note Dame Elish Angiolini’s caution that “independence does not require isolation”.¹³⁰ We agree with her suggestion that in cases where specialist agencies are involved in investigations concurrent with an inquest, **coroners should hold prompt and regular pre-inquest hearings with investigating agencies requiring them to liaise closely and account for the progress of their work and coordination.**¹³¹ Building on this recommendation, our proposed SPI incorporates a pre-hearing at which it would be open to the judge or Senior Coroner to request agencies to conduct specific lines of inquiry,¹³² and to report on whether and how they are working with one another, and how delay is being minimised (see **Chapter II, para 2.66** and **Annexe, row 12**).

Witness questioning

- 3.11 A related issue, raised frequently in the course of our work, is the experience of bereaved people and survivors giving evidence on multiple occasions. This may occur at the early investigative stage, where a number of agencies with discrete objectives require witness evidence relating to a single event. However, the burden of retelling one’s story may stretch over several years: for example, where a person gives evidence at an inquest into the death of a relative and then finds themselves in the witness box once again at a Medical Practitioners Tribunal hearing.

the HSE; Police Scotland; British Transport police; Ministry of Defence Police; the United Kingdom Atomic Energy Constabulary; and fifty specialist reporting agencies. The Lord Advocate issues policy guidelines on how agencies should interact with each other. For example, see the ‘[Investigation of Road Traffic Deaths – Lord Advocate’s Guidelines](#)’, 5 December 2017.

¹³⁰ Angiolini, *supra* note 15, para 14.9.

¹³¹ *Ibid*, p. 240, recommendation 49.

¹³² As a comparator, see also Crime and Courts Act 2013 s. 5 and Sch. 3, which provide the Director of the National Crime Agency with the power to *request* or *direct* another police force to fulfil a task. We do not propose that the SPI judge or Senior Coroner is given powers of direction.

- 3.12 Quite apart from the adversarial manner adopted by certain investigators¹³³ and advocates (which we consider in **Chapter V, paras 5.6-5.10**), evidence from our consultees suggests that the experience of *repeating* evidence to several agencies is in itself “distressing, exhausting and deeply inefficient”. One consultee described the process for bereaved families as a “war of attrition”.¹³⁴
- 3.13 *Patronising Disposition* recognised that “in some instances there may be an immediate need to conduct interviews with bereaved families – for example, to prevent further loss of life, or in cases where for other reasons it is operationally necessary”.¹³⁵ However, Jones stressed “the need for the bereaved family and friends of those who have died to be questioned only as absolutely necessary”.¹³⁶ The Working Party supports this view. It is crucial that the justice system addresses the potentially re-traumatising effect of reliving near-death experiences, or the death of loved ones through several rounds of questioning.
- 3.14 Recognising existing efforts to encourage coordination, we recommend that **where possible, investigating agencies collaborate in the questioning of witnesses. A lead interviewer should aim to gather evidence that can satisfy the objectives of multiple investigations and form part of a cross-jurisdictional dossier.** Investigating agencies should meet with a view to appointing interviewers and briefing them as to the issues on which information is sought.

¹³³ See Angiolini *supra* note 15, para 15.10: “Families cite examples of the police and IPCC questioning them about the lifestyle of the deceased, and incorrect details, false narratives and ‘victim blaming’ about their loved ones”.

¹³⁴ See also ‘[INQUEST report of the Family Listening Day held to support the Rt Rev Bishop James Jones’ Review of the Hillsborough Families’ Experiences](#)’, April 2017 and ‘[INQUEST report of the Family Listening Days held to support the independent review into deaths and serious incidents in police custody](#)’, May 2017.

¹³⁵ Jones, *supra* note 16, p. 33.

¹³⁶ *Ibid.*

- 3.15 The Achieving Best Evidence (ABE) framework,¹³⁷ used in police interviews to allow vulnerable and intimidated witnesses to give their best evidence, should inform the approach of a multi-agency interview.
- 3.16 One technique incorporated into the ABE framework is the cognitive interview,¹³⁸ originally developed by psychologists in the United States at the National Institute of Justice. The cognitive interview is designed to help a witness unlock memories and recall detailed information.¹³⁹ It is conducted through a set of structured steps (free recall; varied free recall; focussed questions; review) with an emphasis on open questioning. By allowing the witness to dictate the agenda within that structure, cognitive interviewing provides a humane way of questioning, and tends to elicit fuller witness statements covering a variety of angles. For bereaved people, survivors and other witnesses who may be suffering from trauma, **interviewers should employ cognitive interviewing techniques to elicit the fullest possible evidence in a single session.**
- 3.17 Witnesses should be given the option of having their own lawyer present during the interview, and of seeking legal advice before signing a draft witness statement.
- 3.18 The ABE framework suggests that for “significant” or “key” witnesses, their interviews should also be video recorded as this is likely to “increase the amount and quality of information gained from the witness; and increase the amount of information reported by the witness being recorded”.¹⁴⁰ Video recording will not be appropriate in the context of a cognitive interview, as the recording device may intrude upon, and interfere with, the free recall and memory retrieval steps that form part of this interviewing technique. However, for witnesses who have not suffered trauma, including experts and eyewitnesses, **interviews conducted during investigations should be video recorded so that the recordings and transcripts can form part of the**

¹³⁷ Ministry of Justice, *‘Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures’*, 2011.

¹³⁸ *Ibid*, para 3.123.

¹³⁹ See Geoff Coughlin, *Unlocking Memories: Cognitive Interviewing for Lawyers* (Ark Group 2015).

¹⁴⁰ Ministry of Justice, *supra* note 137, paras 1.26-27.

dossier. The Working Party appreciates that ABE interviews are resource-intensive and that use of video recording cannot be extended to every witness in cases where there are hundreds on the scene of a fatal event.

- 3.19 Finally, we recommend that in order to reduce as far as possible the potentially re-traumatising effect of interviews, **evidence-gathering teams should undergo training on trauma-informed practice and communication with those who have suffered catastrophic bereavement.** Clinicians (including psychologists and trauma-informed speech and language therapists), and where relevant NGOs with specialist knowledge should play a role in designing and delivering training programmes, in consultation with bereaved people and survivors. For example, we understand that the Infected Blood inquiry team was given training on evidence gathering by the Red Cross.¹⁴¹

Evidence sharing

- 3.20 In order to better progress investigations and reduce the number of witness interviews, **where possible, agencies should continually update one another as information emerges about the circumstances of a fatal incident.** A model is provided in the current MoU between the AAIB and Association of Chief Police Officers (ACPO).¹⁴² Evidence sharing should encompass so far as possible the statements of those witnesses who are not interviewed under caution.
- 3.21 The Working Party recognises the difficulty in evidence sharing between (and indeed rationalisation of) police investigations aiming to ascertain blameworthiness, and other investigations aiming purely to prevent future recurrence. In the latter, there may be strong public interest in the granting of

¹⁴¹ See Infected Blood Inquiry, ‘Newsletter: Issue 6’ (October 2019), p. 2.

¹⁴² Chief Constable Alex Marshall, ‘Memorandum of Understanding between the Air Accident Investigation Branch (AAIB) and ACPO’, 2012, see para 1.1.4. As a general principle, investigating agencies should also collaborate in the development of best practice. The European Network of Civil Aviation Safety Investigation Authorities (ENCASIA) was cited in evidence as an example of a forum in which effective collaboration occurs.

immunities in order to encourage cooperation and learning.¹⁴³ This dictates a degree of separation between investigators where suspicion arises.

3.22 However, subject to data protection, there is nothing preventing the migration of prosecution material to other investigations once the criminal process concludes. We recommend that **where an inquest, inquiry or other form of investigation follows a concluded criminal trial, investigators should consider whether the witness statement (including the victim impact statement) of a bereaved person used at trial might be sufficient to serve as that person’s evidence for the purposes of the investigation.**¹⁴⁴ We would add that where such an arrangement is possible, the bereaved person should be consulted as to whether they wish to provide a further statement in any event.

Early participation of bereaved people and survivors

3.23 As Dame Elish Angiolini noted in her Review:

*It is the immediate aftermath of a death that marks “the point of the process, more than any other, when families are in urgent need of advice, support and information about their rights, and the processes that will ensue over the coming days and months. Unfortunately, it is also the point at which families will be in a state of shock, confusion and grief.”*¹⁴⁵

Yet evidence from our consultees supports our experience that the participation of bereaved people is stymied from the very start.

¹⁴³ This is not to suggest that the grant of an immunity or undertaking will always be appropriate. The Working Party recognises, for example, the controversy caused by the Attorney General’s grant of undertakings in Phase II of the Grenfell Tower Inquiry. However, we have received no evidence in favour of wholesale reform in this area. Where this issue was raised, it was typically in the context of sequencing of investigations (see **Chapter II, paras 2.78-2.80**) or institutional defensiveness (see **Chapter IV, paras 4.32-4.34**). For a helpful guide to the law on undertakings from the Attorney General in public inquiries, see David Barr QC, Kate Wilkinson and Victoria Ailes, ‘Counsel to the inquiry’s note on undertakings’ (Undercover Policing Inquiry, 8 January 2016)

¹⁴⁴ We were informed of at least one death in custody case where this decision was taken, although it is not currently common practice.

¹⁴⁵ Angiolini, *supra* note 15, para 15.8.

3.24 Given that the Senior Coroner holds a duty under Section 1 of the Coroners and Justice Act 2009 (“the 2009 Act”) to conduct an investigation “as soon as practicable”, our proposals in this section predominantly relate to investigations conducted by coroners.

Notifying next of kin

3.25 Next of kin, or personal representatives, of the deceased are afforded more extensive rights than other interested persons in a coroner’s investigation. For example, under Regulation 6 of the Coroners (Investigations Regulations) 2013, the coroner must attempt to notify the next of kin or personal representative of the decision to begin an investigation. Under Regulation 17, the next of kin must be notified of the cause of death in any discontinued investigation.¹⁴⁶

3.26 But the term “next of kin” has no legal definition. The 2014 edition of the Ministry of Justice’s ‘Guide to Coroner Services’ suggests that “next of kin” means the person identified by the coroner or coroner’s office to act as the main point of contact to receive information”.¹⁴⁷ However, there is no guidance for coroners’ officers or indeed for families as to who should serve as the “main point of contact”.

3.27 This presents a particular problem in the case of divided families, where there is “no common approach” between relatives.¹⁴⁸ Coroners’ officers may simply accept that the first person who makes contact should be registered as “next of kin” irrespective of the nature of their relationship with the deceased. Reform in this area should accommodate circumstances where more than one person might require notification from the coroner’s office in order to participate effectively.¹⁴⁹ **The Chief Coroner should issue guidance defining “next of**

¹⁴⁶ See also regs 9, 10, 13, 13, 14, 18 and 20; Coroners (Inquests) Rules 2013, rr. 9, 10 and 25, in addition to regs 6, 9, 10, 13, 14, 17, 18 and 20 of the Coroners (Investigations) Regulations 2013.

¹⁴⁷ Ministry of Justice, ‘Guide to Coroner Services’, 2014, p. 37.

¹⁴⁸ Leslie Thomas QC, Adam Straw, Daniel Machover and Danny Friedman QC, *Inquests: A Practitioner’s Guide* (3rd edn, LAG 2014), para 19.298. See also para 13.2.

¹⁴⁹ We note that this issue is anticipated in the Ministry of Justice, ‘Guide to Coroner Services for Bereaved People’, 2020, p. 6. Bereaved people are advised that “if more than one person needs to be a

kin”, and the term should be explained in communications from the coroner’s office to bereaved people.

3.28 We consider that the definition of “relatives” and “nearest relatives” in Section 26 of the Mental Health Act 1983 provides a suitable model,¹⁵⁰ with two qualifications:

- i. the list should include a long-term partner who is neither the spouse nor the civil partner of the deceased;
- ii. the hierarchy does not account for separated but still-married partners. There will likely be cases where it is inappropriate for such a person to serve as “next of kin”.

Discretion to depart from the hierarchy may prove important in cases where, for instance, a nephew or niece has served as the long-term carer of the deceased.

3.29 Clarifying the definition of “next of kin” will not address those cases where no family members have come forward, or indeed where there is no traceable family. So-called “honour killing” cases,¹⁵¹ and deaths of people with disabilities in long-stay institutions present examples of cases where, in lieu of family members coming forward, the public interest will need to be served in another way. The Working Party recommends that **where a coroner has been unable to identify the deceased’s next of kin or personal representative, they should consider nominating an organisation with sufficient expertise to act as the advocate for the deceased and receive notifications regarding**

contact for the coroner – for example in divided families – please explain this to the coroner’s officer and provide contact details”. However, the guide does not clarify whether more than one person will be entitled to notification under the relevant rules and regulations.

¹⁵⁰ Under s. 26, “relative” means any of the following persons: (a) husband or wife or civil partner; (b) son or daughter; (c) father or mother; (d) brother or sister; (e) grandparent; (f) grandchild; (g) uncle or aunt; (h) nephew or niece.

¹⁵¹ See *R (Southall Black Sisters) v Her Majesty’s Coroner for West Yorkshire* [2002] EWHC 1914 (Admin). In this judicial review regarding interested person status for an inquest into the killing of Nazia Bi and Sana Najid Ali, Southall Black Sisters submitted that “the close family connections between that of [Bi’s] own and her husband’s family would have led to a closing of ranks amongst family members...this is often the case when the family and community wish to preserve family honour and/or are intimidated and pressurised” [24].

the investigation.¹⁵² The organisation should be independent from the circumstances of the death.

- 3.30 Furthermore, we have been told that families are not uniformly given reasons where a decision is taken not to investigate, and so are left unsure as to whether to challenge a decision. We recommend that **where a coroner decides that an investigation should be discontinued, the coroner’s office should ensure that the next of kin or personal representative are always informed of the reasons for the decision within seven days.**

Communication about the procedure

- 3.31 The importance of proper communication has been a constant throughout our evidence gathering. Families consistently speak to the experience of being unaware of the procedural steps ahead, their rights in the process and in particular the possibility of seeking specialist legal representation.
- 3.32 The issue of insufficient communication pervades the different forms of investigation and inquiry. In respect of death in custody cases, Dame Elish Angiolini found that “the sense of frustration and anger at being left completely out of the picture in the first days and weeks of the investigation was evident from the many families I met during the review”, recommending that consequently, “all agencies need to look urgently individually and collectively at their internal processes for disseminating information to bereaved families in these cases”.¹⁵³ Participants in the Grenfell Family Consultation Day convened by INQUEST “felt there was no systematic plan for communicating to families when the Public Inquiry would start, its terms of reference and how families could engage with it”.¹⁵⁴

¹⁵² INQUEST has previously recommended that the Official Solicitor be recognised as an interested person in this category of cases.

¹⁵³ Angiolini, *supra* note 15, para 15.9.

¹⁵⁴ INQUEST, ‘Family reflections on Grenfell: No voice left unheard (INQUEST report of the Grenfell Family Consultation Day)’, May 2019, p. 6.

Immediate provision of information

- 3.33 It is crucial that at the earliest possible point following the initial report of a death to the coroner, bereaved people are informed of the procedural steps ahead and their rights (including the right to be properly represented). In order to make informed decisions, families need information about access to their loved one's body; the post-mortem process (including the possibility of a non-invasive post-mortem); and the possibility of the removal of body parts. It is also essential that family members are informed from the outset about what to expect at an inquest hearing; the roles of the legal professionals; the order of proceedings; the process of giving evidence; and the courtroom layout.
- 3.34 Equally importantly, families need to know how to find relevant organisations offering specialist advice and support about contentious deaths involving investigations, inquests and inquiries and how these processes impact on traumatic bereavement.
- 3.35 We recognise that the Ministry of Justice already publishes a 'Guide to Coroner Services for Bereaved People'.¹⁵⁵ We note that this Guide is clearly written, provides information on rights at each procedural stage and lists sources of support. We also recognise that despite the absence of a formal response to *Patronising Disposition*, the most recent edition of the Guide has incorporated suggestions made in that report, including information on the possibility of a second post-mortem.¹⁵⁶
- 3.36 However, it is unclear how widely and consistently the Guide is disseminated. We recommend that in cases where a coroner has taken the decision to begin an investigation, **provision of the Guide should if possible coincide with the notification of next of kin or personal representative.**
- 3.37 Further, the Guide understates the importance of legal representation in complex cases:

¹⁵⁵ Ministry of Justice, 'Guide to Coroner Services for Bereaved People', *supra* note 149.

