HOUSE OF COMMONS

Justice Committee

Oral evidence: The Coroner Service, HC 282

Tuesday 20 October 2020

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Watch the meeting

Members present: Sir Robert Neill (Chair); Paula Barker; Richard Burgon; Maria Eagle; John Howell; Kenny MacAskill; Dr Kieran Mullan; Andy Slaughter.

Questions 40 to 117

Witnesses

I: Ms Lisa O'Dwyer, Director Medico-Legal Services, Action against Medical Accidents; and Ms Victoria Lebrec, Head of Policy, Campaigns and Communications, RoadPeace.

II: Giles Adey, Coroners Office Manager (Budgets and Contracts), Kent County Council; and Debbie Large, Head of Coroner Service, Kent County Council.

Examination of witnesses

Witnesses: Ms Lisa O'Dwyer and Ms Victoria Lebrec.

Chair: Good afternoon, everyone. Welcome to our second evidence session on the Coroner Service in England and Wales. I am grateful to our witnesses on both panels for coming to give evidence to us. Before we kick off and I ask you to introduce yourselves, we have to go through the usual procedures of declarations of interest. I am a non-practising barrister and consultant to a law firm.

John Howell: I am an associate of the Chartered Institute of Arbitrators.

Rob Butler: I was formerly a non-executive director of HMPPS and a member of the Sentencing Council, but that should not have a relevance for this.

Maria Eagle: I am a non-practising solicitor.

Q40 **Chair:** As they will join us later, I know that Mr Burgon is a non-practising solicitor and Mr Slaughter is a non-practising barrister, so we will make those declarations for them to save them having to do it when they arrive, as they will be doing shortly.

Lisa and Victoria, would you introduce yourselves and your organisations?

Ms Lebrec: I am head of policy, campaigns and communications for RoadPeace, the national charity for road crash victims. We support people who have been bereaved or seriously injured in road crashes and campaign for road danger reduction.

Ms O'Dwyer: I am the director of medico-legal services at Action Against Medical Accidents, also known as AvMA. We are a patient safety and access to justice charity. We offer services to the public, including a helpline, a pro bono inquest service, and a general advice and information service.

Q41 **Chair:** Lisa, there were significant changes with the Coroners and Justice Act 2009. What would you say, in your experience, are the principal areas of change, and have they been consistent?

Ms O'Dwyer: The principal area of change has been that there has been greater consistency. Having said that, there is certainly still a lot of inconsistent practice. We officially launched our pro bono inquest service in 2010, but we were helping members of the public from about 2009.

At that time, prior to the introduction of the Coroners and Justice Act, we saw huge delays in cases. In one case involving the death of a learning disabled lady, we had an adjournment for over two and half years despite the fact that we had had expert witness evidence given.

There were a lot of unacceptable practices. We see far less of that since the introduction of the 2009 Act in 2013, and, without doubt, the

introduction of a Chief Coroner to lead the service has been a very significant contribution to making the service more consistent.

There is still considerable room for improvement. We conduct inquests all around the country and our experiences are not the same. We still see problems with disclosure, access to information, taking the bereaved's availability into account, putting them at the centre of the process, and so on and so forth. There is certainly room for greater consistency, but it is much better than it was.

Q42 **Chair:** That is helpful. I noticed that Tom Luce, who did the fundamental review in 2003, said that he described it in the past as a quasi-judicial service and that he would take the "quasi" out now. Essentially, this is a judicial function now, almost pure and simple. It is a type of judicial hearing, adversarial or not perhaps. Would that fit your assessment?

Ms O'Dwyer: I think you could certainly call it that. I would not take issue with that description of it.

Q43 **Chair:** As you say, it came in in 2013. The Ministry of Justice did a review into the Act's effectiveness in 2015. We have not seen the results of that published. Was your organisation, or others you know, asked to contribute to that review?

Ms O'Dwyer: Yes, we certainly did. Many of the points that we made in our response to that review are still very live issues. Nothing has changed really. There are still those inconsistencies. Those things that I alluded to just now such as inconsistency of disclosure, and lack of frank disclosure by trusts at the outset, are still as pertinent now as they were when we responded in 2015.

Q44 **Chair:** Victoria, out of interest, was your organisation asked to contribute to the 2015 review?

Ms Lebrec: Yes, it was.

Q45 **Chair:** What was the gist of what you said to them?

Ms Lebrec: Quite similar to what Lisa has just said. There are still issues and inconsistencies, and the problem is that families will be treated quite differently depending on where they are in the UK.

Q46 **Chair:** I understand that. We have seen your written evidence. The evidence that we have received in writing has been generally supportive of the establishment of the Chief Coroner and, on the back of that, the training for coroners. What is your assessment from the point of view of your organisation's interest of the training for coroners since the Act, and are there areas where more needs to be done?

Ms Lebrec: I think the training has been good. The key area is that victims—it is a bit of a postcode lottery in this sense—feel like they are not treated with much compassion. A key issue in road deaths is the preventing future death report. Only one in 40 is issued for road deaths.

There needs to be much more training for coroners on the issues surrounding road danger and it is seen that preventing future death reports should be done for road deaths.

Q47 **Dr Mullan:** The issue I want to talk to you about—potentially both witnesses, but particularly Lisa—is medical evidence and insight available to the coroner. Fewer and fewer coroners have a medical background. What has your experience been of the ability of coroners' courts to draw on expert medical advice, and how consistently and with what success do you feel they do that?

Ms O'Dwyer: It is very variable. There are some coroners who are very willing and see the benefit and the need for independent expert evidence to help with their investigation and to ensure that the investigation is robust. We certainly see other coroners who feel that they can rely on evidence given by the trust that is under investigation. That certainly raises issues of conflict on occasions without doubt.

Some coroners will provide experts, and more than one if necessary. It perhaps goes to the issue of training, because not all coroners appreciate the importance that an independent, impartial medical expert witness brings to bear. I make it clear that I do not say for a moment that an independent expert witness is required in all inquests—it would be very fact specific. There will be some cases perhaps where the trust—I say the trust because that is normally who we deal with—may accept that there are some failings or that those failings contributed to the cause of death. In those cases, it is perhaps less necessary, but there are certainly cases where independent expert evidence is required.

We find that we very often have to argue for that at a pre-inquest hearing review. Sometimes that is successful on the first occasion, but not always. With the benefit of our pro bono service, we are able, with the use of counsel, to refresh those requests further down the line where that is appropriate. Very often, that does prove to be successful, but it is very variable. A family certainly would not be able to do that without the benefit of representation unless the coroner takes the initiative to instruct an expert.

Q48 **Dr Mullan:** You mentioned that you will make the argument sometimes unsuccessfully. If you are aware, what tend to be the arguments against that when coroners push back and say, "We don't need one"?

Ms O'Dwyer: It will vary. We have certainly had circumstances where coroners have said, "I can look to the trust for that expert input," and, as I have already alluded to, that in itself raises problems. We have certainly had inquests where the coroner has sought to rely on members of the trust to give evidence where that member of the trust has not been involved in the care of the deceased.

You have to recognise that those people very often work in teams and are not independent and impartial. They may well feel the need to protect

a colleague or there may be other pressures put to bear on the way in which they give their evidence. It is not appropriate to use it in those circumstances.

Q49 **Dr Mullan:** Do you ever see coroners questioning those types of witnesses in a way that makes you feel they are cognisant of that, or do you feel coroners are minded to take evidence from medical experts, even of the trust, at face value?

