



Albion Chambers INQUEST TEAM NEWSLETTER

The Chief Coroner's second Annual Report

The Chief Coroner's Second Annual Report was published on 16 July 2015 addressing a range of aspects concerning the coronial system.

He starts by saying that the coroner service remains essentially a local service, in spite of past calls to make it a centrally run national service. As such, levels of inconsistency between coroners and coroner areas continue. Of particular concern is the disparity in the number of officers appointed to each coroner's office. The Chief Coroner's concerns will no doubt resonate with inquest lawyers who have experienced excellent service and shockingly poor service from coroners' officers in different parts of the country.

The Chief Coroner is therefore working towards a greater consistency in all areas of the coroner domain, through guidance, training and discussion with coroners and all stakeholders.

The lack of national uniformity means that in some areas coroners' officers are employed by the local authority and in others by the police. Those appointed by the police are subject to police disciplinary procedures, while those employed by the local authority are line-managed by the local authority.

It is expected that local authorities will work more closely with senior coroners. For example local authorities should discuss with coroners tendering for the provision of body removal and toxicology services on a regular basis.

In order to create a more effective and resilient coroner service at a local level, the Chief Coroner has encouraged bringing coroner services together under

one roof. Too often coroners' officers are spread in ones and twos across the county.

The work of coroners

Of the 500,000 deaths in England and Wales every year, 223,000 deaths are reported to coroners across England and Wales each year, the vast majority of which are signed off by the coroner after preliminary inquiries as deaths from natural causes. They do not require a formal investigation under the 2009 Act and therefore there is no inquest. Ultimately, some 25,000 cases a year require investigation. This decline of 15% this year from 30,000 cases last year is due to the greater use of preliminary inquiries under section 1(7) of the 2009 Act. This reduction is because coroners are looking more closely at information available in the early stages in order to find that there is no statutory requirement for an investigation.

Many of the 397 jury inquests have concerned deaths in prison or police custody under section 7 of the 2009 Act. Self-inflicted deaths in custody are particularly high, especially amongst those recently admitted to prison.

During the last year, a considerable volume of work has been generated by Deprivation of Liberty Safeguards (DoLS) authorisations by local authorities, restricting the liberty of many residents of care homes or in hospitals, usually the elderly suffering from dementia. Having reviewed the provisions and recent case law, the Chief Coroner concluded (with some reluctance) in his Guidance No.16 that those who die subject to a DoLS authorisation have died 'in state detention' for the purposes of the 2009 Act and therefore each death must be investigated

(with an inquest) under section 1(2)(c) of the 2009 Act.

DoLS applications have increased from 11,300 for the whole of the year 2013-2014 to some 83,100 for the first three quarters of 2014-2015 alone. The Law Commission is considering the impact of DoLS provisions on the coroner service (amongst other matters) and will be consulting shortly on proposed law changes.

Reduction in backlogs

Backlogs of older cases have been very significantly reduced.

Senior coroners are now required to produce an annual return of all cases outstanding after 12 months, setting out the number of days beyond 12 months, the reason for the delay and, where there are a number of such cases outstanding, what remedial steps are being taken to reduce the backlog. The number of inquest cases which have not been completed within the 12 month period has fallen by a dramatic 45% from 2,673 to 1,467, which is less than 1% of all deaths referred to coroners in England and Wales.

The statutory reforms

The principal statutory reforms have worked well. Coroners have embraced the introduction of the distinction between preliminary inquiries and formal investigation by way of inquest. Coroners now focus more readily on early inquiries in order to see whether an investigation (and inquest) is necessary at all. This has reduced the number of inquests across England and Wales, by some 15%, and allowed coroners to concentrate more on the deaths which really require to be explained.

Discontinuance of an investigation where the cause of death has been revealed by a post-mortem examination has also been a useful provision as have the early release provisions of bodies where there is no longer a requirement to open an inquest.

