THE CORONER'S INQUEST IN DEATH INVESTIGATION

Tom Luce, Chair of the Fundamental Review of Death Certification and the Coroner Services in England and Wales and Northern Ireland (2001 – 2003).

One of our objectives in the Fundamental Review of Death Certification and the Coroner Services was to re-establish the coroner's inquest as a viable and effective procedure for investigating complex and contentious deaths, which would enjoy public confidence and security from challenge in the higher courts. We were struck by the amount of litigation in the higher courts over inquest scopes and outcomes (not least in Northern Ireland cases), the scale and instancy of demand for ad hoc public inquiries after contentious or multiple deaths, the development of European Human Rights Convention jurisprudence, and the evidence of a large number of people – lay and professional - who had been through inquests in complex or highly contentious cases and found the process unsatisfactory. All these factors combined to convince us that the inquest in its traditional form and with its traditionally narrow scope was in need of serious reform and reinforcement before it could meet the needs and expectations of the modern public to the standards increasingly required by modern law.

In our report[1] we addressed this objective with recommendations in two areas:

- the scope, management and outcomes of inquests
- the structure of the coroner service.

Inquests

We recommended that:

- the outcome of the inquest should be primarily a factual account of the cause and circumstances the death, an analysis of whether there were systemic failings which had they not existed might have prevented it, and of how the activities of individuals bore on the death. The analysis should in suitable cases examine whether there was a real and immediate risk to life and whether the authorities took, or failed to take, reasonable steps to prevent it.
- the analysis should cover the regulatory or safety regimes designed to protect from risk in the circumstances of the death, and determine whether or not the safety regulations were properly observed or were, so far as the evidence shows, adequate.

[1]Luce, T (Chair) et al: *Death Certification and Investigation in England and Wales and Northern Ireland: The Report of a Fundamental Review 2003*, Cm 5831, The Stationery Office, 2003. The other members were Elizabeth Hodder, Deirdre McAuley, Colin Berry, Anthony Heaton-Armstrong, and Iqbal Sacranie. The report is accessible on www.archive2.official-documents.co.uk/document/cm5831/5831pdf

- There should be improvements in the rights of bereaved families to disclosure of evidence and rights to address the inquest court, and in the coroner's powers to obtain material.
- The short-form "verdicts" ("accidental death", "misadventure", "unlawful killing" etc) traditional in England and Wales inquest outcomes, and the brief and general descriptive outcomes characteristic of Northern Ireland inquests, should be replaced in both jurisdictions by the fuller narrative and analytical outcomes described above, in cases where such a depth and breadth of inquiry is warranted.
- Formal public inquests should always be held in certain defined categories of case, including deaths apparently at the hands of law and order services, prison deaths unless the cause is beyond reasonable doubt natural, certain child deaths, and in other cases where a public forensic examination of the cause and circumstances of death is necessary and justified. Inquests into, for example, suicides not involving neglect or the participation of any third party, and some traffic deaths, would be replaced by investigations accessible to the family and others with a close interest, but not held in public.

Structure of the Coroner Service

In order to set and implement uniform standards and practices in the new coroner service, we recommended:

- the incorporation of the historically separate local coroner districts into two new national coroner jurisdictions, for England and Wales and Northern Ireland respectively
- the appointment of full-time legally qualified coroners to head the new service in each local area, and of a new medically qualified statutory office-holder to oversee the certification of all deaths in each such area
- the appointment of senior judges to act as the judicial head of each of the new national coroner jurisdictions, with powers to give practice directions to the jurisdiction, settle appeals on points of law referred from the first instance level, and to hold inquests in cases of exceptional complexity or contentiousness or appoint another senior member of the judiciary to do so.

Progress So Far

Since we reported two and a half years ago, there has been progress in Northern Ireland with the structural reforms, and cases have been decided in the House of Lords which expand the boundaries of the inquest to provide suitable death investigations where Article 2 of the European Convention on Human Rights is engaged.

In Northern Ireland, the individual coroner districts are being reorganised into a unified national jurisdiction with full-time leadership, and a High Court Judge is to be appointed as the overall judicial head of the new jurisdiction[2]. This welcome progress is owed to the leadership of the Northern Ireland Courts Service and its Ministers, the constructive interest and encouragement of the senior judiciary in Northern Ireland, and the flexibility of Northern Ireland coroners. Also relevant is the fact that Northern Ireland coroner legislation – the Coroners (Northern Ireland) Act 1959 – provides more scope for structural modernisation without fresh primary legislation than the Coroners' Act 1988 which governs the service in England and Wales.