¹⁵⁶ *Ibid*, para 3.10. The Jones and Angiolini Reviews are mentioned specifically at Annex A. See Jones, *supra* note 16, p. 70, Point of Learning 19.

*You do not need a lawyer to attend or participate in the inquest including when you want to ask particular questions or you are giving evidence. The coroner will ensure that the process is fair and thorough, that you are able to participate ... However, there may be times where you might wish to have legal advice or representation in preparing for or attending the inquest, for example where the state or public body has legal representation.*¹⁵⁷

This explanation does not convey the potential urgency of seeking specialist advice in contentious cases (see **Chapter V, para 5.17**). Families to whom we spoke described the daunting experience of arriving at a pre-inquest review hearing unrepresented, to be confronted by State body interested persons represented by teams of solicitors and barristers. **We recommend that the ‘Guide to Coroner Services for Bereaved People’ point out that officials are likely to be legally represented. The Guide should also be amended to advise family members concerned about the circumstances of a loved one’s death to urgently seek specialist legal advice.**

Continuing communication

- 3.38** There is no consistent standard as to the regularity and volume of contact bereaved people might expect from a coroner’s office once an investigation is opened. For example, the MoJ ‘Guide to Coroner Services for Bereaved People’ suggests that bereaved people can expect contact “every three months to update you on your case”,¹⁵⁸ while, the Guide produced by HM Coroner for Inner London South for bereaved parents advises “every 2-3 weeks, unless the [coroner’s officers’] workload makes this difficult”.¹⁵⁹

¹⁵⁷ *Ibid*, para 4.1. Cf. INQUEST, ‘[The INQUEST Handbook: A guide for bereaved families, friends and advisors](#)’, 2016, p. 31: “There are some circumstances of death where we would strongly recommend contacting a specialist solicitor as soon as possible. Where someone dies whilst in the care of an institution (for example, a psychiatric hospital or prison) or following contact with those working for a public authority (the police, for instance) it is advisable to seek specialist legal advice immediately (see Section 5)”.

¹⁵⁸ Ministry of Justice, ‘Guide to Coroner Services for Bereaved People’, *supra* note 149, p. 23.

¹⁵⁹ Senior Coroner Andrew Harris (HM Coroner for London Inner South), ‘[Information for just bereaved parents: A guide to the death investigation process](#)’, 2018, p. 11.

- 3.39 Our consultees and members of the Working Party acting for bereaved families stressed that in practice, communication tends to be irregular, with long periods of silence typically followed by a sudden deluge of information and disclosure shortly before a hearing. In general, we conclude that more regular contact is desirable. However, we recognise that in some cases additional contact may serve to re-traumatise and be unwanted. Moreover a person’s need for regular contact may change as a hearing approaches.
- 3.40 We recommend that **where an inquest is opened, progress updates should be given to family interested persons every three weeks, or by agreement at such interval as the family interested party requests.** The “victim contract” drawn up between certain police forces and victims of crime to regulate contact in accordance with the victim’s wishes may serve as an appropriate model.¹⁶⁰ **Bereaved people should also be able to nominate a lawyer or other advice or support worker to pass on the information.**
- 3.41 JUSTICE has previously recommended that information about justice processes is made available in a variety of formats. The JUSTICE Working Party report *Understanding Courts* suggested that “information should be communicated aurally as well as in written form, and, ideally, involve an opportunity to experience or engage, to be fully understood”, noting the advantages of using video.¹⁶¹ That Working Party found that “the HMCTS video for jury service is an excellent introduction to the role, showing the trial process with a clear and straight forward explanation of what happens and of the juror’s responsibilities ... much of what is contained in this video could be used as an introduction to criminal trials for all lay users”.¹⁶²
- 3.42 Building on a recommendation from that report and reflecting ideas independently voiced in the course of this Working Party’s deliberations, we recommend that **where a coroner opens an inquest, or the Chief Coroner**

¹⁶⁰ See Suffolk Police, ‘Victim and Witness Information’ (undated), p. 2.

¹⁶¹ JUSTICE (2019), *supra* note 19, para 2.4, citing Jan Louis Kruger and Stephen Doherty, ‘Measuring cognitive load in the presence of educational video: towards a multimodal methodology’ (2016) 32(6) *Australasian Journal of Educational Technology* 16.

¹⁶² *Ibid*, para 2.32.

invokes the SPI, bereaved people should be directed to an engaging, clear and professional quality video on what to expect at an inquest. It could feature bereaved family members who have experienced the process as well as court professionals explaining their roles and should lead viewers through actual inquest locations to give a realistic impression of the process. The production should be made with the collaboration of bereaved people.

The post-mortem

- 3.43** Where a coroner has ordered that a post-mortem examination take place, Regulation 13(3)(a) of the Coroners (Investigations) Regulations 2013 requires that particular people be notified.¹⁶³ However, the experience of our members is that notification often comes too late for family members to make informed decisions about the possibility of non-invasive post-mortems or objecting to the post-mortem altogether. Article 8 ECHR may oblige a coroner to take reasonable steps to identify relatives in advance of the post-mortem, “reasonable steps” being dependent on the circumstances of death and the urgency of the post-mortem.¹⁶⁴ We recommend that **where a post-mortem is to take place, the coroner should notify *all* family members whose details are known to the coroner’s office.**
- 3.44** Under Rule 13 of the Coroners (Inquests) Rules 2013, interested persons have a right to receive, on request, a copy of the post-mortem report and any other report or relevant document, subject to the qualifications set out in Rule 15. From our experience, some coroners adopt a paternalistic approach to post-mortem results, in extreme cases preventing bereaved people from reading the results when they consider that these might be distressing. This approach is unlawful and denies bereaved people autonomy. We recommend that in order to give fair notice of potentially distressing content, **post-mortem reports disclosed to family members should be concealed within two envelopes, with a warning inside the outer envelope that the report may contain distressing information.**

¹⁶³ The next of kin or the personal representative of the deceased or any other interested person who has notified the coroner in advance of his or her desire to be represented at the post-mortem examination.

¹⁶⁴ Thomas QC, Straw, Machover and Friedman QC, *supra* note 148, paras 19.14-15.

IV. PRE-HEARING PROCEDURE

We are not prepared to participate in a process where the presence of our clients is pure window-dressing, lacking all substance, lacking all meaning and would achieve absolutely nothing other than lending this process the legitimacy it does not have and deserve. Philippa Kauffman QC.¹⁶⁵

- 4.1 It is a strength of inquests and inquiries that the procedure is a flexible one. Structure is certainly provided by the relevant primary and secondary legislation.¹⁶⁶ However, procedural requirements are less stringent than in the civil and criminal jurisdictions. There are no practice directions and no procedure rule committees keeping the secondary legislation under review. This is partly a reflection of their fact-finding remit and ostensibly non-litigious nature. In the case of inquiries, flexibility is also appropriate given the wide range of potential subject matter.¹⁶⁷
- 4.2 But lack of standard procedure has had the consequence that inquests and inquiries have not always benefitted from the kind of innovation in best practice developed in the criminal and civil jurisdictions. While the Woolf and Jackson reforms encouraged a “cards on the table” approach to civil litigation, bereaved interested persons in inquests typically report a “drip-feed” of documents in the months following the death, often with a glut of material arriving the night before or on the day of the hearing. Furthermore, despite the advances made in the questioning of vulnerable witnesses in the criminal justice system (“CJS”), families in inquests are typically “not prepared for what they [have] described as the intensity and ferocity of the approaches taken by lawyers representing public authorities”.¹⁶⁸ This is exacerbated by the difficulty in accessing public funding for representation at inquests under the current regime, which means that families are almost invariably left to navigate this adversarial battle without specialist legal support and whilst in the midst of grief.

¹⁶⁵ Undercover Policing Inquiry, Preliminary Hearing (21 March 2018).

¹⁶⁶ Principally, the Coroners and Justice Act 2009; Inquiries Act 2005; the Coroners (Inquests) Rules 2013; the Coroners (Investigations) Regulations 2013; and the Inquiry Rules 2006.

¹⁶⁷ Mackie, *supra* note 23.

¹⁶⁸ Jones, *supra* note 16, para 2.72.

- 4.3 Public inquiries give rise to a raft of different concerns. Core participant status, if granted, does allow for publicly funded legal representation. As a consequence, bereaved people are not typically subjected to unrestrained cross-examination. However, families are faced with what is effectively a State-led investigation into the death of their loved one. The appointment of an inquiry chair, with or without an inquiry panel, nominally brings independence from Government; but the selection of the chair and panel members, and terms of reference remain within the purview of a Minister.¹⁶⁹ In this context, the rule that only counsel to the inquiry (“CTI”) and the inquiry panel may ask questions of witnesses¹⁷⁰ can, if exercised inflexibly, serve to thwart participation and erode confidence in the inquiry.
- 4.4 In both inquests and inquiries, lack of candour and institutional defensiveness on the part of State and corporate interested persons and core participants are invariably cited as a cause of further suffering and a barrier to accountability. The Public Authority (Accountability) Bill 2016-17 would have introduced a statutory duty of candour, but despite cross-party sponsorship, the Bill is yet to be debated.
- 4.5 The JUSTICE Working Party report *Understanding Courts* stressed that “putting the user at the heart of the court system is long overdue. Like the tribunals, the courts should ‘do all they can to render themselves understandable, unthreatening, and useful to user’”.¹⁷¹ In this Chapter and **Chapter V**, we consider how inquests and inquiries may similarly be reformed, addressing the issues outlined above in an attempt to place bereaved people and survivors at the heart of proceedings.

¹⁶⁹ Inquiries Act 2005, ss. 4-5.

¹⁷⁰ The Inquiry Rules 2006, r .10.

¹⁷¹ JUSTICE (2020), *supra* note 19, para 2.14, citing Sir Andrew Leggatt, *Tribunals for Users: One System, One Service, Report of the Review of Tribunals* (2001), Overview, at [6].

Public inquiries: laying the foundations

Appointment of inquiry chairs

- 4.6 Appointment of inquiry chairs is governed by Section 4 of the Inquiries Act 2005 (“the 2005 Act”), which stipulates that each member of an inquiry panel is to be appointed by the relevant Minister by an instrument in writing. While judicial appointments were reformed through the Constitutional Reform Act 2005 and the creation of the Judicial Appointments Commission, the 2005 Act effectively results in the “tap on the shoulder” system of appointment for inquiry chairs.
- 4.7 Indeed, despite the manifest seriousness of events that cause or are capable of causing “public concern”,¹⁷² the only requirement for consultation is in relation to serving members of the judiciary.¹⁷³ The Act stipulates that inquiry panellists must be impartial;¹⁷⁴ but there are no further criteria against which appointments should be made.
- 4.8 The Cabinet Office ‘Inquiries Guidance’ suggests:

*The Minister may seek advice from professional, regulatory or other bodies in the appropriate field. The impartiality of the Chair should be beyond doubt ... Depending on the circumstance, the Chair and panel may need to be legally qualified or have expert professional knowledge. Thinking through what type of Chair is required is critical. In some cases, but by no means always, this could be a judge or a senior barrister. Other types of chair to consider include someone with experience in the field. For some inquiries individuals with experience of running or working in large organisations may be more suitable.*¹⁷⁵

¹⁷² *Ibid*, s. 1.

¹⁷³ *Ibid*, s. 10(1), which is with the respective senior judge listed.

¹⁷⁴ *Ibid*, s. 9.

¹⁷⁵ Cabinet Office Proprietary and Ethics Team, *supra* note 7, p. 3.

While it may provide some reassurance that Government Departments are urged to “think through” inquiry chair appointments, the lack of rigour and transparency presents something of an anomaly in the context of public appointments. Ministerial appointments to boards of public bodies or advisory committees, for example, follow the ‘Governance Code for Public Appointments’,¹⁷⁶ which sets out principles for appointments; the composition of assessment panels; measures to ensure transparency; and steps to promote diversity.

- 4.9 Accounts from former chairs do not inspire confidence. Sir Robert Francis QC, Chair of the Mid Staffordshire NHS Foundation Trust Public Inquiry, gave the following account to the Lords Select Committee:

*As far as appointment is concerned, like most chairmen, I had the experience of being phoned up out of the blue and asked to decide within an hour whether I would like to chair the inquiry because the minister was in a hurry to make an announcement. I am frequently asked, probably with some surprise, ‘Why were you chosen?’ I have absolutely no idea, or about the process.*¹⁷⁷

Professor Sir Ian Kennedy, Chair of the Bristol Royal Infirmary Inquiry, added: “my experience was even more dramatic from that, in so far as I was phoned at about 8.30pm to be told that the Secretary of State was delighted that I had agreed to take on this inquiry, which I might say left me with little room to negotiate”.¹⁷⁸

- 4.10 Legitimacy can be undermined by this top-down approach. Consultees from the community affected by the Grenfell Tower fire told us that their confidence in the inquiry was diminished from the outset given the widespread perception that the Chair was a political pawn.

¹⁷⁶ Cabinet Office, *Governance Code on Public Appointments* (December 2016).

¹⁷⁷ Select Committee on the Inquiries Act 2005, *supra* note 30, para 113.

¹⁷⁸ *Ibid.*

Diversity in the appointment of panellists

4.11 In the current appointments process, no formal consideration is given to questions of representation. The tendency of Ministers to select retired High Court judges means that the pool of possible candidates is extremely narrow to start with.¹⁷⁹ The Institute for Government pointed out in 2018 that of the 69 inquiries established since 1990, there had “only been six inquiries with a female chair, fewer than the number of inquiries chaired by someone called either Anthony or William”.¹⁸⁰

4.12 As highlighted by Working Party member Leslie Thomas QC in oral submissions to the Grenfell Tower Inquiry, lack of diversity within an inquiry panel, inquiry team and the legal profession is a further threat to legitimacy:

*...I've asked you to take a long hard look at your panel, your assessors, your team, and ask yourself: does it pass the smell test? Because that relates to perception, public perception... 'Do they speak our language? Do they know anything about social housing? How many of them have lived in a tower block or on a council estate or in social housing?'. That affects confidence. Confidence or lack of it affects participation. And a lack of participation from the very people who matter will affect justice. And a lack of justice is injustice.*¹⁸¹

4.13 One way in which these concerns might have been addressed in Phase I of the Grenfell Tower Inquiry was through the appointment of further panellists to sit alongside the Chair.¹⁸² The PASC's *Government by Inquiry* report found in 2006 that panels provide “a...means of enhancing the perception of fairness and

¹⁷⁹ See Norris and Sheppard, *supra* note 21, p. 16: “Out of the 68 public inquiries run between 1990 and 2017, 44 [had] judicial chairs”. On the unacceptable lack of diversity in the judiciary generally, see JUSTICE Working Party report, *Increasing Judicial Diversity* (2017) and *Increasing Judicial Diversity: An Update* (2020).

¹⁸⁰ Institute for Government, ‘Public Inquiries’, 2018. See also Adams, *supra* note 1.

¹⁸¹ Grenfell Tower Inquiry, *Procedural Hearing*, 11 December 2017, pp. 136-38.

¹⁸² A panel has been appointed for Phase II, although not without further controversy, see Robert Booth, ‘Grenfell inquiry panellist steps down over cladding company links’ (*The Guardian*, 25 January 2020).

impartiality in the inquiry process”.¹⁸³ At the Grenfell Family Consultation Day convened by INQUEST, “families were clear that...their preference for an independent diverse decision-making panel, rather than an individual chair, was the best way to encourage participation, trust and ensure the process reflected the diversity of the affected community”.¹⁸⁴ Families expressed disappointment that consultation had not taken place on the composition of the tribunal.