The provisions for jury inquests are now

more flexible. For example, not all prison deaths require a jury. Overall, jury inquests are down in number from 456 to 397, representing about 1% of all inquests.

Developing the Chief Coroner's reforms

1. The role of Chief Coroner

In the absence of a national coroner service the Chief Coroner remains the central national focus for reform. It is his role to continue to establish national standards in what remains an essentially localised service.

The Chief Coroner has a statutory duty to assess the consistency of standards between coroner areas, in respect of which good progress has been made.

Further consistency has been achieved, for example by extensive training and written guidance on the central areas of coronial work.

Training continues to be an essential part of coroner reform, now compulsory for all coroners. New residential courses were also designed and implemented, induction courses for newly appointed coroners and continuation courses for all existing coroners which have been embraced with enthusiasm.

In addition, the Chief Coroner has devised and presented a number of one-day events (for example, deaths in prison at which the leader of the Albion Inquest team, Kate Brunner QC, spoke), along with events for very different audiences such as bereavement organisations and local authorities.

The Chief Coroner is also working towards national consistency of good practice by providing written advice and guidance to coroners with 18 pieces of separate guidance and five law sheets to assist coroners. These cover such areas as: guidance on Deprivation of Liberty Safeguards; Conclusions of inquests (short-form and narrative- which Kate Brunner QC contributed to), Hearsay evidence and the Discretion of the coroner.

2. Mergers

It is expected that coroner areas will be reduced from 97 to about 75 in number so that each coroner area is an appropriate size. Two mergers occurred last year. Several more are being considered.

3. Appointments, salaries and fees

The Chief Coroner has encouraged older coroners to consider retiring at about 75 and to give way to younger, and hopefully more diverse, post-holders. Some have answered the call.

Following the Chief Coroner's Guidance

No.6 The Appointment of Coroners, appointments have all been open, fair and transparent. Positions are advertised widely and there have been large numbers of applicants for most positions.

The Chief Coroner has no statutory responsibility for the payment or level of payment to coroners but considers that there should be a fresh approach to promote greater consistency and transparency. The current scheme has produced inconsistency with wide variation in payment, both of salaries paid to senior coroners and fees paid to assistant coroners. Salaries of full-time senior coroners were shown to vary by up to £70,000 pa.

As such, the Chief Coroner has suggested that the Senior Salaries Review Body (SSRB), which makes recommendations independently of Government in relation to the pay of all judges and tribunal members, should make a similar assessment for coroners.

4. Senior coroners

The post of senior coroner (formerly coroner) has changed considerably in the last two years.

The Chief Coroner is helping senior coroners to cope with those additional functions of their role. He held a one-day conference in 2014 for all senior coroners on leadership, management and organisation.

5. Investigations and inquests

This year the Chief Coroner has provided advice on aspects of jury cases, such as the new oath for jurors, swearing in jurors individually rather than all together, requiring jury questions to be in writing and not made orally, and the use in some cases of questionnaires to achieve a narrative conclusion.

The Chief Coroner has also given advice to individual coroners this year on a wide range of topics. These have included, for example, applications for reporting restrictions in coroners' courts, dealing with media inquiries and disclosure requirements.

6. Post-mortem examinations

Death investigation has traditionally relied heavily upon invasive post-mortem examinations by pathologists for ascertaining the medical cause of death. The trend over the last 10 years has been a steady reduction from 61% to 40% of post-mortems in all reported cases. However, numbers continue to be much higher in England and Wales than in other common law countries.

The increased use of post-mortem imaging for adults, usually by way of CT scanning, has been encouraged as an alternative, but it has limitations. In many areas of the country no scanning is available, and where it is available it is only available at a cost to the bereaved family with a range of £300 to £1,000 in each case. The Chief Coroner considers it desirable that more post-mortem imaging should be available.

7. Reports to prevent future deaths

Since the publication of last year's Chief Coroner's report, 504 Prevention of Future Death reports (paragraph 7(1) Schedule 5 to the 2009 Act) have been issued.