There has so far been no change to the statute law or regulations governing the conduct of inquests in Northern Ireland or England and Wales. However, in what is generally seen as a landmark case[3], the Judicial Committee of the House of Lords has ruled that, in cases where Article 2 of the European Convention on Human Rights is engaged, the outcome of the inquest as provided for in the England and Wales Coroners' Rules by the phrase "how the deceased came by his death" should be interpreted "in the broader sense previously rejected, namely as meaning not simply 'by what means' but by what means and in what circumstances". The judgement also refers approvingly to the provision in S 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 governing the conduct of Fatal Accident Inquiries in Scotland: "..where and when the death took place; the cause or causes of such death, the defects in the system which contributed to the death, and any other factors which are relevant to the circumstances of the death."

This judgement, and the related judgement in the Sacker case,[4]are both concerned with deaths in prison and they evidently apply also to the investigation of deaths at the hands of state agents since these have also been found to be within the scope of Article 2 of the European Human Rights Convention.

These cases go at least much of the way to establish a scope of inquiry for inquests into Article 2 cases which meet the reform objectives we set ourselves of "re-establish[ing] the inquest as a viable and effective procedure for investigating complex and contentious deaths, which would enjoy public confidence and security from challenge in the higher courts". But they do not of themselves make any direct contribution to the investigation of cases in which Article 2 is not engaged or has not so far been found by the courts to be engaged. These can include, for example, traumatic workplace deaths, deaths (sometimes multiple deaths) from train, bus or aircraft crashes, the sinking or collisions of passenger vessels, deaths to which medical procedures (or their absence) may have contributed, or deaths through catastrophes at football grounds. Such cases are relatively more numerous than prison deaths or deaths at the hands of the law and order services. They do not necessarily occur in facilities directly provided by the state, or implicate personnel directly employed by the state. However, they can certainly be complex and

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[2] *Modernising the Coroners Service – The Way Forward*: The Northern Ireland Court Service, Belfast, 1 April 2005.
[3] *R v H M Coroner for West Somerset ex parte Middleton, 11 March 2004 [2004]UKHL 10*
[4] *R v H M Coroner for West Yorkshire ex parte Sacker, 11 March 2004 [2004] UKHL 11*

contentious, and all occur in environments where the state recognises a regulatory responsibility in the interests of public safety and protection. Some such cases have in recent years proved highly controversial and difficult to handle through the coronial process, in large part because of the restrictions on the scope of the inquest which the House of Lords has now probably remedied for Article 2 cases and the structural weaknesses in the coroner service which, for Northern Ireland, the Northern Ireland Court Service is now addressing.

10. Article 2 begins with a declaration of apparently wide import- "Everyone's life shall be protected by law". As a layman I would not presume to offer an opinion as to whether, as a matter of law, this declaration should be held to cover health and safety protection, medical regulation and transport safety regulation, for example. But it is hard to see any convincing public policy grounds for failing to correct a system in which those bereaved by deaths occurring in such settings cannot be confident of securing investigations of the same depth or quality as are rightly now to be available to those bereaved by deaths in prison or at the hands of the law and order services.

There are two ways in which this anomaly could be addressed. One is to wait and see whether in the course of time the courts extend the interpretation of Article 2 to deaths in these regulated settings. This would necessarily be an uncertain and untidy process, depending as it must on the somewhat random manner in which cases reach the higher courts. The other- far preferable in my view – is for the Government to recognise the strong public policy grounds for tackling the traditional weaknesses of the inquest in all the areas where there is a public need for a properly rounded inquiry, and to put beyond doubt the coroners' powers to provide a suitable inquiry by amending the regulations (and if necessary the primary provisions) so that the standards of inquiry envisaged by the House of Lords for Article 2 cases can be provided equally in other cases to which they are necessary and proportionate.

There are other important reforms outstanding from the recommendations of the Fundamental Review, and the related recommendations of the Shipman Inquiry[5]. They include, in England and Wales, a general modernisation of the structure of the coroner service to match what is already under way in Northern Ireland; a serious and effective response to the problems – notably of scale and quality control - around the coroners' autopsy (in England and Wales the compulsory un-consented autopsy rate remains very high); and providing casework support for coroners independent of the police[6].

Above all, there is the need to replace the present dangerously unreliable death certification process with something safer. That is less obviously a "human rights" issue than some of the others we looked at. It is, however, interesting to speculate whether, if the courts were in due course to extend the interpretation of Article 2, they might find, if presented with a series of cases in which the death certification process had failed to provide a suitable protection of life, that leaving its obvious defects unreformed

[5] Dame Janet Smith, The Shipman Inquiry Third Report: "*Death Certification and the Investigation of Deaths by Coroners"*, Cm 5854 (The Stationery Office, London, 2003).
[6] A Government White Paper and Draft Bill are promised for 2006.

represented a breach of the obligations placed on the state by the European Human Rights Convention.