

LIBERTY

PROTECTING CIVIL LIBERTIES  
PROMOTING HUMAN RIGHTS

**The Draft Coroners Bill  
Liberty Briefing**

**September 2006**

## **About Liberty**

Liberty (The National Council for Civil Liberties) is one of the UK's leading civil liberties and human rights organisations. Liberty works to promote human rights and protect civil liberties through a combination of test case litigation, lobbying, campaigning and research.

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Liberty provides policy responses to Government consultations on all issues which have implications for human rights and civil liberties. We also submit evidence to Select Committees, Inquiries and other policy fora, and undertake independent, funded research.

Liberty's policy papers are available at

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## Introduction

1. The Coroners Bill is designed to address the failures in the current coronial system and will replace the 1988 Act and the 1984 Rules. The stated aims of the coroners system are, to ‘serve family and friends by clarifying the causes and circumstances of death, contribute to the health and safety of the public and provide information on mortality and preventable risks to life’<sup>1</sup>. However, there is a wide consensus that the coroners system is failing to do this. Many coroners are frustrated and in the words of Victor Round, the Secretary of the Coroners Society, ‘really quite frightened about the future’<sup>2</sup>. The draft bill is an attempt to remedy the faults in a system that is largely unchanged since the 19<sup>th</sup> century.

2. In 2003 Liberty published the report *Deaths in Custody: Remedy and Redress*. As a consequence we are responding to this bill specifically in relation to deaths in custody. Liberty agrees with the view of the Joint Committee on Human Rights (JCHR) that ‘When the state takes away a person’s liberty, it assumes full responsibility for their human rights. The most fundamental of these is the right to life’<sup>3</sup>. When the state fails to protect the life of those in its custody it is vital that the full circumstances of the persons death are established and that improvements to the system are implemented to prevent a reoccurrence. This goes to the heart of the Coroners Court’s role. Unfortunately it appears that the coroners’ courts frequently fail to meet their purpose and their human rights obligations. These obligations were expressed by the European Court of Human Rights (ECtHR) in *Jordan v UK*<sup>4</sup> to give the deceased’s family the truth, ensure that lessons are learnt to improve public health and to ensure that if appropriate criminal proceedings are brought.

3. The ECtHR has stated that an Article 2 compliant investigation must be carried out into a death in state custody. This applies whether the death occurs in police detention, in prison or when a person has been detained under mental health laws. In *Jordan* the ECtHR stated that failure to meet the requirements listed below will in itself constitute a breach of Article 2. This position was confirmed by the

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<sup>1</sup> Para 13, p8, Constitutional Affairs Committee Report, 2006

<sup>2</sup> Q107, Mr Round evidence to the Constitutional Affairs Committee Report

<sup>3</sup> p5, Joint Committee on Human Rights, *Deaths in Custody*, Third Report of the 2004-2005 Session. The JCHR also drew attention to the relevance of the bar on inhuman or degrading treatment (article 3) and the prohibition of discrimination (article 14).

<sup>4</sup>(2001) 33 EHRR 38

House of Lords in *Amin*<sup>5</sup>. The requirements are that the investigation must be; made on the initiative of the state (i.e. not civil proceedings), independent, effective, prompt, open to public scrutiny and support the participation of the next of kin.

4. In *Amin*, the House of Lords established that these criteria should apply not only to cases where state agents were actively involved in the death but also ‘where the death was alleged to have resulted from negligence on the part of state agents’<sup>6</sup>. We fully support this, and believe that there should be an Article 2 compliant inquest in all cases where the state has allegedly failed in its obligation to protect life. This should include cases where the early, inappropriate release of a prisoner has resulted in a death<sup>7</sup>.