Ms O'Dwyer: It is very variable, to be perfectly honest. Some coroners are very experienced in healthcare inquest cases. You will be well aware that we make the case repeatedly throughout—not just in this call for evidence but in previous calls for evidence—that there is an argument for specific coroners specialising in healthcare inquests. Those who are confident and experienced in healthcare inquests will be far more probative of people giving evidence in those circumstances. Others will take it at face value, and that is problematic.

Q50 **Dr Mullan:** You have hinted at it, but what impact does that have on the confidence of families and relatives in the evidence that they hear?

Ms O'Dwyer: You have to understand that, for a family, very often the inquest is a really important investigation opportunity. Many of them will have gone through the internal processes of trusts. It may be the complaints process, or on occasions they may have gone through a serious incident review process—not always, I hasten to add—and they feel let down very often by those processes, particularly the complaints process, where they feel that the responses are either not answering the questions or are deliberately trying to obfuscate what has happened by using medical terminology and putting families off as to the truth. They are not getting the answers. They are not getting the candour that they feel they are entitled to.

The coroner's court is the first independent forum, and that gives them the opportunity. Where families see that a coroner may be relying on evidence that has been given by the trust, they feel hugely let down potentially.

Q51 **Dr Mullan:** Victoria, is there anything you want to add on expertise and witnesses?

Ms Lebrec: It is not as applicable to road deaths. Sometimes families feel that too much is put on the victim's medical evidence because it is not so relevant to a road death as such. Sometimes you will go through quite long and very personal details about the medical history of the person who has died, which is not pertinent at all to the reason they have been killed. Often, the driver does not have that same analysis done, which I feel is sometimes unfair. In terms of expert witnesses, I do not think it applies so much.

Q52 **John Howell:** Lisa, you have described variations in procedure between coroners. Do you think that that has any impact on the ability of those

coroners to get to the truth for the bereaved?

Ms O'Dwyer: Yes, I think that the variation does. What the variation demonstrates is that very often it is a matter of a coroner's particular experience of healthcare. An experienced coroner who is perhaps more familiar with healthcare issues is likely to carry out a much more robust and investigative process than somebody who is not. That may well account for part of that variation.

Q53 **John Howell:** What changes would you like to see to the Coroner Service to overcome those difficulties?

Ms Lebrec: There are a few key things there. The main thing is training around road deaths and road danger, but equally in getting to the truth it is incredibly important for victims and bereaved families to have legal representation. In road deaths, the driver is always represented by the insurance company's legal team, and that inevitably sways slightly the way in which the inquest is carried out.

Ms O'Dwyer: I certainly agree with Victoria that training has a part to play. Without a shadow of a doubt, there is a need for families to be represented or to at least have access to advice and information as well as representation beforehand so that they understand what the process is that will help them to access that.

When coroners see families consistently represented and properly advised and informed, that will itself bring about change. Very often, what happens is that you have a coroner who may perhaps be familiar with, in our case, healthcare, and perhaps hear representations from a trust on a regular basis, who is used to relying on those representations and not being challenged on them simply because families are not being represented.

I do agree that representation would make a very big difference. It is about training. There is certainly the need for greater training. I would also repeat that, with healthcare, there really is a place for healthcare specialist coroners in much the same way as you have for military deaths.

Q54 **John Howell:** If I were to take you back to the moment of first contact with the bereaved people who are involved with this, how well do you think the Coroner Service supports them?

Ms O'Dwyer: I think the Coroner Service does as good a job as it can. It is variable and it will depend on the coroner's clerk and assistant and so on. We allude to some stats in our written response. What is overwhelmingly clear to us is that when people come to us, whether it is at the early stage or shortly before a full inquest hearing, the actual knowledge of the processes tends to be quite limited and their access to information and documentation that they are entitled to is also very limited. Many people do not know that, if you ask for the documentation, you are entitled to see it. Even if they access that information, they do

not necessarily know how to marshal the papers, how to process that, and how to prepare themselves.

We have to remember that these are, first of all, grieving people, but also people who do not necessarily have any legal background and have never been exposed to any legal process. It really just goes to the inevitable need for there to be better access to independent advice and information for those. Coroners' clerks do it as best they can.

Ms Lebrec: I agree with Lisa. It is variable, but the key thing to remember is that you need access to specialist support organisations because the types of inquest that you would be helping families through would be quite different from the types of inquests that RoadPeace would be helping families through.

You have to know what to expect on the day. You have to bear in mind that these people are totally traumatised. They might not have gone to an inquest before or understand what the process will be. In the case of road deaths, it is extremely unlikely that you would have a pre-inquest review, which means that families are very unlikely to understand what to expect on the day. It is really about ensuring that the Coroner Service is directing people to specialist support organisations that can explain things to them.

Q55 **John Howell:** Victoria, how would the Coroner Service improve the way it communicates with bereaved people?

Ms Lebrec: One of the key things that Lisa alluded to is publicising the pre-disclosure policy. You could have that on the website. That is one thing.

At the moment, you are mostly likely to get phone calls from coroner offices. One key thing would be to try to ensure that most communications are written so that people can at least refer back to them. In terms of support, it would be ensuring that, at every first possible opportunity, you are directing people to specialist support organisations, whether that be for road deaths or whatever it may be.

Q56 **John Howell:** Do you think it would be an improvement if the Coroner Service signed up to the victims code of practice?

Ms Lebrec: Yes, I do really think that. It is bizarre that it is not yet signed up to the victims code of practice when so many other agencies that deal with victims of crime are. It would be an improvement mainly because it is about ensuring people are being kept informed and get access to support services. That is so important in how victims feel about the outcome of an inquest or other types of crime. Deborah Coles alluded to that in the first evidence session.

Ms O'Dwyer: We would not use the victims code because healthcare inquests do not tend to be about criminal issues. I am aware of the main tenets of the victims code, but I am not familiar with it generally. I would

have no reason to think that it could not have a place and provide support, but it is perhaps less relevant for healthcare inquests.

Q57 **Chair:** Is there perhaps an adaptation of the code on care for witnesses that could be applied to non-criminal inquests—medical negligence, for example?

Ms O'Dwyer: Yes, there is certainly scope for it to be adapted so that it would fit that mould. I am not hugely familiar with the code myself.

Chair: That is helpful.

Q58 **Paula Barker:** My first question is for Victoria. You have talked about access to specialist support organisations, written communications and the victims code of practice. Would you have any other suggestions for how the Coroner Service could be more sensitive to bereaved people?

Ms Lebrec: Where we have seen that there are inconsistencies is that some coroners will not necessarily allow a pen portrait to be read out, and things like that. The main thing would be to ensure that coroners have the bereaved very much at the heart of the process, and that should be enshrined in everything that happens.

A lot of it is to do with how you are speaking to people and bearing in mind that this is the worst day of a family's life, and they are having to go through it. That would be the main thing: access to support services, written communication and improving the websites so that everything is really clear for people to understand.

Q59 **Paula Barker:** Is there anything you would like to add to that question, Lisa?

Ms O'Dwyer: No, I do not think there is. Victoria has covered that.

Q60 **Paula Barker:** The next question is to Lisa. We know that the provision of publicly funded legal services to families' inquests is extremely limited. Do you believe that it affects coroners' abilities to ascertain how the deceased came by their deaths when some interested parties are legally represented and others are not?

Ms O'Dwyer: Almost certainly. I can think of a number of cases that we have run when the family has come to us that the hearing has been set down for half a day with the bare bones of witnesses—pathologists, perhaps, and maybe the individual themselves or the next of kin.