- 4.14 However, the prospect of appointing panellists can be polarising. Some former inquiry chairs to whom we spoke expressed uneasiness at being advised behind the scenes by “expert” wing members where hearing evidence of expert witnesses in public might promote open justice. The Lords Select Committee found that “facility of organisation, clarity of drafting and avoiding lengthening the reporting process are all persuasive arguments for having a single member panel. We recommend that an inquiry panel should consist of a single member unless there are strong arguments to the contrary”.¹⁸⁵

¹⁸³ PASC, *supra* note 44, para 73. Another way of supplementing the expertise of a single chair is through the use of seminars. Norris and Shephard, *supra* note 21, recommended at p. 33 that “to ensure that recommendations are constructed as effectively as possible and with the greatest chance of implementation, inquiries should adopt a seminar process to involve expert witnesses when constructing recommendations”. This particular recommendation was not considered in detail by the Working Party, although it appears to be wholly desirable. It has also proved workable: it was employed in the Ladbroke Grove Rail, Bristol Royal Infirmary, and Mid Staffordshire NHS Foundation Trust Inquiries.

¹⁸⁴ INQUEST (2019), *supra* note 11, para 2.1.2 The lack of panellists was seen as intertwined with the issue of conflict of interest: “we can’t have confidence in a one-person chair [from the establishment] making a single judgement on Grenfell and our experiences. When the state has a hand in the death, then the state has a duty to address the lack of trust and confidence in the process”.

¹⁸⁵ Select Committee on the Inquiries Act 2005, *supra* note 30, para 136. The necessity of appointing panellists was considered in *R (Daniels) v The Rt Hon Theresa May, The Prime Minister* [2018] EWHC 1090 (Admin). The Claimant argued that in refusing to appoint panellists to sit alongside Sir Martin Moore-Bick in the Grenfell Tower Inquiry, the Prime Minister had misdirected herself: she had failed to accept that the maintenance of public confidence is a “key or prime factor” in promoting the statutory purpose of the 2005 Act. The Court ultimately rejected this argument. However, Bean J suggested, *obiter*, that “there are persuasive arguments in favour of the appointment of a panel consisting of a chairman and other members” [46].

- 4.15 CEDR has recommended, “ideally the selection of an Inquiry Chair should be an open process whereby both those involved in the selection and the wider public can see how the selection was made; what the criteria were and why the person was considered suitable. As far as possible, ad hoc procedures or selection should be avoided”.¹⁸⁶ The CEDR report proposes a structured approach to selection exercises, which includes shortlisting of candidates “from a relatively small pool of potential appointees” and “ensuring appointees have no perceived conflicts of interest or experiences/affiliations which might subsequently cause doubt on their impartiality and independence”.¹⁸⁷ Appointees would be assessed against set criteria.
- 4.16 Building on CEDR’s proposal, we recommend that **on the establishment of public inquiries, Government should be advised on the appointment of inquiry chairs and panellists by the Independent Advisory Board to the Central Inquiries Unit (see paras 2.13-2.14). The Board should make its nominations with reference to clear, publicly accessible criteria, taking into account diversity of representation.** The results and details of nomination exercises should be made public so far as possible. In order that the Section 9 requirement for the panellists themselves to be “impartial” is not compromised, those Board members involved in the shortlisting exercise “should be...those who can be readily perceived as being independent and separate from those involved in the [inquiry] process to show impartiality”.¹⁸⁸
- 4.17 The Board’s role would be advisory, but greater consultation can only improve the current system. Assisting Ministers through the provision of expertly compiled shortlists will enhance legitimacy and promote appropriately diverse inquiry tribunals.

Setting the terms of reference

- 4.18 Setting the parameters of any inquiry is of fundamental importance. In evidence to the PASC, the Government submitted that the “terms of reference

¹⁸⁶ Mackie and Way, *supra* note 40, p. 14.

¹⁸⁷ *Ibid.*

¹⁸⁸ *Ibid.*

are a crucial factor in determining [an inquiry's] ambit, length, complexity, cost and, ultimately, its success".¹⁸⁹

- 4.19 The Council on Tribunals warned in its evidence to the same Parliamentary inquiry that: "If the terms of reference are too wide, this may result in unnecessary cost and delay, and may introduce questions which merely confuse the essential issues".¹⁹⁰ However, imposing too narrow an approach risks alienating those principally affected. During the course of one of JUSTICE's inquiry observation visits, an advocate for family core participants submitted that the limitation of that inquiry's scope to "the aftermath, rather than an investigation of the "how and why", was "a bitter pill [for the families] to swallow".¹⁹¹
- 4.20 A number of bodies and experts have suggested that inquiries should facilitate wide consultation on terms of reference¹⁹² and for a particular period.¹⁹³
- 4.21 The Grenfell Tower Inquiry launched a consultation on the terms of reference in July 2017, but this was judged by participants across the inquiry to have been inadequate. Families at the INQUEST consultation argued that "there was not enough research done...they didn't consult enough with the community or engage enough".¹⁹⁴ One of our consultees, representing a public body core

¹⁸⁹ PASC, *supra* note 44, para 74.

¹⁹⁰ *Ibid*, citing HC 1995–96 114, para 5.19.

¹⁹¹ Seeking consensus on terms of reference also arguably reduces the prospect of legal challenge. Judicial reviews were sought of the terms of reference at the outset of the Robert Hamill and Billy Wright inquiries. See *Hamill, Re Judicial Review* [2008] NIQB 73 and *Wright, Re Application for Judicial Review* [2006] NIQB 90).

¹⁹² In their evidence to *Government by Inquiry*, Sir Robert Francis QC and the General Medical Council, PASC, *supra* note 44, para 82, a proposal reiterated by Sir Robert when giving evidence to this Working Party.

¹⁹³ Jason Beer QC, *Public Inquiries* (OUP 2011), para 2.103, noted that at one stage Government had considered stipulating "a 'cooling off' period of perhaps of a few weeks before the terms of reference were set by the minister. The Select Committee on the Inquiries Act 2005, *supra* note 30, also suggested at para 150 that a short period of *no more than a month* should be allowed between the announcement of an inquiry and the finalisation of the terms of reference.

¹⁹⁴ INQUEST (2019), *supra* note 11, para 2.1.2.

participant, described the consultation as “window-dressing which convinced no one,” adding that “finalising terms of reference should be a lengthy process to allow the Chair to research and understand properly the issues at play”.

- 4.22 We agree that **sufficient time should be allowed for the setting of terms of reference, to enable issues to be identified and proper consultation (including with bereaved people and survivors) to take place.** Given the complexity of issues contributing to fatal events such as the Grenfell Tower fire, or indeed the COVID-19 pandemic, we do not consider that the stipulation of a standard minimum window of time is appropriate. However, the exercise must allow for sufficiently wide consultation, followed by proper analysis of responses. This would apply to the SPI as well as to public inquiries.

Venue

- 4.23 The physical environment of inquest and inquiry hearings is often unsuitable for bereaved people and survivors. Insufficient resources can serve as a contributing factor; the ‘INQUEST Handbook’ notes that “some inquest venues have a designated room that the family can use as a waiting room ... if this is not available, the family often find themselves waiting in the same room as other [interested persons], which can in itself be distressing”.¹⁹⁵ On occasion however, distress is compounded by thoughtless layout. One bereaved parent told us that at the inquest into the death of their child, the room was laid out so that they had to share a bench with officials from the NHS Trust in whose care the child had died.¹⁹⁶ One Senior Coroner described how, at the last minute, he had personally moved chairs around the court to prevent members of the press being seated directly opposite bereaved family members.
- 4.24 Participation in public inquiries has similarly been hampered by poor layout. Both the choice of venue and the room geography of Phase I of the Grenfell

¹⁹⁵ INQUEST (2016), *supra* note 157, p. 40. See also Owen Bowcott, ‘Bereaved woman asked to pay £1,000 for private room at inquest’ (*The Guardian*, 10 September 2018).

¹⁹⁶ The officials, we were told, “almost cheered when things went their way” through the course of the inquest hearing.

Inquiry was widely criticised by bereaved and survivor core participants,¹⁹⁷ despite the inquiry team’s stated commitment to accessibility.¹⁹⁸ JUSTICE staff also observed a hearing of the Independent Inquiry into Child Sexual Abuse (IICSA), during which we noted that the room was set up so that the panel was turned away from the survivor core participants in attendance, and a LiveText screen and corporate banner obscured the survivors’ view of the panel altogether.

- 4.25 The Infected Blood Inquiry has made a concerted effort to avoid problems such as these. Recognising the geographical spread of those affected, hearings are held at rotating venues throughout the United Kingdom. In his opening remarks, the Chair stressed that:

*[The inquiry] is not run for the benefit of lawyers, but for people who are involved. So, the hearing room will be designed so that there won't be ranks of lawyers in the front row, obscuring the view of the public, who need to hear, the people who have been infected, affected, those concerned, those touched by the Inquiry. My aim is to have lawyers to one side, press to the other and members of the public in front of the witness, who will take centre stage, as the witness should. The judge won't. There isn't a judge. It is an Inquiry.*¹⁹⁹

Following this example, **local authorities and inquiry teams administrating inquests, SPIs and public inquiries should ensure that venue(s) for hearings are chosen and designed in order to prioritise the needs of bereaved people and survivors.**²⁰⁰

¹⁹⁷ INQUEST (2019), *supra* note 11, para 2.3.

¹⁹⁸ See Mark Fisher, [Letter to Deborah Coles](#) (13 September 2018).

¹⁹⁹ Infected Blood Inquiry, [Preliminary Hearing 24 September 2018](#), p. 6.

²⁰⁰ We note this is already anticipated in [Chief Coroners Guidance No. 2: Location of Inquests](#), para 4: “In reaching a decision on the venue for an inquest...the coroner should take due account, as with all the other inquest arrangements, of the views of interested persons including bereaved relatives and the distances they may have to travel to attend the inquest”.

- 4.26 The Working Party appreciates that expense and availability of suitable venues can pose challenges for inquiry teams. However, in the class of cases with which the Working Party is concerned, **venue design should at minimum aim to position bereaved people and survivors at the heart of the hearing with: adequate views of the panel and witnesses; sufficient separation from any other core participants/interested persons implicated in the events; and access to private, quiet space.**
- 4.27 The JUSTICE Working Party report *Understanding Courts* made a number of recommendations aimed at making court spaces accessible and understandable for lay users.²⁰¹ Several of those proposals are relevant to inquest and inquiry hearing venues. For example, **inquiry teams should ensure that there are clear signs around the venue and prominently displayed maps at the entrances. Signs should also be used within the hearing rooms themselves to indicate to family members as well as members of the public where they should sit and who other people in the room are. Ahead of all hearings, bereaved people and survivors should be given familiarisation tours of the venue.**
- 4.28 The Working Party would suggest that a Central Inquiries Unit within the Cabinet Office (see **paras 2.4-2.7**) is well placed to advise inquiry teams on venue choice and design.

Management of evidence

Disclosure

- 4.29 A number of our consultees and Working Party members who represent families voiced frustration with what they described as the “drip-feed” of disclosed documents from coroners’ offices. One consultee recalled acting in a military inquest:

I think there were about a dozen interested persons...the whole thing turned on radio communications and when they were made. We’d been asking for this to be disclosed, as the Ministry of Defence keeps a

²⁰¹ JUSTICE (2019), *supra* note 19, recommendations 13-15.

handwritten log of every message that goes out. We got a month's worth of logs on the day the inquest opened, and the coroner would not adjourn.

- 4.30 The Working Party appreciates that it is difficult to be prescriptive about disclosure in inquests and inquiries: it is important that the coroner/inquiry team is able to control the investigation and retains the ability to make decisions on relevance. However, in order to avoid the problems and potential unfairness caused by late disclosure, we recommend that **where documents have been received by the coroner and there is no objection from the record-holder, a presumption should apply that disclosure will be made to bereaved family interested persons within seven days of receipt. Where in exceptional circumstances disclosure within that period is not possible, notice should be given to the relevant interested persons.**
- 4.31 In the case of public inquiries, the Working Party recognises that the sheer volume of material can take a significant amount of time for the inquiry team to process for relevance and privilege. However, in order to encourage transparency and promote participation, **the Working Party recommends that SPIs and public inquiries issue regular public updates on disclosure, including the number of documents already disclosed and time estimates for the completion of any processing phase.**²⁰²

The need for candour

- 4.32 Reflecting on Phase I of the Grenfell Tower Inquiry, bereaved families “were...vocal in their dissatisfaction with what they saw as a lack of candour on the part of the authorities and corporate entities. It was a consistent complaint arising in each of the facilitated groups with families criticising perceived evasiveness”.²⁰³
- 4.33 This account resonates with a number of previous reports highlighting “institutional defensiveness” as a pervasive issue in Article 2 ECHR

²⁰² See Grenfell Tower Inquiry, ‘[Update from the Inquiry](#)’, 9 June 2020: “Disclosure figures: as at 8 June 2020, the Inquiry has disclosed 20,752 documents in Phase 1, and 154, 333 in Phase 2, coming to a total of 175,085”.

²⁰³ INQUEST (2019), *supra* note 11, para 2.4.2.

investigations. In her Review of deaths and serious incidents in custody, Dame Elish Angiolini concluded: “it is clear that the default position whenever there is a death or serious incident involving the police, tends to be one of defensiveness on the part of state bodies”.²⁰⁴ Writing on the experience of the Hillsborough families, Bishop James Jones found that South Yorkshire Police’s “repeated failure to fully and unequivocally accept the findings of independent inquiries and reviews has undoubtedly caused pain to the bereaved families”.²⁰⁵ From these and several other accounts,²⁰⁶ it is clear that public authorities and private sector organisations have consistently approached inquiries as if they were litigation, failing to disclose the extent of their knowledge surrounding fatal events unless directed to do so.

- 4.34 In addition to the pain and suffering caused, such a stance contributes to lengthy delays as the inquiry grapples with identifying and resolving the issues in dispute,²⁰⁷ at cost to public funds and public safety. Such institutional defensiveness and the inherent imbalance of power at its heart must so that public authorities and those exercising a public function approach the inquiry process with “their cards on the table”.

Existing duties of candour

- 4.35 A duty of candour already exists at common law in the context of judicial review (“JR”). Unlike civil or criminal proceedings, no formal duty of disclosure is imposed on parties in JR unless the Court orders otherwise.²⁰⁸ The

²⁰⁴ Angiolini, *supra* note 15, para 17.2.

²⁰⁵ Jones, *supra* note 16, p. 81.

²⁰⁶ See, for example: Sir Robert Francis QC, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (HC 947, 2012-13), pp. 103, 114; Equality and Human Rights Commission, *Preventing Deaths in Adult Mental Health Detention* (2015), p. 3, recommendation 3; Lord Toby Harris, *The Harris Review: Changing Prisons, Saving Lives* (Cm 9087, July 2015), paras 7.15-19; Dr Bill Kirkup CBE, *The Report of the Morecambe Bay Investigation* (2015), para 1.24 and recommendation 30; and HHJ Teague QC, *Report into the Death of Anthony Grainger* (HC 2354, 2017-19).

²⁰⁷ Jones, *supra* note 16, para 2.106.