Recommended law changes

The Chief Coroner has recommended that consideration is given to five changes in the law.

1. Quashing an inquest and ordering a new one

At present the High Court's powers are limited to quashing the inquest and ordering a fresh inquest. However, some section 13 cases require only a change to the record of the inquest, and do not need a fresh inquest which may involve extra time and expense, and above all extra distress for families. For example in the case of *Roberts v Coroner for North and West Cumbria* [2013] EWHC 925 (Admin), the outcome of the inquest recorded the deceased as a person unknown. Ten years later DNA testing identified the deceased. A simple alteration of the record by the High Court from person unknown to the named person would have been sufficient, but under the law as it stands a fresh inquest had to be ordered.

2. Deaths at sea

At present the death has to be 'in or near the coroner's area' for the coroner to request the Chief Coroner to direct the coroner to investigate: section 1(4)(a). Accordingly, if the death is beyond the reach of the coastal coroner's jurisdiction because it was not 'near' to the land, there can be no investigation (nor inquest). The Chief Coroner recommends that consideration be given to amendment of the law so that deaths at sea may be investigated by the coroner in the absence of a body even if the death may not have occurred 'in or near the coroner's area'.

3. Discontinuance provisions

Currently, section 4 of the 2009 Act limits discontinuance of a coroner investigation to cases where the cause of death has been revealed by a post-mortem

examination. It is recommended that this provision should be extended to material which reveals the cause of death without a post-mortem examination and there is no other good reason to continue the investigation.

This would give the coroner more flexibility to discontinue an investigation which has been commenced. Material other than from a post-mortem examination may come to light and persuade the coroner of the cause of death. Medical records not previously available or not known about, for example, could identify a natural cause of death and lead a coroner to discontinue an investigation.

4. Second Post Mortem Examinations

Where criminal charges are contemplated, in too many cases bereaved families are further distressed by defence requests for a second (or even third) post-mortem examination without good justification. The Chief Coroner has drafted a proposal which involves the involvement of a Crown Court judge where a charge is brought early with an alternative approach involving the coroner where there is no early charge.

5. Mergers

The Chief Coroner recommends that consideration be given to amending the provisions in Schedule 2 to the Coroners and Justice Act 2009 so as to permit two or more coroner areas to merge (combine) into a coroner area which consists of the area of part of a local authority.

Conclusion

The Chief Coroner concludes as follows; In the opinion of the Chief Coroner much progress has been made across England and Wales. The changes have been positive and the Chief Coroner remains confident that coroners are embracing these changes. The Chief Coroner believes that in the interests of the public the reforms are taking good effect.

The Chief Coroner will continue to develop and encourage reform, through training, guidance, advice, encouragement and support. He will further develop the reforms so that with increased confidence he will be able to report to the Lord Chancellor about further consistency of standards between coroner areas next year.

Those who work in the field will, no doubt, welcome all changes which improve consistency and remove the ongoing vast disparities of practice between different coroners.

Paul Cook

Identifying the virtues of virtual autopsies

A short update to the article on virtual autopsies which appeared in the newsletter published in October 2014. (Click here to view the October 2014 newsletter).

The High Court has recently given guidance as to the approach which coroners should take when considering whether to direct non-invasive post-mortem procedures in cases where a deceased's family had expressed religious objections to the use of an invasive autopsy.

In the case of *Charles Rotsztein v HM Senior Coroner for Inner London* (2015) the deceased's family applied for judicial review of a coroner's decision to direct a traditional, invasive autopsy to discern the cause of death. The deceased was an orthodox Jew. There was disagreement between medics as to whether sepsis or a heart attack had caused her death. Her relatives sought a non-invasive post-mortem procedure on the grounds that Jewish law strictly prohibited desecration of the corpse and required prompt burial. The coroner determined that a traditional autopsy was necessary to ascertain the cause of death with certainty. The family subsequently obtained an injunction preventing an invasive autopsy, and non-invasive procedures determined the cause of death to the coroner's satisfaction. The judicial review was nevertheless heard, as the High Court deemed the matter to be one which was likely to arise repeatedly in the future, and one where guidance was required.