5. In 2003, the Fundamental Review, chaired by Tom Luce, reported its findings on the efficiency of the coronial system. It said that the Coronial system was fragmented, lacked leadership, accountability and quality assurance. It also said the treatment of the bereaved ‘falls below modern judicial standards of openness, fairness and predictability’<sup>8</sup>. In 2004, the Home Office published its position paper, which proposed that the coroners’ courts become a national system under a Chief Coroner. However in the draft bill the Government has drawn back from this position. As a consequence Luce has argued the current draft bill is ‘a very significant retreat from the proposals they made in 2004’<sup>9</sup>. Rather than make fundamental changes to the way the coroners system operates the government has chosen to tweak the system that is already in place. This piecemeal reform has meant that much of the legislation is a wholesale transferral of the 1998 Act and the 1984 Rules. Notwithstanding some important changes, such as the right to appeal a coroner’s decision, we believe many of the intrinsic problems of the existing coroners system have not been addressed.

### **Positive Changes**

6. Under the current system, short verdicts (such as “unlawful killing” or “misadventure”) were the source of additional distress to the bereaved. They gave an

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<sup>5</sup> R v. Secretary of State for the Home Department ex parte Amin [2003] UKHL 51(2003) UKHL 51 6 2:1 Joint Committee on Human Rights, Fourth Report, 2004

<sup>7</sup> Such as the murder of Naomi Bryant by Anthony Rice following his early release from prison authorised by the parole board.

<sup>8</sup> p9, Fundamental Review, 2003

<sup>9</sup> Q94, Tom Luce’s Submission to the CAC, 2006

inadequate explanation of the circumstances of death and were applied inconsistently. Over recent years, narrative verdicts have been introduced following deaths in custody in order to meet HRA obligations. This will continue under the proposed bill. Narrative findings enable juries to go beyond a narrow mandate to consider ‘by what means and in what *circumstances*’ a person died as required by Article 2 (established in the Middleton and Sacker judgments<sup>10</sup>). This includes, ‘whether and to what extent systematic failings were a factor in the death’<sup>11</sup> and in cases of suicide (as in the Middleton and Sacker cases), ‘whether a person takes their own life, in part because the dangers of their doing so were not recognised by the prison authorities’ and ‘whether appropriate precautions could have been taken to prevent the death’<sup>12</sup>. Liberty believes the extension of narrative verdicts will provide better answers to questions the bereaved have about the circumstances of the death as well as helping prevent further fatalities.

7. The Bill states that a charter for the bereaved will be introduced. We are strongly in favour of this. The charter will set out the rights of the bereaved in the coronial process, the objectives and values of the coronial system and expected standards of service. This will help to fulfil the government’s article 2 obligations and should help ensure consistency of practice in the treatment of the bereaved.

8. Under the current coronial system there is no means to appeal a coroner’s decision or judgment, short of a judicial review. We therefore welcome plans to allow interested persons to make complaints and appeal decisions<sup>13</sup>. This is a fundamental and important reform, which brings accountability to coroner’s decisions.

9. We welcome the establishment of a Chief Coroners Office, the commitment to a more professional coroners system and to improved provisions for training. This should improve standards across the system, as should a national leadership. However, it is unclear whether training will be compulsory and where the funding will come from.

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<sup>10</sup> 7 R v. Coroner for the West Somerset and other ex parte Middleton [2004] UKHL 10 and Regina v. Coroner for West Yorkshire ex parte Sacker [2004] UKHL 11

<sup>11</sup> Para298, p85, JCHR

<sup>12</sup> Para 42 a & b, Inquest Submission to the CAC

<sup>13</sup> Clause 60

## Outstanding issues

10. A key role of the coronial service is to improve public health and safety by ensuring that mistakes, omissions and bad practice leading to deaths are not repeated. Unfortunately, Clause 12<sup>14</sup> does not go far enough in ensuring appropriate steps will be taken. In particular, there is no mechanism to ensure that recommendations are made, recorded or implemented. A senior coroner who believes that action should be taken to prevent the reoccurrence of fatalities *may* report the matter to the relevant authorities<sup>15</sup>. There is no responsibility to report findings, and there are no guidelines on cases where recommendations should be made. Furthermore, coroners have no power to ensure their recommendations are implemented, and there are no duties on the part of other agencies to respond or institute changes.