²⁰⁸ CPR Part 54, Practice Direction 54A, para 12. However, as a direct consequence of the recommendations arising from the Mid Staffordshire NHS Foundation Trust Public Inquiry, a statutory duty of candour was imposed on the health sector through Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

duty of candour fills the gap by ensuring that at the outset of a JR the public body provides a true and comprehensive account of the way that it arrived at relevant decisions, “by way of [witness statement] of the relevant facts and (so far as they are not apparent from contemporaneous documents which have been disclosed) the reasoning behind the decision challenged”.²⁰⁹ The public authority must assist the court with full and accurate explanations of all facts relevant to the issue before the court.²¹⁰

- 4.36 The essential principle is that a public authority’s objective should not be to win the case at all costs, but to assist the court in its consideration of the lawfulness of the decision under challenge, thereby serving to uphold the rule of law and improve standards in public administration. It must therefore fully disclose all relevant information, including that which is harmful to its own case.²¹¹
- 4.37 The duty extends beyond mere disclosure. In a recent pronouncement on the duty, Singh LJ observed that:

The duty of candour and co-operation which falls on public authorities, ... is to assist the court with full and accurate explanations of all the facts relevant to the issues which the court must decide. It would not, therefore, be appropriate, for example, for a defendant simply to offload a huge amount of documentation on the claimant and ask it, as it were, to find the “needle in the haystack.” It is the function of the public authority itself to draw the court’s attention to relevant matters; as [counsel for the Respondent] put it at the hearing before us, to identify “the good, the bad and the ugly”. This is because the underlying principle is that public authorities are not engaged in ordinary litigation, trying to defend their own private interests. Rather, they are engaged in a common enterprise

²⁰⁹ *Belize Alliance of Conservation Non-Governmental Organisations v Department of the Environment* [2004] UKPC 6, [2004] Env LR 761 [86] (Lord Walker).

²¹⁰ *R (Quark Fishing Ltd) v Secretary of State for Foreign and Commonwealth Affairs* [2002] EWCA Civ 1409 [50].

²¹¹ *R v Lancashire County Council, ex parte Huddleston* [1986] 2 All ER 941.

*with the court to fulfil the public interest in upholding the rule of law.*²¹²
[emphasis added]

- 4.38 Outside the health sector, public bodies in other fact-finding jurisdictions are assisted by the Treasury Solicitor Guidance: “the principles set out here may have generic relevance to Standard Disclosure under Part 31 CPR in such cases, Norwich Pharmacal orders, applications for specific discovery *and to inquests and inquiries*”²¹³ [emphasis added].

The Bishop’s Charter

- 4.39 In *Patronising Disposition*, Bishop James Jones promulgated a voluntary ‘Charter’ directed at candour, particularly within inquiry and inquest processes.

Charter for Families Bereaved through Public Tragedy

In adopting this charter I commit to ensuring that [this public body] learns the lessons of the Hillsborough disaster and its aftermath, so that the perspective of the bereaved families is not lost.

I commit to [this public body] becoming an organisation which strives to:

1. In the event of a public tragedy, activate its emergency plan and deploy its resources to rescue victims, to support the bereaved and to protect the vulnerable.
2. Place the public interest above our own reputation.
3. Approach forms of public scrutiny – including public inquiries and inquests – with candour, in an open, honest and transparent way, making full disclosure of relevant documents, material and facts. Our objective is to assist the search for the truth. We accept that we should learn from the findings of external scrutiny and from past mistakes.

²¹² *R (Hoareau) v SSFCA* [2018] EWHC 1508 (Admin) [20].

²¹³ Treasury Solicitor’s Department, *‘Guidance on Discharging the Duty of Candour and Disclosure in Judicial Review Proceedings’*, 2010, p. ii.

4. Avoid seeking to defend the indefensible or to dismiss or disparage those who may have suffered where we have fallen short.
5. Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely.
6. Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media.

4.40 We understand from consultees that when adopted, the Charter can have a profound effect. In order to promote cultural change, we therefore recommend that **leaders of public sector bodies sign up to Bishop James Jones’s ‘Charter for Families Bereaved through Public Tragedy’.**

4.41 However, the voluntary nature of the Charter means that it is not a panacea.²¹⁴ In the Grenfell Tower Inquiry, it has only been adopted by the Mayor of London and Royal Borough of Kensington and Chelsea. We have been told that public of authorities are still being advised to consider their stance at inquests within their “litigation strategy” and should be careful to avoid making admissions where possible. The Working Party considers that the time has come for a statutory duty of candour.

A statutory duty of candour

4.42 The Public Authority (Accountability) Bill (“the Bill”), which would have introduced a statutory duty of candour, attracted cross-party sponsorship and was scheduled for a Second Reading in May 2017 but fell after the 2017 General Election.

²¹⁴ Indeed, *Patronising Disposition* supported the introduction of a statutory duty of candour in addition to the voluntary Charter. See p. 102, Point of Learning 13: “I agree with the [Public Authority (Accountability)] Bill’s aims and with the diagnosis of a culture of institutional defensiveness which underpins it. I have drawn heavily on the Bill’s principles in the drafting of the charter and in my proposals for ‘proper participation’ for bereaved families at inquests... I agree with the view that while legislation isn’t the answer to creating a culture of honesty and candour, it is part of the answer”.

- 4.43 The Working Party recommends the introduction of a statutory duty of candour in inquests and inquiries.** We consider that the Bill, which through clause 2 would impose “a duty to assist...official inquiries and investigations”, provides the appropriate framework for introduction of the duty, subject to **paras 4.46-4.48** below.
- 4.44** Clause 1(3) of the Bill makes provision for the manner in which the duty is to be discharged. Clause 1(3)(d) stipulates that public servants and officials shall “make full disclosure of relevant documents, material and facts”. Clause 1(3)(e) requires that they will additionally “set out their position on the relevant matters at the outset of the proceedings, inquiry or investigation”.
- 4.45** The Working Party agreed that a position statement, as envisaged under clause 1(3)(e), should not amount to a pleading, which is adversarial in nature. As the drafters of the Bill put it – “it should include responsibilities and duties, relevant policies, command and control structures, what the institution’s officers/employees did and did not do, good practice, wrongdoing, failures and omissions, and what others did only so far as it impacted on its own performance”.²¹⁵ To that should be added an account of any remedial steps taken since the incident in question.
- 4.46** Whilst there was broad agreement as to the nature of such a statutory duty, there was a divergence of view as to the application of clause 1(3)(e). Should the obligation to provide such a statement arise automatically or be at the direction of the chair/coroner? It was agreed that such a statement would be both appropriate and desirable in most cases; but that will not invariably be so. The underlying facts may be too uncertain at the outset to enable a meaningful position to be set out. There may be a conflict of evidence between different employees of a public body that may need to be resolved by the calling and assessment of the evidence. There may be circumstances in which such statements will prolong, not shorten, the proceedings. Whilst it will be open to the makers of statements to update or amend them in the light of developing knowledge, that will not meet all contingencies. It is therefore proposed that the requirement to provide a position statement should be subject to a tribunal

²¹⁵ Written evidence to Working Party.

power to direct that it should not be made or to give directions as to its timing. In other words there should be a rebuttable presumption that a position statement is required.

- 4.47 Secondly there was a divergence of view within the Working Party as to whether breach of the duty should be subject to criminal sanctions. Clause 3 of the Bill would have created offences for intentional or reckless disregard of the duty (including through misleading the general public, media or the court, or through unreasonable failure to provide a witness statement). We understand that the drafters intended the inclusion of such provisions to serve as a backstop: some of us felt that their inclusion is essential to give the imposition of a statutory duty teeth; others remained unconvinced.
- 4.48 The Working Party agrees **that a statutory duty of candour should be subject to the privilege against self-incrimination.**
- 4.49 The Working Party considers that the introduction of a clearly defined statutory duty of candour will significantly enhance the participation of bereaved people and survivors, giving some sense of the organisation's position at the outset and so limiting the possibility of evasiveness or ambush. Further, and critically, by directing the investigation to the most important matters at an early stage, a statutory duty of candour should strengthen the ability of the inquiry to reach the truth, and to do so without undue delay.

V. HEARING PROCEDURE AND PRACTICE

- 5.1 Inquests and inquiries are nominally inquisitorial proceedings. Indeed, our evidence gathering suggested that there is a firm belief in and commitment to an inquisitorial process amongst professional users. This mirrors the experience of the Lords Select Committee: “all our witnesses who addressed the issue agreed that inquiries were best served by an inquisitorial rather than an adversarial procedure, with the line of questioning directed at ensuring that the panel hear all that they need to know”.²¹⁶ In the inquest context, the very first principle cited in the Government’s 2019 ‘Review of legal aid for inquests’ is that “inquests should be inquisitorial”.²¹⁷
- 5.2 However, despite this aspiration, evidence from bereaved family members and their representatives suggest that, ostensibly, inquisitorial procedures in reality are often a “highly adversarial battle”.²¹⁸ The hostility of the process is described across three chapters of Working Party member Dr Sara Ryan’s account *Justice for Laughing Boy*, which notes “the coronial process, as we were to find out, is an intricate, archaic, law-drenched and uncertain journey in which families without expert legal representation are too easily silenced”.²¹⁹
- 5.3 Recognising that legal processes can be deeply alienating for lay users, and drawing on the proposals in *Understanding Courts*, the Working Party makes four general recommendations applicable across inquests and inquiries:

²¹⁶ Select Committee on the Inquiries Act 2005, *supra* note 30, para 213.

²¹⁷ Ministry of Justice, ‘Final report: Review of legal aid for inquests’, February 2019, para 5. Inquisitorialism is cited throughout as the basis for the current limits on public funding, see paras 26, 36, 45-46, 201.

²¹⁸ Jones, *supra* note 16, para 2.37 (citing David Conn).

²¹⁹ Sara Ryan, *Justice for Laughing Boy* (Jessica Kingsley Publishers 2018) p. 151. Dr Ryan also describes meeting an MP to discuss the process: “[he] remained resolute in his belief that the coronial process was not adversarial. He had an unswerving faith in the strength and integrity of Coroners to – fearlessly – manage the process of grief-stricken families on the one side and a well-armed stock of in-house and external lawyers and barristers on the part of a [public body], with unlimited funds” at pp. 157-8.

- i. **All inquest and inquiry professionals should be encouraged through training, continuing professional development and reflective processes to empathise with bereaved people and survivors**, involving both active and observational methods, such as sitting in the witness box, using a video link, sitting in hearings where they themselves are not acting, and shadowing members of the Coroners Courts Support Service.
- ii. **Careful consideration should be given to communication in the hearing to ensure that – as far as possible – the proceedings can be fully understood by family members and members of the public.**
- iii. **Inquests and inquiries should put systems in place so that vulnerabilities of any interested persons, core participants or other witnesses are identified early and appropriate adjustments made to enable them to effectively participate.**
- iv. **Inquests and inquiries should ensure that bereaved people and survivors are signposted to appropriately specialist sources of support for trauma, including at the close of the legal process.**²²⁰

Using pen portraits

5.4 A number of our consultees drew attention to the potential value of incorporating commemorative biographical tributes (“pen portraits”) in both inquests and inquiries.²²¹ *Patronising Disposition* found that “the use of pen portraits at the fresh Hillsborough inquests helped to put the families at the heart of proceedings. The process was vital in humanising the inquests and was

²²⁰ The [Infected Blood Inquiry webpage](#) has a click-through box labelled “confidential support” clearly visible on the frontpage of its website. This details the telephone counselling service run by the Red Cross, available to anyone affected by treatment with infected blood or blood products.

²²¹ Some families may wish to accompany a prose biographical portrait with other forms of media. Bishop James Jones noted (at p. 100, Point of Learning 9(iv)), “allowing a photograph to be displayed is an important part of putting the family at the centre of an inquest and I can see no proper reason why a coroner should seek to prevent it. The Chief Coroner should ensure that the practice of allowing a photograph to be shown is widely adopted”. The Grenfell Tower Inquiry allowed relatives to use video, music and other media, see Owen Bowcott, ‘[All inquiries should use Grenfell’s tributes model, charity says](#)’ (*The Guardian*, 30 May 2018).

both important and therapeutic for the bereaved”.²²² At the Grenfell Family Consultation Day: “families appreciated the pen portrait and commemorations and highlighted the importance of recognising relatives and humanising a legal process that some described as feeling ‘cold’ and ‘impersonal’”.²²³ Unlike many other elements of the Phase I hearings, “families were in broad agreement that the pen portraits also had a positive impact for the Inquiry team and the legal community”.²²⁴

- 5.5 However, in our experience, understanding varies amongst coroners as to whether pen portraits can be utilised in inquests. We recommend that **the Chief Coroner and proposed Central Inquiries Unit clarify that pen portraits are an important way of placing the bereaved and their loved one at the heart of the process.**

Questioning witnesses

- 5.6 A number of accounts of inquest proceedings suggest that interested persons are on occasion subjected to aggressive and inappropriate questioning. Particularly stark examples are highlighted in INQUEST’s written submission to *Patronising Disposition*:

“At the inquest into the death of Cheryl James, who died at Deepcut Barracks, her father Des James was questioned by a very experienced QC... Q. ‘did it ever occur to you in the numerous emails, letters and other complaints that you wrote over that 15-month period, did it ever occur to you that you yourself might have been distracting Surrey Police from what some might have thought were even more pressing enquiries?’”

“The mother of a young man who was suffering a mental health crisis and was transported in restraints to a police station and died shortly after, was questioned... about her own care for her son, though she had pleaded with officers to take him to hospital. She collapsed following this ordeal...: ‘I was a

²²² Jones, *supra* note 16, p. 100 Point of Learning 9(iv).

²²³ INQUEST (2019), *supra* note 11, para 2.2.

²²⁴ *Ibid.*

witness and the police barrister had me on the stand for three and a half hours. He battered me literally with questions. He accused me of not caring about my son, he was shouting at me, slamming books, was so aggressive. The coroner did nothing for a long time, he was asking very offensive questions and only after three and a half hours the coroner said ‘okay that’s enough now’”.

**INQUEST submission to Review of the Hillsborough Families’
Experiences by the Rt Rev Bishop James Jones (2017), pp. 11-12.**

- 5.7 Dame Elish Angiolini recommended that the Chief Coroner should issue formal guidance to coroners to prevent inappropriate or aggressive questioning of next of kin by counsel for interested persons.²²⁵ Certainly, coroners have a vital role to play in controlling questioning during hearings.²²⁶ This should be supplemented by proactive case management; for example, the second Hillsborough inquests included a procedural stage akin to a ground-rules hearing to prepare for the questioning of witnesses suffering from post-traumatic stress disorder.
- 5.8 The vast majority of consultees agreed with us as to the potential value of training on questioning vulnerable witnesses – for advocates and tribunals. One senior lawyer told us that before acting as counsel to the inquest in a major hearing, they “had a long session with a psychologist, asking him lots of questions. You can think you’re pretty good, but there are always techniques to be learnt”.
- 5.9 Recent JUSTICE Working Parties *Understanding Courts* and *Prosecuting Sexual Offences* recognised the importance of “[c]ontinuing professional development training courses on vulnerable and intimidated witnesses, such as the [ICCA] *Advocacy and the Vulnerable* training programme and guidance on questioning vulnerable witnesses in toolkits produced by the Advocates’

²²⁵ Angiolini, *supra* note 15, p. 243, recommendation 76.

²²⁶ One of our consultees suggested that limiting adversarial questioning falls within the scope of the principles set down by Lord Justice Clarke in his *Public Inquiry into the Identification of Victims Following Major Transport Accidents* (Cm 5102, 2001), which include “respect for the deceased and the bereaved” and “a sympathetic and caring approach throughout”. The consultee stressed that any training or guidance to coroners should be centred on Lord Justice Clarke’s principles.

Gateway (TAG) [which] provide excellent guidance for legal professionals on how to approach the questioning of vulnerable witnesses”.²²⁷ Those Working Parties found that although “current training and guidance on adaptive styles of questioning and treatment tends to concentrate on ‘vulnerable’ and ‘intimidated’ witnesses”,²²⁸ the techniques learnt (could and indeed should) have broader application.²²⁹

- 5.10 We consider that there is much to be learnt from best practice developed for cross-examination in criminal trials. This was an impression enthusiastically greeted by consultees with practices straddling both jurisdictions. Consequently, we recommend that **advocates and coroners questioning witnesses in inquest and inquiry hearings should be required to complete the ICCA Advocacy and the Vulnerable training programme**. Further, we recommend that the **Advocate’s Gateway should consider providing a toolkit for questioning witnesses in inquests and inquiries**.