When we take a look at it and we go through the medical records, we realise that what is required is for a number of witnesses to be called, sometimes for independent expert evidence as well. I can think of a number of cases where we have gone from a half-day inquest to a three-day inquest, and in some cases even longer than that, almost without doubt.

Q61 **Paula Barker:** Is there anything you would like to add, Victoria?

Ms Lebrec: Paula, I am sorry. The wi-fi cut out a bit and I did not hear your question. Do you mind repeating it?

Q62 **Paula Barker:** Of course, that is not a problem. I was just talking about the provision of publicly funded legal services for families at inquests and the fact that it is extremely limited. Does it affect the coroner's ability to ascertain how the deceased came by their death when some parties are represented legally and others are not?

Ms Lebrec: It does to a certain extent. In road traffic accident collisions, it is easier to understand exactly the cause of death in that sense than perhaps what Lisa is talking about. The biggest impact is in the experience for the family by not having legal representation. That is a big thing.

Q63 **Richard Burgon:** How well do coroners keep in mind that the bereaved may have no idea whatsoever of the law and procedure at inquests?

Ms O'Dwyer: Perhaps I could start by saying that we frequently see pre-inquest review hearings being called and families who attend those on their own do not have access to the documentation. The vast majority of families do not need to ask for documentation so they may not have access to any statements. The vast majority of families that we deal with do not even necessarily know about the internal investigation process such as the serious incident reporting processes.

If you do not have access to the basic documents that the coroner is relying on when you attend a pre-inquest review hearing, you cannot be prepared for that, whether you are represented or not. You need to have access to that information well in advance. Bearing in mind if you are an individual who is perhaps facing this forum on their own for the first time in a legal process that is completely alien to them, the thought that a bereaved person would go through the documentation on their own and be able to make sense of it and to know what the coroner would need at that time in a pre-inquest review is a very big ask.

Ms Lebrec: I agree with that. With road deaths, there is the extra difficulty where you are not going to have a pre-inquest review in all likelihood. It will often be the first time that they have ever gone to an inquest when they attend for their loved ones. People tend to be completely unprepared for that. Even though there is the pre-disclosure policy, which is a good thing, the majority of families do not know to ask for the evidence ahead of time and coroners vary in their compassion from that perspective. You cannot be prepared for an inquest without having that information before.

Q64 **Richard Burgon:** I want to follow that up with a question on legal aid and legal advice. In limited circumstances, some bereaved families are able to access publicly funded legal services, and this is an invaluable support that families need to help them to navigate complicated, adversarial proceedings. One barrier to this support is a requirement of

families to meet legal aid funding conditions. In your experience, how do barriers to legal aid impact on bereaved loved ones' ability to play a full and proper role in inquests?

Ms O'Dwyer: It plays a big role. There are two things about that. There is the legal aid funding aspect. The process for applying for legal aid funding can be quite slow. Where those decisions are made can often be inconsistent. The fact that it is a slow process means that if the inquest has already started, because legal aid is not retrospective, even if it is granted, there is still a funding issue. That can prevent people from getting representation as a consequence of that.

Exceptional funding is available, and there has been a review of it. Exceptional funding is exceptional in name and, quite frankly, exceptional in nature as well. People generally do not access it at all. Unless people are able to get pro bono representation or they pay for it themselves, the only other way they are going to be able to get any form of representation at the inquest is if they enter into a conditional fee agreement arrangement, and they will only do that if a solicitor believes that there are reasonable prospects of a civil claim being brought and being successful.

In many ways, for those individuals who do not necessarily want to bring a civil claim, that route—a very important one for many people because it is the only way they will get representation at an inquest—has effectively potentially bribed them to civil proceedings that they may not necessarily want. What they want is to be represented at the inquest and to be heard and to have their voice heard.

There are a number of things about the fact that legal aid is so very difficult to get. It is not just the way that these applications are processed, but it is also about the alternatives it leaves people. Very few people can afford to pay for legal representation privately. The alternative is often a conditional fee agreement, which is not an ideal way of funding an inquest, especially when it is clear that trusts—they are what we are dealing with most of the time—are represented, whether by an NHS resolution panel firm or in-house through specialist staff.

That, too, is public funding. Trusts are accessing public funding, but individuals who have the greater call and the need to ask questions, and to draw the coroner's attention to probative issues that need further investigation and so forth, do not have that same access, so their efforts are effectively thwarted.

Ms Lebrec: I agree with everything Lisa said. It is worth pointing out that the Ministry of Justice guide says that victims and bereaved families do not really need legal representation. In the case of road deaths, either we are able to sort out some pro bono representation or families who are pursuing a civil claim will have legal representation.

It is quite a difficult thing to expect families to do that. First, the bereavement guidelines are incredibly low. Secondly, when a loved one has been killed, people often see it as blood money. They do not want to go down that route. People often do not want to do it even though it is well within their right to pursue a civil claim and therefore have representation at an inquest.

Q65 **Chair:** It has been put to us by the Ministry of Justice that a lot of cases do not involve substantial disputes as to fact and so on. Therefore, you do not need legal representation, even though some public agency may have legal representation. Does that stack up according to the evidence that you see in your work, or is there always some degree of dispute potentially or an issue where some forensic help is needed?

Ms Lebrec: It is meant to be inquisitorial, isn't it? There is not so much dispute but it is just the way in which families feel they can then ask questions of the driver. The driver will be told by the coroner or by the legal representation they have that they do not need to answer certain questions. That is quite traumatising for families.

Q66 **Chair:** What was your thought on that, Lisa?

Ms O'Dwyer: I would say that there are areas of dispute quite often. Families may well be asking pertinent questions and may have asked those same questions in the complaints process. Those questions are very often relevant to how a person came about their death. The dispute aspect of it does arise.

The difference is that, if a family is not able to express themselves as well because they are represented in person, there might be a perception that they do not need representation; but that is not our experience. We have criteria and we are looking for certain things, so it may be that in some cases not every family needs to be represented. Certainly, in the ones that we see, the trusts are represented and families should be represented at the same time.

Q67 **Maria Eagle:** As somebody who, when I practised law many years ago, ran medical negligence cases in the civil court, and as somebody who for well over 23 years represented and tried to help my constituents, who are bereaved Hillsborough families, I have quite a lot of experience one way or another not directly of the coroners' courts but of the impact that coroners' inquests can have on bereaved families. They often do not feel, despite the fact that coroners' courts are technically inquisitorial, that what is going on is an inquisitorial process.

Quite often it is seen by various parties as a preliminary to the litigation, which, be it criminal or civil, can go on for very many years and is seen as part of a first skirmish. Is that your experience, Lisa O'Dwyer, when it comes to victims of medical accidents or of deaths caused in medical settings?

Ms O'Dwyer: You are right. Some inquests do lead to civil claims and it can appear to be adversarial. The vast majority of people who come to us do not want litigation. What they want is answers. They want to know the truth. Furthermore, what they want to know is that what has happened to their loved one is that something has gone wrong and that changes are made so that it does not happen to somebody else. That is the overwhelming driving force for the people whom we represent and whom we see.

Sometimes, we see that people come to us and they have the inquest. They become quite enraged by the fact that trusts have not been open and honest with them but they have had to go through this very gruelling process to get any sort of answers whatever. Sometimes, that in itself results in civil proceedings being taken. The award of damages for the death of somebody under the Fatal Accidents Act is extremely low and, for many, an insulting award. Litigation is not for the fainthearted and that is not necessarily what people's motivation is. It is to get to the bottom of what happened—to find the truth.