11. In the past coroners have been found to be making identical findings and recommendations which were not implemented<sup>16</sup>. We welcome the fact that the Chief Coroners report will be presented to parliament<sup>17</sup> so that contentious issues can be scrutinised. However, we do not believe this addresses the problem of recommendations. Department of Constitutional Affairs Minister Harriet Harman has stated that the Government aims to ‘meet bereaved families concerns’<sup>18</sup>. One of the primary concerns of the bereaved is that lessons should be learnt from their loved-ones death. This is unlikely to happen under the proposed legislation. It is vital to the improvement of public health that mechanisms to implement change are written onto the face of the bill.

12. Liberty believes that if proper recording mechanisms are established inquests can have long term benefits. In *Deaths in Custody: Redress and Remedy*, we explored coronial systems in Ontario, Canada and New South Wales in Australia. In N.S.W recommendations are an integral part of the inquest process and they are logged in a detailed document at the end of the inquest. This document is available to the public and is tabled in parliament. Doing this can exert political pressure on Government to take action. The N.S.W Coroners Office is also creating a database of all verdicts and

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<sup>14</sup> Outcome of Investigation

<sup>15</sup> Clause 12 (2)

<sup>16</sup> P37, Liberty

<sup>17</sup> Schedule 8, Clause 5 (3)

<sup>18</sup> 6.2.06 column 608, Harriet Harman, Hansard Report

recommendations. This will be a mechanism to monitor implementation and could open the government to civil prosecution if the recommendations are not enacted<sup>19</sup>. In Ontario, the inquest jury gives the verdict and makes recommendations. The recommendations are published centrally, and are sent to all parties involved. Implementation is monitored on an annual basis by a department of the Chief Coroners Office<sup>20</sup>. Liberty, Inquest, the Fundamental Review of Coroner's Services and the Constitutional Affairs Committee's Report agree that recommendations can and should be a driver for positive change. We believe that recommendations should be made at the end of every inquest, and that these be centrally recorded and monitored.

13. In the event that an inquest is suspended, clause 22 allows an inquest to be resumed, if 'a senior coroner thinks there is sufficient reason for doing so'<sup>21</sup>. Inquests are often suspended in the event of a criminal prosecution being brought. However if the defendant enters a guilty plea and thus no evidence is heard it is unlikely that Article 2 requirements could be satisfied. To ensure this does not happen, Liberty believes that there should be a rebuttable presumption that in such cases the inquest will be resumed. It is also worth making the point that it is questionable that any criminal prosecution could effectively satisfy Article 2 requirements. In *Middleton*<sup>22</sup> the House of Lords said that the requirement of a coroners inquest in determining how a person came by their death required 'how' to be interpreted as 'by what means and by what circumstances'. The purpose of a criminal investigation is not to determine the circumstances but to establish whether proof of guilt of the offence charged has been established beyond doubt.

14. Under clause 30 (1) the coroner can issue directions to prohibit the publication of information. This can be enacted on the application of an interested person or on the coroner's own motion. We hope the government will issue guidelines to coroners on the circumstances in which directions should be published.

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<sup>19</sup> P38, Liberty

<sup>20</sup> p38, Liberty

<sup>21</sup> Clause 22, (1) (a), Draft Coroners Bill

<sup>22</sup> R v. Coroner for the West Somerset and other ex parte Middleton [2004] UKHL 10

15. Inherent to the Right to a Fair Trial (Article 6 ECHR) is a privilege against self-incrimination. Under Clause 42 of the Draft Bill witnesses can be required to appear at a coroner's court. The ECHR does not necessarily protect the individual from being required to answer questions when this is in the public interest. However answers given during an inquest cannot be used as evidence in a subsequent trial. There are good reasons for arguing that that the public interest in obtaining the truth is sufficient justification for forcing answers to questions asked in inquest proceedings even where this will force the witness to admit they have committed offences. Compliance with Article 2 is dependant on the inquest receiving as much information as possible. This could be especially important in cases of deaths in custody, where there are lessons to be learnt to improve public health and prosecutions are rare. However, it is vital though that the families of the deceased in particular are aware of the inadmissibility of any admissions made in criminal cases.