The court noted that the guidance given by the Chief Coroner in his Guidance Note No.1 of September 4, 2013, entitled "The Use of Post-Mortem Imaging (Adults)" was limited to what a coroner should do

once it had been decided that a non-invasive procedure should be used. It did not give advice on whether or not a non-invasive procedure should be used. The court therefore filled the gap with the following guidance:

(a) there had to be an established religious tenet that an invasive autopsy was to be avoided before any question of avoidance on ECHR art.9 grounds could arise (freedoms relating to religious observance);

(b) there had to be a realistic possibility that non-invasive procedures would establish the cause of death and would permit the coroner to fulfil their duty;

(c) the whole post-mortem examination had to be capable of being undertaken without undue delay;

(d) the performance of non-invasive or minimally-invasive procedures must not impair the effectiveness of an invasive autopsy if one was ultimately required;

(e) non-invasive procedures could be adopted without imposing an additional cost burden on the coroner (the judgment was delivered extempore in early August and no transcript is available to date to elucidate this part of the judgment; it is not clear whether the court believed that non-invasive procedures were not more expensive than invasive procedures, or was indicating that the bereaved family should bear any extra cost).

The case has been heralded as a landmark victory for religious groups which oppose invasive autopsies. It is hoped that this guidance will encourage consistency between coronial areas, and assist those who for religious and cultural reasons seek non-invasive autopsies.

Kate Brunner QC

Inquest and Coroner Courts

A case update

As the moderator for Inquests and Coroners UK, the largest and most active LinkedIn group for professionals who practise in this area, the writer is in a privileged position

to read and review thoughtful, intelligent, well-researched posts, keeping the writer and the members of the group up-to-date on developments in this fast changing jurisdiction.

In this short note, I will attempt to distil the hard work of others, to review the

developments in Coronial law from late 2014 until autumn 2015.

Funding

Without exception practitioners who work in this field are single minded in their pursuit of answers to the central question of 'how'? Whether acting for families, for individual interested persons, or organisational interest persons, or the state, the lawyers involved want the process to be fair, to be thorough and to be fit for purpose and, for this reason, the cuts in civil legal aid, through LASPO depriving individuals of proper representation, was rightly condemned across the board.

The courts agreed. In *Joanne Letts v Lord Chancellor* (2015), a case which concerned the death of a patient whilst in psychiatric care, found the Exceptional Funding Guidance (Inquests) issued by the Lord Chancellor incorrectly interpreted the scope and effect of the state's operational duty under article 2. For the word 'incorrectly' read; 'made it far too narrow'.

Letts is a very welcome decision, especially for those families who lose loved ones whilst they are under the care (and control) of the state.

Costs

In *Amelda Lynch v Chief Constable of Warwickshire and others* (2014), an appeal in the civil rather than coronial jurisdiction, the court considered the costs of the legal representation of claimants at an inquest and to what extent they were recoverable in the related civil claims brought against the defendants. Costs judges had to consider the proportionality of the approach adopted by claimants in each individual case, and in principle, inquests costs were recoverable as costs "of and incidental to" the civil proceedings.

As important background it should be noted that the Coroner/Jury did find that that the deceased's death was contributed to by the failures of the defendants.

When dealing with the inevitable costs application in the civil action, the defendant argued that the claimant had gone too far for the purposes of gathering evidence by having both leading and junior counsel and solicitors in attendance at the inquest, who did not need to be at the inquest in order to plead their case, and that the court should be cautious in endorsing representation at the inquest in order to advance the a civil case. The counter argument was that their team's active participation in the inquest had achieved results which led to the jury's favourable findings, that those findings had broken

the defendant's will to defend the claim (it settled) and as such the inquest could properly be seen as the key to the civil claim.