Q68 **Maria Eagle:** I wonder whether the statutory duty of candour that has been placed in health settings on professionals has made the difference to the Coroner Service and to the proceedings and the satisfaction of families who have been bereaved in that process.

Ms O'Dwyer: I would suggest that very few families that we come across have satisfaction as a result of the statutory duty of candour. The statutory duty of candour is an important piece of legislation potentially, but trusts do not necessarily understand how it should be implemented. There is the need for greater training among medical staff to realise what their duties are.

Under the statutory duty of candour, there is an ongoing obligation to update families as their investigations progress and to communicate those updates to them. There is an obligation under the statutory duty of candour for what has gone wrong to be written. We sometimes refer to those as duty of candour letters.

I can say without any hesitation that the families who come to us invariably have not heard of the duty of candour, or, if they have heard of it, they certainly have not had a duty of candour letter, and they certainly do not get updates. There seems to be a general feeling that once an inquest is called or a similar process, whether it is civil litigation or anything like that, the duty to update families about the progress of internal investigations ceases. We never receive any updates from families along these lines.

Q69 **Maria Eagle:** Would it be your observation that it is not really being implemented properly?

Ms O'Dwyer: There is a lack of understanding about what the obligations are. It is an important piece of legislation. It needs to go much further.

There is a greater need for training, and there is a greater need for families to understand and for them to appreciate that there is this duty and they have that right to be told about it. It is about increasing awareness and information about it as well.

Q70 **Maria Eagle:** One of the things that—it is my experience too and you have both said it—bereaved families want is to know what happened and to know that lessons can be learned so that it is not going to happen to anybody else. That can go in both settings that you both deal with in bereavement. Victoria Lebrec, how consistent in your experience are coroners when it comes to issuing prevention of future death reports? Prevention of future death reports is one way, if they work and are followed up, of fulfilling the second wish that most bereaved families have, which is to try to make sure lessons are learned and something similar does not happen to any other family. Do you have any observations on how consistent coroners are when it comes to issuing prevention of future death reports following road crash deaths?

Ms Lebrec: I do. I would like to thank two of our members, Chris and Nicole Taylor, whose daughter was killed in a road crash, who have done a really fantastic analysis that we have included in our submission on prevention of future death reports and how they are issued in road deaths. Only one in every 40 road deaths gets a preventing future death report, which I think is much too low, particularly when you compare it to railways and accidents at work.

In road deaths, 2.6% will get a prevention of future death report; 19.6% of railway crashes will get a PFD; and 8.7% of accidents at work. That is comparatively quite small.

It is extremely inconsistent across different coroner areas. For example, the Isle of Wight reported four preventing future death reports for 25 road deaths. Cambridgeshire and Peterborough reported zero out of 253 road deaths. That is an analysis that was done over the last seven years—since 2013—on PFDs. It is inconsistent.

I reiterate that families just want to know that their loved one has not died completely in vain and that something is being learned from it. That comes across time and time again. PFDs are a great initiative, but they need to be used more and they need to be used consistently.

Q71 **Maria Eagle:** My experience of medical negligence issues is that this is often the wish of the family as well where something has been found to have gone wrong: they want lessons learned. Prevention of future death reports might be an effective tool in that setting, too. Do you have any observations on how effective they are and whether they might be made more effective in a healthcare-related deaths setting?

Ms O'Dwyer: Prevention of future death reports are potentially a very powerful tool. I do not think that is where they sit at the moment. It is a missed opportunity. In our experience, coroners do make prevention of

future death reports, but what happens is that, when we have a response from a trust, the follow-up on whether the changes and actions that have been suggested by that trust have been implemented is just not there. There is a huge missed opportunity. Patient safety is a critical issue on a number of levels, not just for the potential to reduce civil claims but also for protecting the public more generally.

If you have a good, robust investigation process that the coroners' courts certainly can deliver on, which produces a prevention of future death report, what happens is that the report is made and you get a response. There is no independent body following that up. There is no independent oversight. There is nobody policing or monitoring it, and that is almost a waste of resources.

I would go a step further and say that it is not just the prevention of future death report. What we often see are action plans that are produced effectively sometimes perhaps to head off a coroner making a prevention of future death report. A plan is presented to a coroner saying, "This is what we have done. These are the changes we are going to make," and the coroner feels that perhaps the need to make the prevention of future death report is not quite so necessary.

Those action plans are as valuable as the prevention of future death reports themselves, and they too should be collated and publicised, and they really do need the same monitoring, policing and follow-up as a prevention of future death report. They are potentially extremely invaluable tools but they are certainly not being implemented as effectively as they could and should be.

I do not know if you have ever looked at the prevention of future death reports that are reported on the coroner's website. You will get the prevention of future death report. You will often get the response to that, although that tends to be very much slower to be published. Trying to find how many times the same PFD has been made in relation to the same trust is an extremely time-consuming and lengthy process, which for most people, even ourselves, is just not feasible to wade through over the last five years.

More could be done in collating that information and making it accessible and looking for themes. It should not be just a local issue. It should not just be pertinent to the particular trust that the PFD or the action plan has been made. It should be incumbent on trusts nationwide to be looking to see whether the failings that have occurred in a trust are relevant to them and, furthermore, looking at what has been done to make those changes to prevent the same issues arising in the future.

Ms Lebrec: All the points that Lisa made are applicable to road deaths as well. It is such a missed opportunity to not be able to go on to the website and search for road deaths by theme and in different local authorities to understand whether there is a particular problem with certain types of crossings on particular roads. It is not transparent and

there is no one that is following this up in the same way as you would do with HSC, for example. You would have an inspectorate that is then following up these recommendations and reports that are issued. I really agree with what Lisa said and I think it is a real missed opportunity.

Chair: That is very helpful, thanks. Lisa and Victoria, thank you very much indeed for your time and your evidence today. It has been very helpful to us. It is very much appreciated. If there is anything else that suddenly strikes you, please feel free to add some supplementary evidence. I think that has been very comprehensive.

Examination of witnesses

Witnesses: Giles Adey and Debbie Large.

Q72 **Chair:** Mr Adey and Ms Large, it is very good to see you. Will you identify yourselves and the organisations you represent?

Giles Adey: I am semi-retired. I used to head up the Coroner Service before I retired. I manage the council's budget for the Coroner Service and our contracts with the NHS for mortuary provision and funeral directors for body removals.

Q73 **Chair:** That is for Kent County Council, is it not?

Giles Adey: Yes.

Q74 **Chair:** Do you also look after Medway, the unitary authority?

Giles Adey: Yes. The county council provides a service for Medway Council and we have a service level agreement with it in terms of cost sharing.

Debbie Large: I am head of the Coroner Service. I took up the post after Giles retired in January 2015. Prior to that I worked as a coroner's officer for the Met police for a number of years. I was then teaching death investigation to coroners' officers and undergraduate students. I have been involved in the Coroner Service in a range of different roles since 1998.

Q75 **Chair:** That is very helpful. You both have very wide experience of the service. You were there before the 2009 Act and a lot of the changes we have seen.

Debbie Large: Yes.

Q76 **Chair:** How would you characterise the most important changes we have seen? Are there bits of the various inquiries over the years that gave rise to that Act still outstanding? What do you think are the big changes, and what is left to do?