Limitations on questioning witnesses in inquiries

- 5.11 Questioning of witnesses in public inquiries is governed by Rule 10 of the Inquiry Rules 2006, which stipulates that only the CTI may ask questions of witnesses, subject to limited circumstances in which a legal representative of a witness or core participant is directed by the chair to ask questions,²³⁰ or makes an application to do so.²³¹

²²⁷ JUSTICE (2019), *supra* note 19, para 3.55. As noted in the corresponding footnotes: *The Advocacy and the Vulnerable* training programme has been designed to ensure that all advocates, when dealing with vulnerable witnesses, understand the key principles behind the approach to and questioning of vulnerable people in the justice system, irrespective of the nature of the allegation, or the jurisdiction in which the advocate appears: see the [ICCA website](#). [The Advocate’s Gateway](#) provides free access to practical, evidence-based guidance on vulnerable witnesses and defendants. It currently has 18 toolkits, for criminal, civil and family jurisdictions, and cross-cutting general guidance. See also JUSTICE Working Party report, *Prosecuting Sexual Offences* (2019), para 4.57-8.

²²⁸ *Ibid*, para 3.54.

²²⁹ *Ibid*, paras 3.57-58.

²³⁰ The Inquiry Rules 2006, r. 10(2).

²³¹ *Ibid*, rr. 10(3)-(5).

- 5.12 The rule plays an important role in maintaining the inquiry’s focus and ensuring that the inquiry can proceed within its set timetable (and consequently its budget). We have heard of a number of inquiries in which the rule has been applied without controversy, typically with the CTI handling the bulk of questioning and then core participants’ legal representatives asking particular questions touching on specialist topics or areas particularly important to their clients (cleared in advance with the CTI’s team).
- 5.13 However, exercise of the rule is entirely dependent on the approach taken by the chair. Some inquiries have adopted a markedly inflexible approach; one lawyer acting in the Renewable Heat Incentive Inquiry told us that they had not been able to ask a question for two years. The Grenfell Tower Inquiry also adopted a strict interpretation of Rule 10 during Phase I, with considerable implications for participation of bereaved, survivor and resident core participants:

*Chief amongst [families’ frustrations] were concerns as to why their lawyers did not have the power to directly question those giving evidence, instead having to submit questions in advance to counsel to the Inquiry. Many felt this placed them one stage removed from proceedings and felt the five-day time frame for lodging questions limited their ability to digest evidence before framing their follow up.*²³²

- 5.14 The inquiry team justified the approach taken by referencing the “inquisitorial” nature of the proceedings.²³³ However, this inflexibility to the rule has contributed to a profound sense of alienation. Family members expressed the view that: “legal representatives should be able to put questions forward rather than passing them on post-it notes. It is about the way in which you deliver the question...there is a way in which it is delivered now that makes it less impactful”.²³⁴

²³² INQUEST (2019), *supra* note 11, para 2.4.1.

²³³ Fisher, *supra* note 198, p. 4.

²³⁴ INQUEST (2019), *supra* note 11, para 2.4.1.

5.15 We consider that these limitations are incompatible with a number of core inquiry objectives: uncovering truth, ensuring accountability and reassuring core participants that their views are being taken into account. It may also fail to discharge the State’s obligation to carry out an effective investigation into whether serious violations of Convention rights have occurred; an enhanced investigation must enable effective involvement of next-of-kin.²³⁵ We therefore recommend that **Rule 10(4) of the Inquiry Rules 2006 should be amended to allow the legal representative of a core participant to ask questions of a witness where Articles 2, 3 or 4 ECHR are engaged. The chair should retain discretion to refuse (with reasons) a line of questioning and to impose time limits on any questioning.**

Publicly funded legal representation

5.16 In 1986 JUSTICE recommended that legal aid be made available to all “properly interested persons” as the legislation then defined them, where the then Secretary of the Legal Aid Committee thought fit, but in contemplation of any death taking place within State control.²³⁶ Public funding for legal representation in inquests is still heavily circumscribed and only available through the Exceptional Case Funding (ECF) scheme. ECF may be granted only where it is required by Article 2 ECHR or where representation is in the “wider public interest”²³⁷ such that it “is likely to produce significant benefits for a class of person, other than the applicant and members of the applicant’s family”.²³⁸

5.17 The current arrangements mean that legal representation at inquests is out of reach for the vast majority of bereaved people. The Working Party appreciates that the bulk of the 30,000 inquests opened each year are very short (sometimes only an hour, often less) and frequently completed on paper. However, in the class of complex cases concerning the Working Party, specialist legal

²³⁵ *Al-Skeini and Others v. the United Kingdom* (2011) 53 EHRR 18 [167].

²³⁶ JUSTICE Working Party Report, *Coroners Courts in England and Wales* (1986) at pp. 15-17.

²³⁷ Legal Aid Agency, ‘*Inquests – Exceptional Cases Funding – Provider Pack*’, 15 May 2020, p. 3.

²³⁸ *Ibid.*

representation is invariably essential.²³⁹ In a compelling passage, Dame Elish Angiolini addressed the issue in respect of death in custody inquests:

*It is manifestly nonsense to assume that a grieving family could undertake the process of sifting through many hundreds of pages or volumes of evidence in order to formulate pertinent questions, and indeed, face hostile questioning without support. This is not a reflection on their intellect but on the impact of grief, anxiety and the sheer volume and complexity of absorbing material while suffering.*²⁴⁰

5.18 Inquests into contested deaths involve complex legal issues, including scope; the application of Article 2 ECHR; public interest immunity; anonymity; and disclosure. State and corporate interested persons are typically able to deploy ranks of solicitors, junior barristers and QCs to advise and advocate on these issues.²⁴¹ In this context, to claim that families’ effective participation can be guaranteed by the coroner and the “inquisitorial” nature of the process is to ignore the reality.

5.19 Further, evidence from our consultees suggested that the extensive financial disclosure necessitated by the means assessment is an intrusive and demeaning

²³⁹ See [submissions made by the CTI to the London Bridge Inquests](#) (26 June 2019), pp. 165-6: “...in our respectful submission, the part played by [counsel for the families] and their instructing solicitors has been of great assistance in exploring the issues and allowing the Inquests to be as rigorous as they have been”. In response, the Chief Coroner “entirely endorsed” the CTI’s observations.

²⁴⁰ Angiolini, *supra* note 15, para 16.60.

²⁴¹ For example, in the London Bridge inquests, legal representation for public authorities comprised:

- three QCs and a Junior for the Secretary of State;
- one QC and one Junior for the Metropolitan Police;
- one QC for the City of London Police;
- one QC and one Junior for the British Transport Police;
- one junior for the London Ambulance Service;
- one junior for the London Fire Commissioner;
- one junior for Transport for London;
- one junior for the City of London Police; and
- one junior for the IOPC.

All of the above were supported by full solicitor teams. The Working Party is grateful to Hogan Lovells for the provision of this information.

process, in circumstances where the cost of representation in an inquest is in any event beyond those of any reasonable means.

5.20 A number of previous reviews have made recommendations for the provision of non-means tested publicly funded advocacy in inquests where the State is represented. These include: the final report of the Bach Commission;²⁴² Dame Elish Angiolini's Review;²⁴³ *Patronising Disposition*;²⁴⁴ and the Chief Coroner's *Third Annual Report: 2015-16*.²⁴⁵

5.21 Despite the collective force of these recommendations,²⁴⁶ the Ministry of Justice reached the following conclusion in its February 2019 'Final report: Review of legal aid for inquests':

129 [...] In the main, responses from bereaved families and representative bodies suggested that public funding for families in these cases is required to ensure that there is an equality of arms [...] However, a number of stakeholders pointed out that it should not be assumed that in cases where the state has legal representation, representation for the family is necessarily required nor that it enhances the results of the coroner's investigation. They suggested that the addition of further lawyers might actually hinder the process, by making the process more adversarial and legally complex.

130. We have also looked into the financial implications of this option. We have estimated that this option would result in an additional spend of between £30 million and £70 million. Having taken all of these considerations on board, we have decided that we will not be introducing

²⁴² The Bach Commission, *The Right to Justice: the final report of the Bach Commission* (2017), p. 33.

²⁴³ Angiolini, *supra* note 15, p. 238, recommendation 33.

²⁴⁴ Jones, *supra* note 16, p. 98, Point of Learning 9(i).

²⁴⁵ HHJ Peter Thornton QC, *Report of the Chief Coroner to the Lord Chancellor, Third Annual Report: 2015-2016* (2016), see paras 201-3.

²⁴⁶ See also INQUEST, 'Now or never! Legal Aid for Inquests', February 2019.

*non-means tested legal aid for inquests where the state has representation.*²⁴⁷

The Working Party considers this response to be wholly inadequate.

5.22 Government expresses no willingness to cap the number of advocates representing State bodies, claiming “it must be right that, for example, police or prison officers have representation at inquests where there is the potential for their job to be at risk”.²⁴⁸ It is not clear how this precautionary approach chimes with the view of the process as “inquisitorial”. It also suggested that “public bodies are very much aware of the cost of instructing lawyers and consider sharing legal resource where possible, keeping the number of lawyers to a minimum”.²⁴⁹ This claim is not borne out by the sums spent. Last year, responses to Freedom of Information Act requests submitted by organisations including INQUEST gave a sense of partial Government spend on inquest representation:²⁵⁰

Mental Health: Responses from 26 [of 53] trusts revealed that **£4,026,787.45** was spent on legal representation. In the same year the Legal Aid Agency paid a total of **£117,968** towards fees for legal representation at inquests for families following the death of a relative in contact with mental health services.

Policing: Just over **£41,000 (£41,265)** was granted by the Legal Aid Agency towards legal fees for families’ representation for those who had died in police custody. 32 of 44 police forces responded, revealing that their legal bills came to **£409,744.81**.

²⁴⁷ Ministry of Justice (2019), *supra* note 217, paras 129-30.

²⁴⁸ *Ibid*, para 185.

²⁴⁹ *Ibid*.

²⁵⁰ See INQUEST, ‘[New figures reveal “shocking” funding injustice faced by bereaved families at inquests](#)’, 1 October 2019. In respect of the data, the article notes that private providers are not included, and multiple agencies or individual members of staff/police are often separately represented at inquests.

Prisons: In 2017, the Ministry of Justice spent **£4.2million** on Prison and Probation Service legal representation at prison inquests, while granting just **£92k** in legal aid to bereaved.

Julie’s Mental Health Foundation, BBC Radio 4 File on 4; INQUEST

- 5.23 The imbalance exposed by these figures serves to preclude effective participation and may in consequence impede the ability of an inquest to discharge its function as a full and fearless investigation. **The Lord Chancellor should amend the Exceptional Funding Guidance (Inquests) so as to provide non-means tested public funding for legal representation for families where the State has agreed to provide separate representation for one or more interested persons.**²⁵¹

Warning letters

- 5.24 Our terms of reference explicitly prioritise the needs and experiences of bereaved people and survivors. However, it is axiomatic that inquires must extend fairness to all participants, including to those who may be criticised in any report arising from the process. The formal mechanism for giving notice to those who may be subject to criticism is a “representation process”,²⁵² encompassing “Maxwellisation” or “Salmon Letters” in non-statutory inquiries and “warning letters” in statutory inquiries.
- 5.25 We recognise the importance of this process. The Stephen Lawrence Independent Review has been cited as an example of an investigation in which the final report was substantially amended in light of new information revealed by Maxwellisation.²⁵³ However, a number of our consultees voiced concerns

²⁵¹ Amendment of the Guidance would bring a collateral benefit. In our experience, the availability of public funding for advocacy in Article 2 ECHR inquests invariably leads to extensive argument as to whether Article 2 is engaged (and subsequent judicial review challenges). Adoption of our recommendation would address this source of delay and expense.

²⁵² Terminology from Andrew Green QC, Tony Peto QC, Pushpinder Saini QC, Fraser Campbell and Ajay Ratan, ‘A Review of “Maxwellisation”’, 2016, para 2.

²⁵³ Mark Ellison QC, *The Stephen Lawrence Independent Review: Possible corruption and role of undercover policing in the Stephen Lawrence case, Volume One* (HC 2014, 1038-1), pp. 154-6.

regarding the regime under the Inquiry Rules 2006, which they felt to be onerous and inflexible.

5.26 Rule 13(3) provides that “the inquiry panel must not include any explicit or significant criticism of a person in the report, or in any interim report, unless (a) the chairman has sent that person a warning letter; and (b) the person has been given a reasonable opportunity to respond to the warning letter”. This stipulation can lead to considerable delays and cost; in evidence to the Lords Select Committee Sir Robert Francis QC observed, “in practice I think my inquiry was extended by at least six months by having to undertake a rule 13 process.”²⁵⁴ Sir Brian Leveson asserted that “if I had obeyed [Rule 13] to the letter, [it] would have killed any prospect of doing the [Leveson Inquiry] report in time”.²⁵⁵

5.27 In a thorough review commissioned by the Treasury Committee, a team led by Andrew Green QC concluded:

- a. *The common law imposes no rigid requirement that a Representations Process must always be conducted. What is required is that a person be given a fair opportunity to respond to criticism prior to its publication in a report.*
- b. *It follows that, if a person has already been given a fair opportunity to respond to the substance of a proposed criticism contained in a draft report (such opportunity being given at the evidence-gathering stage of an inquiry), there is no need to give that person a further opportunity to make any representations prior to publication of the report.*
- c. *It is important that those conducting inquiries have flexibility to determine the procedures (including any procedures relating to the Representations Process) to be adopted for the purpose of fulfilling the terms of reference of the particular inquiry in a way that is fair, while recognising the importance of expedition and cost efficiency.*²⁵⁶

²⁵⁴ Select Committee on the Inquiries Act 2005, *supra* note 30, para 246.

²⁵⁵ *Ibid*, para 247.

²⁵⁶ Green QC et al, *supra* note 252, para 13.

5.28 Consequently, the authors “endorse[d] the recommendation of the House of Lords Select Committee on the Inquiries Act 2005 that Rules 13 to 15 should be revoked”.²⁵⁷ Drawing our recommendation more narrowly, **the Working Party recommends that the mandatory requirement to warn a person of criticism in Rule 13(3) of the Inquiry Rules 2006 be revoked.** We would retain the discretionary power to warn and the current requirements for confidentiality and contents of warning letters otherwise contained in Rules 13-15.

²⁵⁷ *Ibid.* The authors note, “Government initially rejected this recommendation, but then agreed (in July 2015) to reconsider the position. It does not appear yet to have done so”.

VI. LEARNING, ACCOUNTABILITY AND SYSTEMIC CHANGE

Forty-three years and one month before Hillsborough, 33 people died and over 500 were injured at an FA Cup tie between Bolton Wanderers and Stoke City...The Home Office inquiry, chaired by Moelwyn Hughes, criticised the police and ground officials for not realising the significance of the build-up outside the ground...Moelwyn Hughes made many recommendations to prevent such a disaster happening again. Professor Phil Scraton²⁵⁸

- 6.1 A key feature that distinguishes inquiries from other parts of the justice system is the expectation that recommendations will be made to prevent similar events from recurring. Indeed, it has been argued that this is the *primary* function of an inquiry: “to be forward-looking, to improve government and public services, and to prevent the same mistakes from being made again – is the most important contribution that an inquiry can make to the wider public interest”.²⁵⁹
- 6.2 The report by the Institute for Government *How public inquiries can lead to change* noted that many inquiries have delivered valuable legislative and institutional change, citing the establishment of the Rail Accident Investigation Branch, CRB checks and more effective gun control.²⁶⁰ However, relative to their expense,²⁶¹ the expertise they accumulate and the importance of the subjects they address, the success of inquiries in precipitating meaningful change remains questionable. In the Executive Summary of the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Sir Robert Francis observed that “the experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent”.²⁶²

²⁵⁸ Scraton, *supra* note 2, pp. 37-8.