16. The Lord Chancellor is given the power to make provisions, 'disapplying or limiting the application of Clause 42, (the coroner's power to summon witnesses or demand evidence) relating to evidence or documents of a description specified in regulations'<sup>23</sup>. As stated earlier, the compulsion power is extremely relevant to Article 2 compatibility. When the Bill is published we hope the Government will take the opportunity to explain the scope and circumstance of anticipated regulations during parliamentary debate.

17. The Coroners Bill gives coroner powers of entry, search and seizure<sup>24</sup>. Senior coroners can, with approval of the Chief Coroner, enter and search property. We do not take any particular issue with the creation of these powers. However, it is important that anyone exercising them is subject to proper accountability. In particular they should be governed by Code of Practice B issued under the Police and Criminal Evidence Act 1984<sup>25</sup>.

18. At present there is no centralised coronial service. The appointment of staff and funding for the coronial system comes from local authorities. The Draft Bill

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<sup>23</sup> Clause 43 (2)

<sup>24</sup> Clause 50

<sup>25</sup> Police and Criminal Evidence Act 1984 Code B - code of practice for searches of premises by police officers and the seizure of property found by police officers on persons or premises

misses the opportunity to create a more centralised service. The fragmented nature of the coronial service has led to inconsistency in practice and standards. The Luce Report recommended that the Government nationalise the coroners system, making it centrally funded, with a national leadership and training structure. In the position paper referred to above in paragraph 5, the Home Office seemed to acknowledge the Government's acceptance of a case for centralisation and we hope the Bill when published will reflect this.

19. A centralised system could also allow for standardised training of coroners. Ideally the Coronial system should, as much as possible, be brought into line with the civil court system. It should be organised and funded on a national level with accountability to a national leadership. This could help to ensure that national standards were met and the service is fully accountable.

21. The disclosure of evidence to all interested parties before the inquest is of fundamental importance, especially in cases concerning deaths in custody. However there is currently no legal obligation to do so. In 1999, the Home Office published a voluntary code of disclosure; instructing that in deaths in custody cases, evidence should be disclosed 'not less than 28 days before the date of the inquest proceeding'<sup>26</sup>. However, this voluntary code has frequently proved to be ineffective. There is no disclosure obligation in the Draft Bill so it seems that the current voluntary system will remain in place. In *Deaths in Custody: Remedies and Redress* we called for 'a stronger statutory (disclosure) obligation which would standardise practices and create more confidence in the system'<sup>27</sup>. We hope that the Bill when published will create this.

22. Where disclosure is granted, it is the policy of the court services to levy a disclosure fee of £1.10 + VAT per photocopied sheet<sup>28</sup>. This is beyond any real expenses the court service incurs and, in cases where there is substantial evidence, will be outside of the means of many families. For disclosure to support effective participation for families (as required by article 2) it should be affordable. In cases

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<sup>26</sup> Para 17 of Home Office Circular 20/1999

<sup>27</sup> P43

<sup>28</sup> Para 302, JCHR

involving deaths in custody the court service should cover the cost of copying evidence.

23. The draft bill fails to propose any changes to the legal funding available to the bereaved. This will continue to be granted on a financially assessed basis and in tightly defined exceptional circumstances. While families can apply for funding based on significant public interest many families of those who die in custody, even those with limited financial means, have to fund their own involvement in controversial inquests. This is despite the fact that effectively unlimited funding is available for lawyers to represent the police, prison service and other public bodies. For families to participate effectively in the inquest process they need legal representation. Liberty agrees with the JCHR that ‘in cases of deaths in police custody, funding for legal assistance should be provided to the next of kin’<sup>29</sup>.

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<sup>29</sup> 309, JCHR