The court held that costs judges had to consider the proportionality of the approach adopted by claimants in each individual case, and, in principle, inquest costs were recoverable as costs "of and incidental to" the civil proceedings, as per *Roach v Home Office* (2009).

Cases involving long running inquests invariably stood the approach referred to in *Roach* on its head. Instead of it being a cost-effective method of gathering evidence, it became a disproportionately expensive way of doing so. On each of the ten days of the inquest the claimant's full team had attended. The court stated that no (civil) case management judge would allow costs of the magnitude claimed by them. Though the agreed damages were high, the costs claimed by the claimant were disproportionate and the sensible 'necessity' test had to be applied.

In short, litigation teams can't get round the civil costs case management regime by front-loading an inquest with a Rolls-Royce service.

Expert evidence

In *Rebecca Chambers v HM Coroner for Preston* (2015) the deceased had been found hanged in his cell in 2004. In 2007, a jury returned a verdict that contributing factors to his death were family problems and bullying, but that there was not enough evidence to suggest that the prison was aware of the bullying. The Coroner's decision that independent expert evidence was not required was appealed on the ground of 'insufficiency of inquiry'. It was argued that there was evidence of 'neglect' and that independent psychiatric evidence must be called in cases of suicide.

The Court disagreed. In suicide cases, there was established case law that a finding of neglect was only permissible where there had been a gross failure to provide basic medical attention and a direct causal connection between the neglect and the death. In addition, the Court found that as to whether independent psychiatric evidence had to be called in every case of prison suicide, each case had to be determined on its own facts. To suggest otherwise would be to fetter the discretion of the coroner, who had a wide discretion in deciding which witnesses to call.

This protection of the Coroner's discretion is a recurring theme during the case law in 2014 and 2015 and reflects the Chief Coroner's guidance in his note

'Law Sheet No. 5' titled Discretion of the Coroner, published approximately six months ago.

Juries

The case of *Richard Davey v HM Coroner for Leicester City and South Leicestershire* (2015) serves as a useful reminder as to the decision making process that is required when a Coroner is considering whether to empanel a jury or not. The inquest concerned death of an 84-year-old who had died in hospital during an aortic valve implantation procedure where the deceased developed 'a bleed'.

It was argued by the family that a jury should have been empanelled due to the family's contention that a systemic failure caused or contributed to the death. The coroner refused to empanel a jury.

On appeal the Court found that the coroner had not erred in concluding that there was no evidence to found a legitimate suspicion that there was a systemic failure inherent in the procedure. The evidence revealed a number of possible mechanisms for the bleed that occurred but whichever the mechanism, there was no basis for a proper suspicion that a systemic failure caused or contributed. Whilst it was not necessary for the purpose of s.8(3)(d) of the Coroners Act 1988 to establish a causative link between the circumstances, the continuance or possible recurrence of which was prejudicial to the health of a section of the public and the individual in question, there was no evidence before the Coroner that in any other case there had been such a systemic failure. The Coroner's decision was carefully and well reasoned; she set out the law 'admirably and correctly' and understood her task under s.8(3)(d) before coming to a conclusion to which she was entitled to reach.

It is clear that the evidence-based approach is still central to this type of determination, alongside the continued protection afforded to a Coroner's discretion as referenced above.

Richard Shepherd

Albion Chambers Inquest Team



Kate Brunner QC
Call 1997 QC 2015
Team Leader, Recorder
Upper Tribunal Judge



Stephen Mooney
Call 1987



Fiona Elder
Call 1988



Paul Cook
Call 1992
Recorder

Team Clerk Nick Jeanes



Jason Taylor
Call 1995



Kirsty Real
Call 1996



Richard Shepherd
Call 2001



Anna Midgley
Call 2005



Simon Emslie
Call 2007



Alexander West
Call 2011

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