Giles Adey: As previous witnesses alluded to, we now have a Chief Coroner who supports leadership, guidance to coroners and setting

national standards. He is now supported by two Deputy Chief Coroners, so there is huge progress in a move to a more uniform service.

The Chief Coroner provides an annual report to the Lord Chancellor that is laid before Parliament and highlights the challenges facing the service. That very helpfully includes a model coroner area that sets out how an area should be working.

The Chief Coroner now has responsibility for mandatory training for all coroners and, importantly, coroners' officers. Debbie can give you a little bit of insight into that.

The Chief Coroner holds an annual conference for local authorities where we discuss the issues of the day, but also look at the future challenges.

Finally, under the 2009 Act local authorities now appoint all coroners, whereas previously, if I remember rightly, assistant coroners and assistant deputy coroners were the personal appointments of coroners. As local authorities we now appoint all coroners. The Chief Coroner has issued a very helpful guidance note to local authorities, so we have a much more robust, open and transparent process uniform to all, and we are seeing some fantastic new talent coming into the service as a consequence of that. Therefore, there are some very positive changes, but there are also a few negatives.

Q77 **Chair:** What would you say are the negatives?

Giles Adey: In earlier evidence we were told there would be an 18-month post-implementation review to assess whether any financial burdens were falling on local authorities as a consequence of the Act. That review did not take place. Previous witnesses seemed to suggest that they had been involved in the review. I certainly do not recall that review and I do not think Debbie does either, but she can talk in much more detail about how that has impacted on the service day to day.

One big thing was missing—again, previous witnesses alluded to it. André Rebello, secretary of the Coroners' Society, referred to the need for an inspectorate of coroner services. If I remember rightly, that was in the first draft of the original Bill, but it was not present when the Act came into being.

As for those areas where perhaps the service is not being delivered to national standards and where perhaps local authorities may be failing in their duty in investing sufficient resources, or where coroners have a particular way of running their areas, there is no process for local authorities to fall back on in terms of some form of independent review of the service. As a minimum, what we would be looking for in future is some peer review, which would take place on a fairly regular basis, the recommendations of which would be binding on local authorities and coroners.

Chair: That is very helpful.

Debbie Large: Giles mentioned implementation of the 2009 Act. There was an expectation that it would be cost-neutral, but in practice we have found that it has created a significant additional financial cost to the local authority. That has happened for a range of reasons. The reduction of timeframes for inquests, which was absolutely the right thing to do, has required larger court capacity and created a bigger manpower and resource requirement. The 2009 Act introduced the investigation stage. The intention was to remove inquests that were being held only because they were pending results.

Q78 **Chair:** Debbie, will you explain for the lay person what that is?

Debbie Large: As for investigations, at a post-mortem the pathologist might take blood or tissue samples for further analysis. That takes some time; depending on the tests, it can take several weeks. Prior to the 2009 Act that would have necessitated the coroner opening and adjourning an inquest to release the body. The investigation stage means that the coroner starts an investigation and can release the body, and will proceed to an inquest only if the results that come back necessitate an inquest.

Q79 **Chair:** If not, you do not have an inquest.

Debbie Large: We do not have an inquest unless it is warranted by the findings of the post-mortem. It has reduced the number of inquests for that reason, but the workload attached to the case is the same.

As for the new legal framework, as well as increasing the complexity of the workload, the experience coroners report to us is that more cases are being challenged. There is also the impact of article 2 of the Human Rights Act and the complexity and workload that go with that along with that. At the same time, hospital and care home deaths now, quite rightly, undergo greater scrutiny. The complexity of those cases has increased.

The introduction of the Chief Coroner has introduced some consistency, but both of the previous witnesses have said that that has not necessarily been the case.

Kent and Medway have four separate coroner areas. We have two senior coroners and one senior coroner runs three areas. The Coroner Service team, the council staff, work as one team. We have made great strides in achieving consistency in Kent and Medway up to a point because coroners remain independent judicial officers.

In Kent, the size of jurisdictions used to be based on case load, but the complexity of the cases in the areas is now particularly significant. In our four coroner areas we have six acute hospitals across four trusts, a mental health trust as well as motorways and ports, which is quite significant for a local authority area.

The introduction of the Act, which was the right thing to do—I was involved in some of the work in preparing for it—has created a lot of additional work, and funding for that has not followed.

Q80 **Chair:** No doubt the local authority would want this under new burdens, would it not?

Debbie Large: Yes. Giles mentioned the new burdens doctrine.

Q81 **Chair:** I used to know about that as the Minister. What it comes to is that it has not been forthcoming. You make the point that your area has complexity because of the types of institutions. We heard evidence from one coroner that there are about seven prisons in the area.

Debbie Large: That is our area; we have seven prisons.

Q82 **Chair:** There will be others where they have none.

Debbie Large: Yes.

Q83 **Chair:** Therefore, how the workload works out is a bit arbitrary.

Debbie Large: Yes.

Q84 **Chair:** There are 88 coroner areas; it is a lot more than police forces or top-tier local authorities. Is that too many? What do you think?

Giles Adey: At the moment I think there are 85 coroner areas and the Chief Coroner has in mind to bring that number down to about 75 through mergers. In Kent, we have four coroner areas and our plan is to merge those into one, but the way the legislation is written currently means we can merge those four areas only when we have vacancies for senior coroners in three of them. Therefore, at some point we would hope to get the four in Kent down to one.

Q85 **Chair:** You have talked about the value of having a senior coroner. On one occasion when Judge Thornton, then Chief Coroner, gave evidence he said, "You've got one bit of the equation; you have me; you've got the training okay, but you do not have the national service and national funding." Is it time to move to a national service? It would take the burden off you and stop the need for you to lobby Government for extra funding.

Giles Adey: In terms of funding, that does present real challenges to the local authority. In an ideal situation we would want to see that funding ring-fenced so that, whatever the cost is to the county council, the costs are covered.

As to moving to a national service, there are inconsistencies, but from the county council's perspective we have not really considered the pros and cons of that. What we would like to do is await the outcome of the deliberations of this Select Committee and, if there is to be a proposal to move to a national service, that is the point at which we would take the opportunity to comment.

Q86 **Chair:** Another thing Judge Thornton said, albeit back in 2013, was that you had a situation—I think you alluded to it in your evidence—where senior coroners were appointed by the local authority, but not employed

by it, coroners' officers were employed by the police, so their line management went in different places, and admin staff were employed and managed by the local authority. Somehow, as I think Debbie hinted at, you have a judicial officer who has to balance those relationships, which no other type of judicial officer has to do. How does that get itself resolved in practice?

Debbie Large: In Kent, all the Coroner Service team are employed by Kent County Council. Employment was transferred from Kent police in 2014. We have managed to address a lot of the difficulties created by that arrangement. In Kent County Council Giles and I have very good working relationships with our coroner team. It is a difficult one because coroners direct all judicial activity and it is KCC staff who carry out their instructions, but they have no line management role. We work with the coroners to find a path through that and it is successful in Kent. Because of my work with coroners' officers, staff associations and years of training coroners' officers, I am aware that that situation is not mirrored across the country. In practice, some coroners' officers find it very difficult being employed by either the police or local authority but working under the direction of the coroner, because employers do not always understand the role or relationship.

For us in Kent, the beauty is that I worked as a coroner's officer for a number of years. I have been involved nationally on stakeholder groups for a number of years and I have a very good understanding of it. We do not have those problems in Kent because I understand the bigger picture.

Chair: That is very helpful.