²⁵⁹ Norris and Shephard, *supra* note 21, p. 8.

²⁶⁰ *Ibid.*

²⁶¹ *Ibid.*, p. 4.

²⁶² Francis QC, *supra* note 206, para 41.

- 6.3 That observation corresponds with the Grenfell experience. Although the Chair found in Phase I that the aluminium composite material (ACM) cladding panels provided the “primary cause” of fire spread up the tower,²⁶³ at time of writing Government has spent less than a quarter of what it promised to replace ACM cladding on other structures, leaving 300 high-rise buildings at risk three years after the disaster.²⁶⁴
- 6.4 Moreover, the Grenfell Tower fire itself demonstrates the consequences of failing to implement previous recommendations. Following the Lakanal House tower block fire in 2009 that led to the deaths of six people, the coroner issued Rule 43 letters in 2013 finding *inter alia* that the “stay put” policy and Building Regulations were in need of review.²⁶⁵ These recommendations were not implemented by the time of the Grenfell Tower fire, over eight years after the previous incident.
- 6.5 Rule 43 letters were replaced by Prevention of Future Death (PFD) reports following enactment of the Coroners and Justice Act 2009 (“the 2009 Act”). Schedule 5, paragraph 7(2) of the 2009 Act provides that a person to whom a Senior Coroner makes a PFD report must give a written response to the Senior Coroner. However, as noted by Dame Elish Angiolini, “coroners are not able to follow up or enforce recommendations in their PFD reports”.²⁶⁶ Dame Elish stressed how in the context of deaths in custody, lack of enforcement creates an accountability vacuum, exacerbated by the fact that no one is held formally responsible for implementing recommendations arising from IOPC investigations.²⁶⁷
- 6.6 Consequently, a 2018 INQUEST report on the deaths of 25 women in custody since March 2007 found “a series of systemic failures around self-harm and

²⁶³ The Rt Hon Sir Martin Moore-Bick, *Grenfell Tower Inquiry: Phase I Report Overview* (October 2019), para 34.4.

²⁶⁴ National Audit Office, *Investigation into remediating dangerous cladding on high-rise buildings* (HC 2019-21, 370).

²⁶⁵ See HH Frances Kirkham CBE, *Letter to the Rt Hon Eric Pickles MP* (28 March 2013).

²⁶⁶ Angiolini, *supra* note 15, para 17.23.

²⁶⁷ *Ibid.*

suicide management and inadequate healthcare”, in addition to “other contributory factors [including] lack of staff training, poor communication and poor record keeping”.²⁶⁸ This is despite 15 PFD reports relating to the deaths having been issued over the same period.

- 6.7 The reasons why institutions fail to change – behavioural, cultural, political as well as legal – are complex, and stretch beyond the scope of this review.²⁶⁹ However, the Working Party felt that it was critical to consider how the justice system might be reformed to promote meaningful implementation following the inquiry process. We appreciate that this is of central importance to those principally affected by catastrophic events, who see recommendations formulated at the conclusion of the legal process, then hear about deaths in similar circumstances months or years later.

Inquiry design

Limited tenure of judicial chairs

- 6.8 Where judicial chairs are appointed, there is an inherent limitation in their ability to initiate a process of systemic change:

*By nature of their training and experience, judges tend to see the end of an inquiry as a hard point of separation, after which their involvement ceases...their oaths preclude them from getting involved in politics... However, such a wall between an inquiry and its aftermath entails the loss of the chair’s unique standing and moral authority, which often make them one of the most effective advocates for their recommendations.*²⁷⁰

²⁶⁸ INQUEST, ‘Still Dying on the Inside’, May 2018, p. 16.

²⁶⁹ See Bennett Institute for Public Policy, ‘Workshop Report: Policy Lessons from Catastrophic Events’, May 2020, Introduction. Various root causes include a “focus on regulatory requirements rather than doing what is right for people”; a lack of diversity (including cognitive diversity) in decision-making roles; a failure to take opportunities to learn from “near-misses”; a reliance on simple fixes and resistance to acknowledging complexity; in addition to organisational systems, processes and cultures.

²⁷⁰ Norris and Shephard, *supra* note 21, p. 17.

- 6.9 Evidence to the Select Committee on the Inquiries Act 2005 underscores the point. Beatson LJ suggested that “unless an inquiry directly concerns the administration of justice, or where there has been prior agreement about this...a judge should not be asked to comment on the recommendations in his report or to take part in its implementation”.²⁷¹ Lord Gill added that “once the inquiry chairman has reported, that is the end of it as far as the chairman goes. His job is done, and I would not wish to be involved in any follow-up. The implementation of recommendations is an entirely different exercise. That is for the politicians and the Executive to do”.²⁷²
- 6.10 One way this inherent limitation can be counteracted is to incorporate time-limits for implementation within the drafting of recommendations. Each of the detailed recommendations arising from the Ladbroke Grove Rail Inquiry was given a time limit paired with an institution responsible for its implementation.²⁷³ This pragmatic approach, however, is atypical.

Scrutiny by inquiries

- 6.11 Despite the limitations outlined above, inquiries can themselves play a part in monitoring implementation of recommendations. The Independent Inquiry into Child Sexual Abuse (IICSA) has incorporated monitoring into its processes:

How the Inquiry monitors institutional responses to recommendations

The Inquiry expects that where recommendations are addressed to an institution, the institution will act upon those recommendations and publish the steps they will take in response, along with a timetable for doing so. The Inquiry suggests that, unless otherwise stated, institutions should do this within six months of the recommendation being published. The Inquiry monitors the responses of institutions through the following formal process:

²⁷¹ Select Committee on the Inquiries Act 2005, *supra* note 30, para 268.

²⁷² *Ibid*, para 277.

²⁷³ The Rt Hon Lord Cullen PC, *The Ladbroke Grove Rail Inquiry: Part 1 Report* (2000), p. 225.

- *Recommendation published by Inquiry*

- *After 3 months: 1st letter*

The Inquiry will send a letter noting the Inquiry's expectation that the institution publishes its response within six months.

- *After 6 months: 2nd letter*

If a response is not published, the Inquiry will send a further letter noting the Inquiry's expectations that the institution will publish a response imminently.

- *After 7 months: 3rd letter*

If a response is not published, the Inquiry will send a third letter noting the Inquiry's disappointment that the institution has not yet published its response. The Inquiry will publicly state that it has written to the institution.

- *After 9 months: Request for statement under Rule 9 of the Inquiry Rules*

If a response has not been published, the Inquiry will request a statement from the institution which sets out their reasons for not having published any response. The Inquiry will publicly state that it has requested this information and the response received will be published on the Inquiry's website.

- *After 12 months: Witness statement required under the Inquiries Act*

If an institution fails to provide the requested statement and has not otherwise published an adequate response, the Inquiry's Chair, Professor Alexis Jay OBE, will exercise her powers under section 21 of the Inquiries Act 2005 to require a witness to provide a statement. The Inquiry will publicly state that it has taken this action and the response received will be published on the Inquiry's website.

HCSA, [‘Process for monitoring responses to Inquiry recommendations’](#)

- 6.12 The Working Party agrees that this method of monitoring has considerable attraction, given the continuity that it provides between the formulation and the evaluation of recommendations and the transparent, open nature of scrutiny. The Working Party recommends that **where the timescale allows, public inquiries should incorporate a formal process for tracking the steps**

taken by addressees of interim recommendations. INQUEST has written to the Grenfell Inquiry asking that it be employed in the Phase II hearings.²⁷⁴

6.13 However, this form of scrutiny is only available to those inquiries whose lifespan allows for the formulation of interim recommendations and a period for their implementation (IICSA was announced in 2014 and converted to a statutory inquiry in 2015). It may not be feasible in shorter inquiries.²⁷⁵ In one frequently cited example, Sir Michael Bichard reconvened the Soham Inquiry six months after it reported, to monitor the progress of his recommendations²⁷⁶, which demonstrates that it may be possible to encapsulate an element of review. Nevertheless, while the Working Party strongly supports scrutiny of the implementation of recommendations by the inquiry team where feasible, longer-term scrutiny is very likely to require external oversight.

External oversight

6.14 It is perhaps unsurprising that inquiries often fail to bring about change, as “there is no routine procedure for holding the Government to account for promises made in the aftermath of inquiries”.²⁷⁷ Quite apart from those instances where Government has indicated that recommendations will be implemented, there is no routine procedure for Ministers to explain why they have *rejected* inquiry recommendations. After initial investigations, several rounds of written and oral evidence, analysis and a final report, there is little to prevent inquiry recommendations vanishing into the ether where the political will to implement is lacking.

²⁷⁴ Deborah Coles, Letter to Sir Martin Moore-Bick (17 January 2020).

²⁷⁵ This form of scrutiny may be possible in a long or delayed inquest, if the coroner decided to exercise powers under Coroners and Justice Act 2009 sch 5, para 7 before the conclusion or indeed before the final hearing. But this would be unlikely – see Coroners (Investigations) Regulations, reg 28(3): “A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation”. However, if a report were issued, the response would be required within 56 days from the date the report was sent. The coroner could receive further evidence during the course of the inquest to ascertain whether the circumstances still exist and whether a further report is required.

²⁷⁶ Sir Michael Bichard, *The Bichard Inquiry Report* (HC 2003-04, 653), para 78.

²⁷⁷ Norris and Shephard, *supra* note 21, pp. 3-4, citing Department for Constitutional Affairs, ‘Memorandum by the Department for Constitutional Affairs’ (HC 2003-04, 606-ii).

A National Oversight Mechanism

- 6.15 There have been repeated calls for the establishment of a public sector body dedicated to monitoring the take-up and implementation of inquiry recommendations and inquest PFD reports.
- 6.16 Bishop James Jones has proposed the introduction of an Independent Commissioner for Inquiries.²⁷⁸ Under this proposal, the Commissioner, supported by a secretariat, would play a role in the sponsorship of inquiries, avoiding conflicts of interests where Government Departments are implicated (see **paras 2.8 and 2.12, note 47**), and performing advisory functions similar to those envisaged for the Central Inquiries Unit (see **paras 2.20-2.24**). However, it would also “play a part in relation to the monitoring of inquiry recommendations...[assisting] Parliament and the public in ensuring recommendations are not simply neglected”.²⁷⁹
- 6.17 INQUEST has campaigned over a number of years for the establishment of a ‘National Oversight Mechanism’.²⁸⁰ In evidence to the Angiolini Review, the organisation provided the following submission:

INQUEST believes that there is an overwhelming case for the creation of a national oversight mechanism tasked with the duty to collate, analyse and monitor learning and implementation arising out of custodial deaths. Any new framework must be accountable to Parliament to ensure the advantage of parliamentary oversight and debate. It must also provide a

²⁷⁸ The Rt Rev Bishop James Jones, ‘Concluding Observations: the need for an independent Commissioner for Inquiries’ [extract from speech provided to the Working Party], September 2018. A Commissioner would provide “a place to hold and share expertise over establishing and running inquiries. Indeed it would be well placed to achieve efficiencies in procuring accommodation and IT and other services which in practice are challenges individual inquiries face afresh every time”.

²⁷⁹ *Ibid.*

²⁸⁰ See INQUEST website, ‘INQUEST Campaigns’.

*role for bereaved families and community groups to voice their concerns and help provide a mandate for its work.*²⁸¹

- 6.18 Dame Elish Angiolini endorsed the proposal, recommending the establishment of an “Office for Article 2 Compliance”.²⁸² There is little material difference between the proposals. Noting that reform of deaths in custody policy concerns not only policing, “but also local government, the NHS and other health providers, and other agencies”, Dame Elish stressed that “in order that the findings of this review are properly taken forward, coordinated action taken over a sustained period of time within a broad range of agencies is required. It *needs to be concentrated in one place* with resources and organisational memory” [emphasis added].²⁸³
- 6.19 Despite the substantial body of research marshalled in the Angiolini Review, and the author’s finding that the preventative function of Article 2 ECHR processes is “not yet being achieved adequately or consistently”, Government dismissed the proposal in a single paragraph, finding that “a new and distinct Office for Article 2 Compliance is [not] the most effective means of driving compliance with Article 2 of the [ECHR]. Rather, it must be recognised that existing agencies have a role to play here and their collation and dissemination of learning in this area must be made more effective...coroners, inspectorates, watchdogs (such as the IPCC) and the Ministerial Council on Deaths in Custody should work towards strengthening their collaboration in this regard...”.²⁸⁴
- 6.20 The Working Party considers that encouraging greater collation and dissemination of information (**Chapter II**), enhanced collaboration (**Chapter III**) and the establishment of a discrete national oversight mechanism are not mutually exclusive. Failure of public authorities to implement the findings of

²⁸¹ Angiolini, *supra* note 15, para 17.26.

²⁸² *Ibid*, para 17.22-36.

²⁸³ *Ibid*, para 17.36.

²⁸⁴ HM Government, ‘Government response to the Independent Review of Deaths and Serious Incidents in Police Custody’, October 2017, para 2.108.

the Lakanal House Rule 43 Letters in England,²⁸⁵ Government’s own 2018 Biological Security Strategy²⁸⁶ and the litany of inquest PFD reports arising from deaths in custody illustrates the need for a new and independent watchdog. **The Working Party supports proposals that an independent body be established to monitor the implementation and effectiveness of recommendations arising from death investigations.**

Location

- 6.21 We considered the possibility of the Central Inquiries Unit serving as the new watchdog. The unit should have capacity to act as a secretariat to Government Departments, to monitor and inform them on any obligation to respond to relevant inquiries.
- 6.22 However, we conclude that independence from Government is an essential feature of any monitoring body and would be a key factor in securing public trust. The new body should be a creature of – and accountable to – Parliament. This may allow for liaison with Parliamentary Select Committees where appropriate (see **paras 6.27-6.32** below).

Functions

- 6.23 The EHRC, whose functions are contained in the Equality Act 2006, may serve as an instructive analogue. Like the EHRC, any national oversight mechanism should be empowered to *monitor* recommendations and actions taken to implement them;²⁸⁷ to *report* on the performance of those tasked with

²⁸⁵ As noted by the Bennett Institute, *supra* note 269, p. 12: “This did not need to be the case. Both the Welsh and Scottish devolved governments responded to the recommendations made by the coroner in the inquest into the deaths at Lakanal House by changing regulations. For example, Welsh legislators enacted new regulations which provide that all new and changed use domestic premises must have an automatic fire suppression system installed which controls and extinguishes fires without human intervention”.

²⁸⁶ HM Government, *UK Biological Security Strategy* (July 2018).

²⁸⁷ See Equality Act 2006, s. 11-12.

implementation;²⁸⁸ to *give notice of non-compliance*²⁸⁹ (where, for example, no action is taken within a specific time) and to require recipients of such notices to *prepare an action plan*.²⁹⁰ However, we do not anticipate the national oversight function would be at anywhere near the scale of the EHRC or require the kind of resources afforded to it. For instance, it would not be expected to make applications to court for injunctions,²⁹¹ bring its own judicial reviews²⁹² or itself provide legal assistance.²⁹³

- 6.24 Given the rapid turnover of Secretaries of State, the new body might also play a role in briefing new Ministers on the status of the relevant implementation projects. Ideally, it would also prepare thematic reviews regarding implementation of related recommendations across multiple inquests and inquiries, so that inquiry recommendations and PFD findings are not viewed in silos but rather as part of a broader project to promote public safety.
- 6.25 As noted by Dame Elish Angiolini,²⁹⁴ there would inevitably be a cost associated with this recommendation. However, as with our proposal for the SPI (see **paras 2.40-2.85** and **Annexe**), the Working Party considers that the proposal would bring long-term savings in preventing future deaths and the costly investigations, inquests and inquiries that follow.
- 6.26 In any event, we note that in the last Parliamentary Session, the Government had proposed creating a new arms-length role or office in the form of the Independent Public Advocate.²⁹⁵ In the course of consultation on the proposal, JUSTICE expressed concern that as conceived it might “duplicate, or indeed

²⁸⁸ *Ibid*, s. 16(3).