Q87 **Andy Slaughter:** I want to pursue the issue of organisation a little further. I think my colleague has some questions on financing.

It is a bit unfair on you because, from what you have said already, it sounds as if you are making the system work as best it can, and that requires some structural and employment changes but a good level of competence and co-operation. However, where it goes wrong it can go wrong quite badly for various reasons, because there is not that same chain of command and ability to step in, as it were.

You said you want to amalgamate the four areas. Do you feel that the four areas you cover are equally well resourced and have the appropriate amount of support?

Giles Adey: In terms of the four areas in Kent, in the past—I go back some way now—perhaps the service was not funded to the level it should have been. The total gross budget for our service is £6 million. That is a significant sum of money and a significant investment by the county council, but by virtue of the fact that our team is co-located in one place we are providing the same level of resource across each of those areas.

Q88 **Andy Slaughter:** You must be aware that in other areas—I am not asking you to name names—that will not be the case. Either the

reorganisation has not been done, the funding is not there, or there are problems that it is impossible for a local authority to address. Even a local authority as big as yours has no disciplinary powers over a coroner. It can ask and advise, but what do you do if there are difficulties and the service is not performing?

Giles Adey: That is one of the challenges. I talked earlier about the need for an inspectorate. As local authorities, where things are not going right, either through lack of investment in the service or coroners having a particular way of working that does not necessarily fit with the local authority's ethos, other than taking a complaint to the Judicial Conduct Office, it is very difficult. We have nowhere to go. I would certainly like to see some form of inspectorate, reviewing services and having some teeth in being able to make recommendations that local authorities and coroners would need to adopt, but from talking to our colleagues up and down the country I know it does vary considerably.

Q89 **Andy Slaughter:** The Judicial Conduct Office is limited in what it can do. It is almost as if everyone is working with the tools at their disposal but they are not made for the current task. Being honest about it, do you think that a root-and-branch reform is the way forward? The Chair referred to Peter Thornton's comments. I think he went back to the 1970s and said there were calls then for a national Coroner Service and for proper processes of supervision and organisation. Would you rather see that happen even if it means some loss of local control?

Giles Adey: That is a difficult one; I touched on it earlier. As an authority we have not come to a conclusion either way about a local or national service. It feels like a local service, but there needs to be some consistency. Clearly, we have not got that.

On what I would call the wider performance issue, we very much fall between two stools. Perhaps I can give you a practical example from several years ago. This does not involve any of our current coroners. I had some concerns about the post-mortem rate in a particular area, which seemed very high compared with other areas.

When I spoke to the coroner and tried to get a view on why that should be the case, the answer I got was not one I really expected and was not really satisfactory. Therefore, I had a word with the Chief Coroner and said I had these concerns. His response was, "Giles, these are issues of performance. I have no remit in terms of performance. You need to raise those with the Judicial Conduct Office." I raised them with the Judicial Conduct Office and its view was, "We don't deal with performance; the Chief Coroner deals with it." Therefore, we fall between these two stools at the moment. In terms of bringing about that consistency, is a national service the right way to go? I am not convinced.

Q90 **Andy Slaughter:** I share your pain. I have been through that process myself, but, surely, other aspects of the judicial system still have a strong local connection. For example, until we lost a lot of courts, there

was a big feeling that within a town or area they were its courts, its magistrates and even its judges, and yet it is still regulated at national level. You are obviously wedded to a system in which you have put in a lot of effort and tried to make it work, but do you not honestly think it would be better if there was more streamlining and control so that when you pull levers they are actually connected to something?

Giles Adey: In terms of greater consistency of process, you have national standards and they apply across the board, so I absolutely agree with that premise.

Q91 **Andy Slaughter:** Debbie, do you have any comment on that?

Debbie Large: I would like to see some national benchmarks and standards, but I am sitting on the fence at the moment in terms of whether you have to achieve that by nationalising the service.

Q92 **Andy Slaughter:** That is all very well, but what happens if individuals or services fall below those benchmarks? What do you do then? Who then has the responsibility?

Debbie Large: I think Giles has already mentioned that at the moment there is not anything we can do.

Q93 **Richard Burgon:** Local authorities have a statutory obligation to fund their local coronial services. How does this affect the resourcing of other important local services?

Giles Adey: Perhaps I can pick that up as manager of the budget. It is a statutory service that is totally demand led. As local authorities, coroners have very little control over the number of deaths referred to them. As local authorities, we have to meet all the costs, but we have very little control over expenditure. I have already said that the budget is not ring-fenced or directly funded by Government, and we think that perhaps it should be.

We can control expenditure to a degree through our contracts with the national health service and funeral directors, but sometimes that can work against us. As an example, last year our coroner removal contracts came to an end. In the four years prior to that, the cost to the council had been £107,000 annually. After the new contracts were put in place, that cost increased to £560,000 annually, so it was an increase not far short of £500,000 a year. The reason for it is that funeral directors used to subsidise in part or in full the cost of those removals.

We have also seen significant funding pressure due to the lack of pathologists in Kent in particular, but we also know that other areas are feeling our pain. As a consequence of what are fairly low or derisory fees—they have not been updated since at least 2007—we have had to increase the fee that we pay to our local pathologists.

In the same year as the pressure on funeral director contracts, we had to increase our budget for fees to pathologists by £350,000. Therefore, in

just a short time—over the course of a year—we had to put into the budget an extra £1 million.

In addition to that, our contracts with the NHS are now moving much more towards full-cost recovery for mortuary provision. That was not always the case in the past, so perhaps it was a false economy.

The Coroner Service competes with other frontline council services for funding. For example, if we have an in-year pressure like we did last year, the council has to look across at its other services for where it will fund those pressures.

In terms of local decision making and democracy, members make choices. We are in a very challenging situation at the moment, but if services are to be cut to plug financial gaps, members have a say in those decisions. In the Coroner Service they do not have any say at all. It often means that in our service—I did some work on this earlier this year—the only element of control of expenditure that we really have is our staffing budget. As soon as you start to look to save money, inevitably you consider cutting staff numbers. As soon as you start to cut staff numbers, you begin to provide a poorer and worse service to bereaved families who need to be at the heart of everything. Therefore, it really is a very challenging environment.

On the positive side, one of the things we look at in how we plug that funding shortfall is invest-to-save schemes. We invest capital and that will deliver revenue returns at a later date. We have been working very closely with our senior coroners and have developed a business case for digital autopsies to sit alongside invasive post-mortems.

We are validating the numbers at the moment, but potentially we are looking at a capital investment of £3 million that would be repaid over a period of nine years, after which it would deliver significant annual revenue savings. There are some very real challenges for us in managing the fact that coroner services are not able necessarily to put something into the pot when the local authority has to be able to make savings.

Q94 **Richard Burgon:** That was very useful, Giles. Unless Debbie wants to add to that, I have a supplementary question.

I was looking at National Audit Office figures showing that Government funding for local authorities has decreased by almost 50% since 2010. Giles, as you described, this has left local authorities with increasingly tighter budgets needing to make difficult decisions about where to channel their decreased funding.

In your answer, you mentioned that the only real scope local authorities have in relation to coroner services is in the number of staff and, I presume, terms and conditions of staff. Are you able to reflect further on how the cuts in local government funding over the past 10 years have changed the way local authorities approach staffing in coronial services—numbers of staff, pay and terms and conditions—and, crucially, how this

has affected bereaved families in terms of the service they get, the nature of the service and the speed of it?

Giles Adey: I can certainly talk about the county council's perspective. We have invested heavily in staff over the past five years. I believe that we probably have staff numbers about right. Debbie will be able to confirm that. I am acutely aware from talking to colleagues up and down the country that the investment by some local authorities in coroners' officers and support staff numbers is not the same. Those local authorities will have different local challenges and funding priorities. I think it is fair to say that in some cases that funding focus has not necessarily been on the Coroner Service.

Q95 **Richard Burgon:** Giles, that is really useful. Would Debbie like to add anything?

Debbie Large: I agree with Giles. We have followed the current Chief Coroner's model coroner area in staffing as a ratio to referral numbers. We have restructured our coroner officer role and identified an investigative element, a court duty element and an administrative element. Therefore, rather than having a coroner's officer who does everything, we have created a team structure and are able to develop particular skills and things. Again, that has given us a little bit of team structure.

In making the role attractive, giving different entry points and giving people the opportunity for progression through different roles, if they wish it, the county council has been very supportive of staff. Our pay probably sits on the mid-point on the salary scale across England and Wales. We have lost some experienced coroners' officers to the new Department of Health medical examiner service because the DOH pays a significantly higher salary for a very similar role. This year we have lost some experienced coroners' officers and I suspect that has been mirrored across the country as well.

I know from my national role that some coroners' officers work in areas where the staff feel that the numbers are insufficient. Their workloads and stress levels are very high, and it is very difficult in some other areas. That relates to local authority and police employers; it is not one or the other.

Richard Burgon: Thank you, Debbie and Giles. That is very useful indeed.

Q96 **Rob Butler:** We have covered quite thoroughly the financial aspects of the service. Will you talk a little about broader resources? What about access to courtrooms for inquest and pre-inquest hearings? Debbie, do you feel there is sufficient access both locally and nationally, from what you are hearing from colleagues elsewhere, too?

Giles Adey: Debbie, do you want to pick that up in terms of where we are going locally with co-location?

Debbie Large: Kent County Council is currently working on a project to provide a central court office complex where multiple coroners' courts, all of the coroner team and all the Kent County Council staff will be co-located. We are looking to provide digital courts, and we have been running virtual courts because of Covid. We are now doing a piece of work to explore how we can continue to offer virtual attendance post Covid.

We understand that a virtual court platform is being rolled out in other court settings, and Kent County Council would be very keen to be able to get access to that for the coroner's court as well. We are currently using Microsoft Teams, which is not designed for the purpose for which we are using it but it has enabled us to continue to deliver courts throughout the Covid response.

Q97 **Rob Butler:** When we are through Covid—however long that may take—do you think that that virtual approach would be appropriate for inquest and pre-inquest hearings? What would your ideal scenario be in terms of physical space?

Debbie Large: I would be very sad to see that everything was virtual, but some people would like to attend an inquest but find it difficult—for example, families overseas. We have had families fly over from Australia for an inquest. If they choose to do that, that is fine, but it would be very nice to be able to give them a suitable alternative, should they choose to take it up. We have premises that will enable physical attendance. It is just made more difficult at the moment because of Covid compliance. Kent County Council is still proceeding with its plan to deliver the courts that we were planning to do.

Q98 **Rob Butler:** Putting Covid to one side for a moment and thinking about the more general approach, typically do you find it relatively straightforward to find court spaces that have rooms for families to wait separately from other interested parties at court, for example? Maybe you can give us both your Kent perspective and the national perspective from your wider role.

Debbie Large: At the moment, in Kent, we borrow various council meeting rooms and try to book supplementary rooms so there are meeting rooms for families with counsel or interested parties. If we know there is a need for that, when we book a venue, we will take account of the meeting room needs. We have planned that into our court complex; it is an integral part of that plan. I am aware that nationally that is not always the case and in some areas the provision is unsatisfactory.

One of the things I am mindful of is the message that sends to families if they are being asked to meet in a place that is not really appropriate or suitable. Kent is not there yet. We are doing the best we can, but we are working towards a purpose-built solution.

Q99 **Rob Butler:** Giles, is there anything you want to add to that?

Giles Adey: Only that during my time as head of the service the court facilities available in Kent were very sketchy right across the county. We probably had seven or eight different court settings and very different buildings not fit for purpose. The facilities that perhaps we should have been providing at the time were not being provided. As Debbie said, in Kent we are moving to a solution for us, but we are acutely aware that other areas are not resourced to the same extent as we are in bringing everything together in one place but with all the right facilities.

Q100 **Rob Butler:** It might seem a simplistic question with a very obvious answer but it is perhaps just as well to get it on the record. How important are the right physical surroundings and environments to both bereaved families and the effectiveness of what needs to be done?

Debbie Large: I would say it is quite critical.

Q101 **Rob Butler:** Will you expand on that?

Debbie Large: The earlier witnesses made reference to this being one of the most difficult days for that family. If they arrive at premises where there is not a proper space to meet and they may have legal representation, but there is no meeting space and they have to go outside and have a conversation in the corner of a car park, that is not going to give them confidence in the process. For me, they could very easily receive the message that it was not important.

Rob Butler: That is extremely useful and helpful.

Q102 **Dr Mullan:** In quite a few of your answers you have touched on specific pressures on staff and financial challenges. For example, you talked about the cost of pathology and body removal. To what extent has the Chief Coroner's model been useful in discussing resources with your four senior coroners, pulling together what a model service looks like and having those discussions about funding, staffing and so on?

Giles Adey: I think the current model coroner area has been around for three or four years. It has certainly been very helpful to us in having those conversations with our senior coroners in developing the service and facilities. It very helpfully sets out guidance about the number of coroners' officers who should be provided. The difficulty is that that has been predicated on case load death referrals. What it does not necessarily do is take into account the complexity of the area and the number of inquests held, and we would certainly like to see a change to that.

We understand that an updated model coroner area is due to be published imminently and we await the outcome of it. The Chief Coroner's guidance and the model area can sometimes present challenges for the local authority in funding burdens. For example, the current model requires that assistant coroners do a minimum of 15 days a year, plus their mandatory training. There is clearly a cost to that. There should,

rightly, be a number of days to ensure coroners are up to date in working practices, but sometimes there is a financial burden.

The other point about the model area is that as local authorities we are constantly benchmarking each other on costs and numbers. One thing local authorities feel is missing is that we have the guidance on coroners' officer numbers, but we do not have guidance on coroner numbers. It would be really helpful in understanding what the Chief Coroner's view is on what a small, medium and large-size coroner area might look like in the context of a senior coroner, areas coroners and assistant coroners, but again that would need to be predicated on the complexity of the area, not just case load.

Q103 **Dr Mullan:** Debbie, do you want to add to that?

Debbie Large: It is a useful starting point for discussions. It has been very helpful for me in setting my staffing levels. Kent County Council has been supportive of the staffing levels of our team and it has staffed us according to the Chief Coroner's guidance, so it has been useful for us.

Q104 **Dr Mullan:** For example, among your four coroners what is the variation from the model and the differences between each, and in what way?

Debbie Large: We have two senior coroners. One of our senior coroners runs three of the coroner areas. The two senior coroners collaborate. The council team is one team who have worked for all four coroner areas, and in our processes and procedures the quality of our staff is applied equally across Kent and Medway residents. That works fine. Obviously, the two senior coroners are independent of each other and are entitled to have different views about things, but KCC takes a collaborative approach with our coroners.

Q105 **Dr Mullan:** You have a group of coroners and look to the national model as an interesting and helpful aid on the ground. What still leads to differences? You have said they can run it in different ways; they are independent. As long as you feel comfortable talking about it, what are the differences you see in how they approach it?