²⁸⁹ *Ibid*, s. 21.

²⁹⁰ *Ibid*, s. 22.

²⁹¹ *Ibid*, s. 24.

²⁹² *Ibid*, s. 30.

²⁹³ *Ibid*, s. 28.

²⁹⁴ Angiolini, *supra* note 15, para 17.36.

²⁹⁵ Ministry of Justice, ‘Consultation on establishing an Independent Public Advocate’ (Cm 9701, 2018).

encroach on, the role of [independent] legal representatives”.²⁹⁶ However, the commitment expressed in the proposal that “we should never again see families struggling, as we did in the many years that followed Hillsborough, against the very system that was supposed to deliver answers – and, ultimately, justice” is to be welcomed.²⁹⁷ The Working Party considers that the best way to achieve this is to ensure that implementation of recommendations is routinely (and transparently) monitored by an external body, so as to prevent the continual recurrence of deaths in similar circumstances.

Parliamentary Oversight

- 6.27 Whilst we consider that the reform with the greatest impact would be the establishment of an independent monitoring body, more could be done within existing arrangements to monitor the implementation of recommendations.
- 6.28 Parliamentary Select Committees have been underused in holding Ministers to account for their role in implementing inquiry recommendations. In *How public inquiries can lead to change*, the Institute for Government noted that only six of the 68 inquiries established since 1990 have received dedicated follow-up by a select committee. The authors formulated a recommendation to address this apparent lacuna in accountability:

The Liaison Committee should consider adding an eleventh core task to the guidance that steers select committee work: scrutinising the implementation of inquiry findings. This scrutiny should be based on a comprehensive and timely government response to inquiry recommendations after the publication of an inquiry report. Departments should update the relevant select committee on implementation progress on an annual basis for at least five years following an inquiry report. In

²⁹⁶ JUSTICE, ‘Ministry of Justice – Establishing an Independent Public Advocate consultation: JUSTICE consultation response’, December 2018, para 5.

²⁹⁷ Ministry of Justice (2018), *supra* note 295, Foreword.

*instances where the information provided is unsatisfactory, select committees should move to hold full hearings as soon as possible.*²⁹⁸

6.29 Noting an increasing appetite amongst Parliamentary select committees for holding Ministers to account,²⁹⁹ the Working Party endorses and restates the Institute for Government’s recommendation. The recommendation provides a feasible way of ensuring that inquiry recommendations do not simply disappear for lack of political will. Further, it ensures that where recommendations are rejected, Government must explain why, and do so in public.

6.30 We note the response to the Institute for Government’s recommendation by the Liaison Committee:

*The case was well argued, and it is clear that there does need to be some form of follow-through for such inquiries when they have reported, and the absence of any such mechanism is a significant shortcoming which can reduce the impact of these expensive undertakings and let government and others off the hook. However, we also recognise that such monitoring is a significant call on resources and could only be done through an increase in staff. It might also be best done in a centralised way, even within Parliament, rather than left to individual committees for which different inquiries and their outcomes will engage very different levels of political engagement.*³⁰⁰

The Working Party acknowledges the argument as to resources; and would suggest that introduction of an independent monitoring body would provide the “centralised” method suggested by the Liaison Committee without increasing the demands on Parliamentary committees.

²⁹⁸ Norris and Shephard, *supra* note 21, p. 4. The authors recommend, “where full hearings are necessary, the approach of the Health Select Committee to the Mid Staffordshire NHS Foundation Trust Public Inquiry provides an excellent model”.

²⁹⁹ House of Commons Liaison Committee, ‘The effectiveness and influence of the select committee system: Fourth Report of Session 2017-19’ (HC 1860, 2019), para 289.

³⁰⁰ *Ibid*, para 13. The proposal has since been expanded to cover inquiry recommendations, see ‘INQUEST Parliamentary Briefing, Grenfell Debate’, October 2019.

- 6.31 In addition, the Working Party recommends that **Ministers directly accountable for the implementation of inquiry and SPI recommendations should, where recommendations are accepted, be required to report back to Parliament with an Implementation Plan.**
- 6.32 The Working Party recognises that enacting this recommendation may require amendment to the Inquiries Act 2005. However, we are of the view that this is worthwhile: where inquiries cannot themselves monitor implementation; the Legislature must play a greater role in holding to account the Executive for implementing the recommendations of inquiries it has itself commissioned. The production of an Implementation Plan, against which a Department's actions might then be assessed, would give select committees a meaningful reference point when performing this function.

Survivor Testimony

- 6.33 In addition to “establishing the facts”; “learning from events”; “reassurance”; and satisfying “political considerations”, Sir Geoffrey Howe’s suggested “functions” for any public inquiry include “catharsis or therapeutic exposure”.³⁰¹ Inquiries, Howe reasoned, provide an opportunity for reconciliation and resolution, by bringing protagonists face-to-face with each other’s perspectives and problems.
- 6.34 Many of our professional consultees suggested that inquests and inquiries can serve a cathartic function, but the claim that they actually do so should be treated with caution.³⁰² As Working Party member Dr Sara Ryan explained to us:

³⁰¹ Kieran Walshe and Joan Higgins, 'The use and impact of inquiries in the NHS' (2002) 325 *British Medical Journal* 895, summarising Geoffrey Howe, 'The Management of Public Inquiries' (1999) 70 *Political Quarterly* 294.

³⁰² See also Scraton, *supra* note 2, p. 379: “‘Closure’, particularly in the context of inadequate investigations, unreliable evidence, flawed inquests and an inconclusive private prosecution...is an imposed expectation for the benefit of others” and Jones, *supra* note 16, p. 3: “People talk too loosely about closure. They fail to realise that there can be no closure to love, nor should there be for someone you have loved and lost. Furthermore, grief is a journey without a destination. The bereaved travel through a landscape of memories and thoughts of what might have been”.

There are a lot of assumptions made about the experiences of families within inquiry processes with no underpinning evidence. These assumptions are typically made by (senior) professionals who may base them on their own understanding of how things should be. Embedded within these well-meaning assumptions are clichés, judgements and often a good dose of patronising. A key assumption is catharsis and I find it bewildering and disconcerting that the experience of giving evidence in an enquiry process, being forced to re-live and revisit unspeakably traumatic events and be questioned (or even interrogated) about them is seen as somehow positive.

- 6.35 Nevertheless, inquests and inquiries should seek to promote clarity for those affected by catastrophic events, both through their findings, and through the way in which they treat bereaved people and survivors. An entirely voluntary mechanism that appears to have served a cathartic function is IICSA’s Truth Project.³⁰³ This facility allows survivors to share their story in a confidential, secure environment. The Working Party understands that the Project has received a 98% satisfaction rate from its users, many of whom disclose that the project represents the first time they have felt listened to by someone in authority since suffering abuse, often several decades prior. The Truth Project does not form part of the evidential base for the inquiry hearings but is used to produce an aggregated and anonymised statistical pool.
- 6.36 INQUEST’s Family Listening Days, including the Grenfell Consultation cited a number of times in this report, provide another forum for bereaved and survivor testimony. These reflective events also “offer public bodies, policymakers and other bereavement-focused organisations the opportunity to hear directly from family members about the circumstances surrounding a person’s death in detention/custody, or in a similarly contentious circumstance”³⁰⁴ but without the pressure of the formal process and constraint of giving evidence. There is a particular emphasis on hearing families’ recommendations for improving current practice.

³⁰³ See IICSA website, ‘[The Truth Project](#)’.

³⁰⁴ See INQUEST website, ‘[Family Listening Days](#)’.

6.37 Drawing on the strengths of these two models, **inquiry and SPI teams should consider incorporating a non-evidential forum to facilitate the therapeutic giving of testimony by bereaved people and survivors.**

VII. CONCLUSION AND RECOMMENDATIONS

What often goes unmentioned is the high price paid by bereaved families in remaining involved in the lengthy, complicated investigation and inquest process. The emotional and physical impact of state related deaths on generations of families should not be forgotten, nor the way it is exacerbated by state denial and defensiveness, secrecy, insensitivity, delays, funding problems and lack of accountability... When they function at their best inquests are a vital way of exposing unsafe practise and shining a spotlight on the state and its agents and holding them to account for abuses of power, ill treatment and misconduct. In other words, inquests can save lives. Deborah Coles, Executive Director, INQUEST.³⁰⁵

- 7.1. JUSTICE asked us to convene this Working Party to address the erosion of public trust in the response of the justice system to deaths giving rise to public concern. These may occur either in incidents causing multiple fatalities, or arising from a pattern of systemic failure. If it is to enjoy the confidence of the public, the justice system must provide a response that is consistent, open, timely, coherent and readily understandable.
- 7.2. As we have sought to demonstrate, it is clear that in many respects such characteristics are manifestly lacking in the current arrangements. Our detailed recommendations are directed at remedying such shortcomings by building on the strengths of the present system of inquests and public inquiries. We think that this set of proposals, if implemented, will provide a cohesive and cost-effective system, with the prospect of a reduction in duplication and delay, and which in turn should serve to increase public trust.
- 7.3. While we consider that our recommendations will improve processes for all users of the system, our terms of reference committed us to prioritise the needs and experiences of bereaved people and survivors. As Dame Elish Angiolini has trenchantly observed, the State's responsibility to these groups under Article 2 ECHR is to ensure that they are involved in the investigation in a meaningful way. Lip service is often paid to the importance of placing

³⁰⁵ Deborah Coles, Introduction to 'INQUEST submission to Review of the Hillsborough Families' Experiences by the Rt Rev Bishop James Jones', April 2017, p. 3.

bereaved people and survivors at the centre of proceedings; with some notable exceptions, the reality falls far short of that aspiration.

- 7.4. Meaningful participation depends first and foremost upon an understanding of the process, which in turn depends upon proper communication as to what it is for, what is involved, what is to happen and when. People thrown into the system need to know from the outset what part they can play, whether they can be represented, and if so whether their representative will be able to ask questions, and whether they will be able to see any documentary material. The importance of effective communication cannot be overstated.
- 7.5. However, implementing proper communication is only part of the solution. The Working Party recognises that institutional defensiveness of State and corporate bodies in inquests and inquiries, so graphically described in *Patronising Disposition*, can only serve to undermine public confidence and to prolong hearings with the likelihood of a consequential increase in costs borne by public funds. We consider that the proper observance of a statutory duty of candour would be likely in many cases to shorten proceedings, and contribute to the cultural change necessary to prevent inquisitorial proceedings being treated as adversarial.
- 7.6. We recognise that a number of our recommendations, such as the establishment of an Independent Advisory Board to the Central Inquiries Unit, a coroner services inspectorate, and a National Oversight Mechanism for monitoring the implementation of recommendations, will have cost implications. But it is our considered view that our recommendations, if implemented and when viewed as a coherent set of proposals, could in the long-term lead to significant savings to the public purse by the reduction of delay, duplication and future recurrence.
- 7.7. Inevitably, there were further issues raised during the course of our work that that fell beyond the scope of our recommendations. The Attorney General's *fiat*; the role of the media and of insurers; public interest immunity; undertakings; deaths arising from movement of people through migration;³⁰⁶

³⁰⁶ On this issue, see the work of the [Last Rights Project](#) coordinated by the charity Methoria.

and the (lack of clear) constitutional principles underpinning public inquiries all warrant further consideration in light of our proposals.

Coronavirus (COVID-19)

- 7.8. Our work began before the onset of the pandemic. But the current coronavirus crisis provides “an excellent example of the limitations of the current system for the investigation of multiple deaths involving potential systemic failures”,³⁰⁷ reinforcing the relevance and timeliness of this project.³⁰⁸
- 7.9. To date, there have been upwards of 41,381 coronavirus deaths in the United Kingdom. There have been widespread calls for a public inquiry. Given the high number of fatalities, the broad socio-economic issues relevant to causation and the disproportionate effect of the virus on BAME communities, it has been argued persuasively that this is the only form of investigation with sufficient scope and compulsive force able properly to address these issues.³⁰⁹
- 7.10. The Prime Minister has committed to holding an independent inquiry at an appropriate time.³¹⁰ However, the establishment of an effective public inquiry ultimately depends on the Government’s willingness to open a full investigation into its own handling of the crisis.³¹¹ It is hard to think of a potential sponsoring Department that would not also be implicated. Should the Government fail to call an effective public inquiry, the justice system’s ability

³⁰⁷ Paul Bowen QC, ‘Learning lessons the hard way – Article 2 duties to investigate the Government’s response to the Covid-19 pandemic’ (*UK Constitutional Law Association*, 29 April 2020)

³⁰⁸ Beyond the remit of this project, JUSTICE has undertaken considerable work on socially distanced court spaces and best practice for remote hearings to enable the justice system to continue to function, while ensuring the effective participation of all court users. Much of this work is relevant to how inquests and inquiries can be heard in the wake of the pandemic.

³⁰⁹ See Daniel Machover, ‘Why now is exactly the right time to set up a coronavirus inquiry’ (*The Guardian*, 6 May 2020)

³¹⁰ ‘Coronavirus: PM promises future independent inquiry’ (*BBC*, 15 July 2020)

³¹¹ See Nicholas Griffin QC and Richard Spafford, ‘Covid-19 public inquiry: Asking the right questions’ (*The Law Society Gazette*, 18 May 2020)

to otherwise conduct an effective investigation under the current arrangements would be limited.³¹²

- 7.11. Our recommendations, in particular our proposal for a *special procedure inquest*, aim to equip the justice system with a means of effective investigation less dependent on the mercy of successive governments. Further, they aim to ensure that the implementation of recommendations is monitored – a crucial objective if we are to understand how the virus has killed so many and how to avoid future recurrence.

³¹² Particularly as the Ministry of Justice may find itself implicated due to alleged failures to protect sub-contracted cleaning staff, see Jack Shenker, 'Death at Justice: the story of Emanuel Gomes', *Tortoise Media*, 6 July 2020.

Recommendations

Establishing public inquiries

1. A dedicated Central Inquiries Unit should be developed within the Cabinet Office (**para 2.7**).
2. The Unit should advise inquiry secretariats on best practice. This will involve updating and maintaining publicly available ‘Inquiries Guidance’ (**para 2.20**).
3. The Unit should ensure that lessons learned papers are completed by inquiries secretaries and should analyse and disseminate core findings from completed lessons learned papers (**para 2.21**).
4. The Unit should conduct standardised procurement exercises for the physical and digital infrastructure of inquiries (**para 2.22**).
5. The Unit should provide a repository of chairs’ reports, lessons learned papers, statements of values and procedural protocols from previous inquiries, as well as retaining a database of previous secretaries and solicitors (**para 2.23**).
6. The Unit should have a public-facing role, taking questions from the media and ensuring that the information it compiles is held on a publicly accessible, clearly structured website (**para 2.24**).
7. The Unit’s team should be supported by an Independent Advisory Board. The Board should include representation from bereaved people and survivors of catastrophic events. Membership of the Independent Advisory Board should be published (**para 2.13**).
8. At the close of a public inquiry or *special procedure inquest*, members of the inquiry/inquest team should be seconded to the Central Inquiries Unit for between six and twelve months in order to share recent experience. Civil Service Human Resources should work to ensure that such a period is recognised as a valuable element of civil service career progression (**paras 2.17 and 2.19**).
9. Where a public inquiry is established to investigate one or more deaths, the inquiry, where possible, should be required to answer the four statutory inquest

questions - who the deceased was, and how, when and where the deceased came by his or her death (**para 2.47**).

Coroners and the Office of the Chief Coroner

10. The position of the Chief Coroner should be made a full-time appointment (**para 2.35**).
11. A small Coroner Service Inspectorate should be established. The Inspectorate would monitor timeliness of process, standards and suitability of the physical environment and the provision of prompt and clear information to families across the coroner system (**para 2.36**).
12. The Office of the Chief Coroner should explore how best to compile and publish narrative conclusions online where those conclusions highlight systemic failings (**para 2.39**).