Giles Adey: In Kent, because we have this collaborative approach where we have two senior coroners and not four now, as Debbie said, we are working closely with them on a day-to-day basis. We meet them on a regular basis to horizon-scan challenges coming down the line and on potential future funding pressures.

We are working with them and together we are able to resolve those problems. As Debbie said, we have one pool of staff working in one location and we are moving to a co-location of courts and court space. Broadly speaking, it feels to me as if the four areas are now very much working together.

Q106 **Dr Mullan:** You have mentioned some disadvantages to the model in that it does not really give you guidance around case complexity.

Depending on scale and the number of people involved, how possible would it be for them to determine exactly what you would get in terms of case complexity in every area every year? Adjusting it for that must be quite hard.

Giles Adey: Yes, and that is perhaps why we are where we are at the moment in not having guidance around coroner numbers. The Chief Coroner in his model coroner area talks about that having to be a local discussion between the local authority and the senior coroner, but it is difficult to say. When local authorities are benchmarking, it is difficult to understand why there should be such stark differences between areas. It would be helpful to have some advice, but I do understand the challenges in arriving at what the numbers might look like for a particular area.

Q107 **Dr Mullan:** As you say, it would be helpful to have a way of everybody agreeing how they are going to map it and measure it so that there is at least some comparison.

Giles Adey: Absolutely.

Q108 **Dr Mullan:** Do you think there are any other disadvantages in the national Coroner Service model?

Giles Adey: One of the things that I know previous witnesses have talked about is the "pathology" challenge, perhaps moving to regional mortuary provision. Local authorities in the south-east have discussed that on several occasions over the years. The difficulty is that we have never come to a point where regional mortuary provision is at the top of the respective local authorities' priorities and it has been very difficult to arrive at a decision that that is the right way to go. Regional provision would make absolute sense, but the question is how it would be funded. I think the challenge would be for Government in funding the capital or set-up costs, because of the difficulties of agreeing it locally, and then for local authorities in a region to collaborate and work together on the revenue consequences. Does that help?

Q109 **Dr Mullan:** Yes. Thank you, Giles. Is there anything you want to add, Debbie?

Debbie Large: I agree with Giles. It is difficult. Geography comes into play, because with a regional mortuary for our region we would be covering lots of miles, so there are some difficulties around that.

Q110 **Chair:** Debbie, you said that you had moved to virtual hearings during the Covid pandemic. Have there been any other pressures from changed working you have had to undertake?

Debbie Large: At no notice, we went paperless and used Teams to run inquests. All of our staff worked from home. That has been a challenge. I have been immensely impressed by our staff, who have a really difficult job. They went home and got on with it. Working from home, we dealt with probably a 50% increase in the referral rate over the lockdown period. We have worked very carefully with our team to make sure it

keeps work-home boundaries very clear. Our saying is always, "Leave death at the door; don't take it home with you." That has been a challenge for us. Our team continues to work from home.

We are preparing for the possibility of having some attendance at the office as we plan for our usual winter pressures, plus possibly an increase in Covid-related deaths.

In Kent we have one eye on transition as well. We are mindful of that. The coroners are full-time coroners. They worked from home. That was to make sure they kept dealing with all the referrals. They did all the preparation for inquest hearings, and assistant coroners who did not need to shield came in to run the courts. The coroners had to have a physical presence in our court, and we relied on volunteer court staff to come and run the laptops for the virtual hearings.

Therefore, we managed to maintain court hearings throughout. It has been a challenge, but we have successfully kept our service going, and that has been down to the hard work of the whole team.

Q111 **Chair:** I am sure we want to thank all of your team and coroner staff generally for the work they are doing.

Debbie Large: Nationally, staff went to work from home and made it work.

Chair: It has been pretty tough for everybody. I know that is appreciated.

Q112 **Andy Slaughter:** To continue that theme, what were your waiting times like before Covid struck? I know that some coroner services had a bit of a backlog in any event. What would be the typical waiting time, and how would that relate to jury inquests? What change has there been? Where are you now with the backlog? We are looking at backlogs and capacity in lots of other parts of the justice system, so I just wonder how you are coping.

Debbie Large: We have not been able to deliver any jury inquests since March. We have now identified a venue where we can deliver jury inquests, which will be up and running. We have a large jury inquest starting on 2 November and we will restart jury inquests after that, subject to any further Government advice that is forthcoming.

From 1 January to 30 September this year we delivered 1,124 inquests. In the same period last year there were about 100 fewer inquests. I have to say they are not like-for-like inquests, but obviously all the inquests that we have delivered in that time are those that have not gone on to our backlog.

We have not been able to deliver inquests where they are quite complex and there might be legal representation and a need for physical attendance at the court and juries.

We have a significant backlog of those days in court. We are currently identifying additional venues and recruiting additional staff to make progress with those cases. We were not able to deliver all of our inquests, but we did deliver those that we could.

Q113 **Andy Slaughter:** Rather than look at numbers of cases, we should perhaps look at the number of days or the complexity of cases. Is that giving you concern, particularly as we may have some further period of lockdown to come? I am trying to get a feel for how long people may be waiting for inquests in serious cases. Can you say how many jury inquests you have backed up?

Debbie Large: Prior to lockdown we were hearing the majority of our inquests within three months. There are some cases that cannot be heard that quickly because we are reliant on other organisations to provide us with reports, but we were hearing our routine cases within three months. We have a significant backlog of cases in terms of court days. It troubles us because obviously families are waiting for conclusions, but we have had to follow Government guidance.

As a council we are competing with courts for large venues, so it is difficult. We have a recovery plan to work through our inquest backlog in Kent. I cannot speak for the national position because I have been very much focused on Kent, but I suspect other areas will be in a similar position. Because our inquest numbers are probably among the highest compared with other local authorities, I suspect our backlog is probably the largest, because we tend to have a large number of inquests, but we are making provision to bring in additional staff and we are seeking additional venues, and the coroner team is large enough for us to run multiple courts once it is safe to do so.

Q114 **Andy Slaughter:** No criticism is intended. I just want to get a feel for it. In percentage terms, where do you say you are compared with a year ago? Would you say you have 50% more days to timetable, or something like that? Do you know—if you do not know perhaps you would let us know afterwards—how many jury inquests you are waiting to try to schedule?

Debbie Large: I do not know the number of jury inquests we are waiting to schedule. I do not know how many cases are ready to list; I would have to come back to you on that. We have estimated and we are making provision for 220 court days as additional capacity. That is what we are making provision for. It is an estimate. We are working with the senior coroners to identify the number of court days they need.

Q115 **Andy Slaughter:** Additional to what? What would be your baseline number before you add on those 220 days?

Debbie Large: We have about 1,100 inquest hearings a year, but I do not know what that equates to in terms of days.

Q116 **Andy Slaughter:** I will leave it there. If you have any of those figures,

perhaps you could let the Committee have them afterwards. It would be quite useful to see how you are comparing with magistrates courts, Crown courts and things like that.

Debbie Large: Yes.

Q117 **Chair:** Giles, do you have anything to add?

Giles Adey: I have nothing to add. Debbie is the expert on the day-to-day operations.

Chair: Thank you very much for taking the time to give evidence to us, Giles and Debbie; it is very much appreciated. We give thanks to all of your colleagues for what you are doing, and we are very grateful to you for your help in relation to this inquiry. The evidence session is concluded.