Special Procedure Inquest

13. A new *special procedure inquest* should be established to reduce duplication across inquests and inquiries, and ensure deaths arising from a pattern of systemic failure are investigated in context. The *special procedure inquest* should be opened to investigate:
 - i. multiple fatalities, i.e. two or more deaths occurring in circumstances giving rise to serious public concern or for other good reason; and
 - ii. any death which a coroner has reason to suspect requires investigation and which, by reference to another death or deaths, may give rise to issues of systemic failure. The issues may arise either:
 - a. from an inquest or inquests already held or;
 - b. from a death or deaths (including deaths in other coroner jurisdictions) in which no inquest has yet been held.

The possibility of the *special procedure inquest* should not prejudice Government's ability to establish a public inquiry under Section 1 of the Inquiries Act 2005 (**paras 2.41, 2.51 and 2.60**).

14. The establishment and conduct of the SPI should be guided by a clear and publicly accessible *Protocol*. The *Protocol* would include standard terms of reference, to be adapted according to the circumstances of the case (**para 2.61**).
15. There should be a presumption that criminal proceedings, if commenced or expected, will precede the *special procedure inquest*. The Working Party recommends that this presumption should also apply in the establishment of public inquiries (**para 2.79**).
16. The judge or Senior Coroner conducting the *special procedure inquest* should retain discretion as to whether the investigation should be opened notwithstanding any ongoing prosecution, where delay is likely to be inordinate and/or where the fair trial rights of potential suspects are unlikely to be prejudiced by concurrent investigations (**para 2.80**).

Opening Investigations

17. Bereaved people and survivors in investigations into contentious deaths should be afforded the relevant entitlements outlined under the Code of Practice for Victims of Crime (the “Victims Code”) (**para 3.5**).

Coordination of investigations and evidence gathering

18. Coroners should hold prompt and regular pre-inquest hearings with investigating agencies to require them to liaise closely and account for the progress of their work and coordination (**para 3.10**).
19. Where possible, investigating agencies should continually update one another as information emerges about the circumstances of a fatal incident (**para 3.20**).
20. Where an inquest, inquiry or other form of investigation follows a concluded criminal trial, investigators should consider whether the witness statement (including the victim impact statement) of a bereaved person used at trial might be sufficient to serve as that person’s evidence for the purposes of the investigation (**para 3.22**).

21. Where possible, investigating agencies should collaborate in the questioning of witnesses. A lead interviewer should aim to gather evidence that can satisfy the objectives of multiple investigations and form part of a cross-jurisdictional dossier. Interviewers should employ cognitive interviewing techniques with witnesses who have suffered trauma, to elicit the fullest possible evidence in a single session (**paras 3.14 and 3.16**).
22. Where appropriate, for example with experts and eyewitnesses who have not suffered trauma, witness interviews should be video recorded (**para 3.18**).
23. Evidence-gathering teams should undergo training on trauma-informed practice and communication with those who have suffered catastrophic bereavement (**para 3.19**).

Early participation of bereaved people and survivors

24. The Chief Coroner should issue guidance defining “next of kin”, and the term should be explained in communications from the coroner’s office to bereaved people (**para 3.27**).
25. Where a coroner has been unable to identify the deceased’s next of kin or personal representative, they should consider nominating an organisation with sufficient expertise to act as the advocate for the deceased and receive notifications regarding the investigation. (**para 3.29**).
26. Where a coroner decides that an investigation should be discontinued, the coroner’s office should ensure that the next of kin or personal representative is always informed of the reasons for the decision within seven days (**para 3.30**).
27. Coroners should if possible provide the ‘Guide to Coroner Services for Bereaved People’ in conjunction with the notification of next of kin or personal representative (**para 3.36**).
28. The ‘Guide to Coroner Services for Bereaved People’ should point out that officials are likely to be legally represented. The Guide should also be amended

to advise family members concerned about the circumstances of a loved one's death to urgently seek specialist legal advice (**para 3.37**).

29. Where an inquest is opened, progress updates should be given to family interested persons every three weeks, or by agreement at such interval as the family interested party requests. Bereaved people should also be able to nominate a lawyer or other advice or support worker to pass on the information (**para 3.40**).
30. Where a coroner opens an inquest, or the Chief Coroner invokes the SPI, bereaved people should be directed to an engaging, clear and professional quality video on what to expect at an inquest (**para 3.42**).
31. Where a post-mortem is to take place, the coroner should notify all family members whose details are known to the coroner's office (**para 3.43**).
32. Post-mortem reports disclosed to family members should be concealed within two envelopes, with a warning inside the outer envelope that the report may contain distressing information (**para 3.44**).

Pre-Hearing Procedure

33. Local authorities and inquiry teams administering inquests, *special procedure inquests* and public inquiries should ensure that venue(s) for hearings are chosen and designed in order to prioritise the needs of bereaved people and survivors (**para 4.25**)

Public inquiries: laying the foundations

34. On the establishment of public inquiries, the Independent Advisory Board to the Central Inquiries Unit should advise Government on the appointment of inquiry chairs and panellists. The Board should make its nominations with reference to clear, publicly accessible criteria, taking into account diversity of representation (**para 4.16**).

35. Sufficient time should be allowed for the setting of terms of reference, to enable issues to be identified and proper consultation (including with bereaved people and survivors) to take place (**para 4.22**).

Management of evidence

36. Where documents have been received by the coroner and there is no objection from the record-holder, a presumption that disclosure should be made to bereaved family interested persons within seven days of receipt should apply. Where in exceptional circumstances disclosure within that period is not possible, notice should be given to the relevant interested persons (**para 4.30**).
37. *Special procedure inquests* and public inquiries should issue regular, public updates on disclosure, including the number of documents already disclosed and time estimates for the completion of any processing phase (**para 4.31**).
38. Leaders of public sector bodies should commit to Bishop James Jones's 'Charter for Families Bereaved through Public Tragedy' (**para 4.40**).
39. A statutory duty of candour in inquests and inquiries should be introduced, subject to the privilege against self-incrimination (**paras 4.43 and 4.48**).

Hearing Procedure and Practice

40. All inquest and inquiry professionals should be encouraged through training, continuing professional development and reflective processes to empathise with bereaved people and survivors (**para 5.3i**).
41. Careful consideration should be given to communication in the hearing to ensure that – as far as possible – the proceedings can be fully understood by family members and members of the public (**para 5.3ii**).
42. Inquests and inquiries should put systems in place so that vulnerabilities of any interested persons, core participants or other witnesses are identified early and appropriate adjustments made to enable them to effectively participate (**para 5.3iii**).

43. Inquests and inquiries should ensure that bereaved people and survivors are signposted to appropriately specialist sources of support for trauma, including at the close of the legal process (**para 5.3iv**).
44. The Chief Coroner and proposed Central Inquiries Unit should clarify that pen portraits are an important way of placing the bereaved and their loved one at the heart of the process (**para 5.5**).
45. The Lord Chancellor should amend the Exceptional Funding Guidance (Inquests) so as to provide non-means tested public funding for legal representation for families where the State has agreed to provide separate representation for one or more interested persons (**para 5.23**).
46. The mandatory requirement to warn a person of criticism in Rule 13(3) of the Inquiry Rules 2006 should be revoked and left to the discretion of the inquiry chair (**para 5.28**).

Questioning witnesses

47. Advocates and coroners should be required to complete the ICCA *Advocacy and the Vulnerable* training programme to ensure appropriate questioning of witnesses (**para 5.10**).
48. The Advocate's Gateway should consider providing a toolkit for questioning witnesses in inquests and inquiries (**para 5.10**).
49. Rule 10(4) of the Inquiry Rules 2006 should be amended to allow the legal representative of a core participant to ask questions of a witness where Articles 2, 3 or 4 ECHR are engaged. The chair should retain discretion to refuse (with reasons) a line of questioning and to impose time limits on any questioning (**para 5.15**).

Learning, Accountability and Systemic change

50. Where the timescale allows, public inquiries should incorporate a formal process for tracking the steps taken by addressees of interim recommendations (**para 6.12**).

51. The Working Party supports proposals that an independent body be established to monitor the implementation and effectiveness of recommendations arising from death investigations (**para 6.20**).
52. The Parliamentary Liaison Committee should consider adding an eleventh core task to the guidance that steers select committee work: scrutinising the implementation of inquiry findings (**para 6.28**).
53. Ministers directly accountable for the implementation of inquiry and *special procedure inquest* recommendations should, where recommendations are accepted, be required to report back to Parliament with an Implementation Plan (**para 6.31**).
54. Inquiry and *special procedure inquest* teams should consider incorporating a non-evidential forum to facilitate the therapeutic giving of testimony by bereaved people and survivors (**para 6.37**).

VIII. ACKNOWLEDGMENTS

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Sir Robert Michael Owen

Chair

July 2020

ANNEXE: STRUCTURE FOR SPECIAL PROCEDURE INQUESTS

	<u>EVENT/ACTION</u>	<u>PROCESS</u>
STANDARD PROCEDURE		
1A	Fatal event	Multiple fatalities i.e. 2 or more deaths occurring in circumstances giving rise to serious public concern or for other good reason
1B	Fatal event	Any death which a coroner has reason to suspect requires investigation and which, by reference to another death or deaths, may give rise to issues of systemic failure The issues may arise either (i) from an inquest or inquests already held or (ii) from a death or deaths (including deaths in other coroner jurisdictions) in which no inquest has yet been held In the latter case one or more transfers may take place under existing provisions in ss.2, 3 Coroners Act 2009 and inquests held together
2	Report of death or deaths to local Senior Coroner (SC)	By doctor, police, prison, Local Authority (LA), news media, other See the Notification of Deaths Regulations 2019 Report of death in SC's area is a pre-condition to the duty to investigate: s.1 Coroners and Justice Act 2009 (CJA 2009)
3A	SC commences investigation immediately SC orders post-mortem where necessary	s.1, CJA 2009 s.14, CJA 2009 See Chief Coroner's <i>Mass Fatality Checklist</i>

	In case of multiple fatality event SC activates when necessary special arrangements, e.g. chairs Identification Commission	
3B	SC informs Chief Coroner (CC) immediately	
3C	SC contacts family/families (when their identity is known)	To explain actions and procedures; to provide full information on the deaths
4	SC considers release of body for burial or cremation	SC has legal “possession” of the body (<i>R v Bristol Coroner, ex parte Kerr</i> [1974] QB 652) until release
5	SC opens inquest(s) and adjourns	Explains possible procedures including timetable Evidence of identity given (if known)
SPECIAL PROCEDURE		
6A	CC decides on information available whether SPI is required CC may need to make further inquiries CC must inform Government that decision has been made or is pending	According to <i>Protocol for Special Procedure Inquests</i>
6B	Alternatively, Government recommends that CC adopt SPI	According to <i>Protocol</i>
7	In any event, whether SPI invoked or not, Government retains option to establish public inquiry	s.1, Inquiries Act 2005
8A	If SPI not invoked, local SC will continue investigation and inquest	ss.1, 6, CJA 2009

8B	<p>If SPI invoked, within 7 days of fatal event CC appoints judge or Senior Coroner (local or other) to conduct inquests</p> <p>CC may invoke SPI later when further information comes to light (e.g. of other cases involving similar systemic issues)</p>	<p>Appointments to be taken from pool of judges/Senior Coroners trained in advance to conduct SPI hearings (or exceptionally from outside pool, particularly where special expertise is required)</p> <p>Circuit judge to be appointed if closed evidence likely (see below)</p> <p>If judge to be appointed, Lord Chief Justice must approve: Para.3, Sch.10, CJA 2009</p>
9	Administrative focal point: Central Government Secretariat	
10	The cost of the investigation and inquest(s) will be paid from central funds	(As in the Hillsborough and Birmingham pub bombings inquests)
HEARINGS		
11	Appointed judge/SC announces date and venue of first preliminary hearing, to be held within 14 days of fatal event and at local venue	<p>Date and venue published on coroner's page of LA website; notified to family/families (and media)</p> <p>Judge/SC follows <i>Protocol</i> inc. notifications and draft Agenda for hearing</p>
12	Judge/SC notifies investigation agencies (as appropriate) to attend for directions Legal representation optional	<p>According to <i>Protocol</i></p> <p>Agencies such as police, prison authority, secret services, AAIB, MAIB, PPO, HSE, NHS Trust, Ambulance service etc.</p> <p>Judge/SC, exercising coroner power of investigation (s.1), may request agencies to conduct specific inquiries</p>
13	Draft Agenda (see <i>Protocol</i>)	<p>Draft Agenda to include -</p> <ol style="list-style-type: none"> 1. Terms of reference for investigation and hearings (see <i>Protocol</i>) 2. Provisional timetable, inc. date of second preliminary hearing 3. Directions to agencies to provide progress report (within 21 days)

		<ol style="list-style-type: none"> 4. Identity of interested persons (see s.47(2), CJA 2009) 5. Representation 6. Whether Article 2 ECHR arguably engaged 7. Whether jury required (s.7 CJA 2009) or assessors (see 18 below) 8. Whether closed evidence likely 9. Preliminary issues of scope (inc. potential systemic issues) 10. Other preliminary matters
14	First preliminary hearing In public Preferably in local coroner's court	To follow Agenda (above)
15	Further preliminary hearings In public	Agenda(s) to include - <ol style="list-style-type: none"> 1. Matters left over from first hearing 2. Progress of investigations 3. Further investigation 4. Scope 5. List of witnesses 6. Disclosure 7. Jury bundle (if jury) 8. Date, venue for final hearing
16	Continuing investigation and disclosure	
17	CC to have oversight and advisory role (but not decision-making)	E.g. to monitor timetable; to ensure family participation; to advise/inform judge/SC (not decide) on joining of related inquests
18	Final inquest hearing In public Conducted by judge/SC either alone or with jury or with 2 lay assessors (judge/SC to decide which)	<u>Jury</u> mandatory provisions apply; discretionary provisions to apply where possible (see s.7(2) and (3)) <u>Jury/lay assessors</u> : not to be used where closed evidence may be called and relied on No jury if evidence too complex (apply civil test)

	<p><u>Representation</u> - if State agency or agencies represented, State must provide funding for representation for family/families (one team only unless obvious conflicting interests) IPs may ask questions of witnesses (discretion of judge/SC to limit those who may ask questions) <u>Evidence</u> - Open; and closed (where necessary, exceptionally)</p>
<p>19 Inquest findings and conclusion</p>	<p><u>Findings and conclusion</u> - answers to 4 statutory questions (who, how, when and where the deceased came by their death(s)); medical cause of death; conclusion as to the death: see ss.5 and 10, CJA 2009; Rule 34, Form 2, 2013 Rules <u>Findings of fact</u> - neutral but capable of being judgmental (as in Article 2 ECHR inquests); capable of being admitted as evidence in civil proceedings <u>Findings</u> may not decide civil liability or criminal liability on part of named person</p>
<p>20 Inquest recommendations</p>	<p><u>Recommendations</u> to prevent future deaths. These may be wider than under present law in Sch.5, CJA 2009; evidence may be heard and specific recommendations made</p>
PARTICIPATION	
<p>21 Family participation will be guaranteed</p> <ul style="list-style-type: none"> • by early and continuing detailed communication from (a) the SC initially, and subsequently (b) the Secretariat on behalf of the appointed judge/SC, shortly after judge/SC is appointed 	<p>Including provision and explanation of the <i>Protocol</i></p>

- by grant of interested person status
- by involvement at the first and subsequent preliminary hearings
- by full disclosure of relevant (but not closed) material
- by representation (funded by the State) at hearings if one or more State agencies is represented

CRIMINAL PROCEEDINGS

22

If criminal proceedings commenced, prosecution will usually precede inquest - judge/SC will have discretion to decide

Exceptionally, inquest will proceed first - e.g. where delay of inquest will become inordinate and subsequent fair trial is unlikely to be prejudiced



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