HOUSE OF COMMONS

Justice Committee

Oral evidence: The Coroner Service, HC 282

Tuesday 8 September 2020

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Watch the meeting

Members present: Sir Robert Neill (Chair); Paula Barker; Richard Burgon; James Daly; Miss Sarah Dines; Maria Eagle; John Howell; Dr Kieran Mullan; Andy Slaughter.

Questions 1 to 39

Witnesses

I: André Rebello OBE, Senior Coroner Liverpool and Wirral Area, Hon Secretary, Coroners' Society of England and Wales; and Dr Mike Osborn, President Elect at the Royal College of Pathologists, Chair of the Death Investigations Committee.

II: Deborah Coles, Executive Director of INQUEST; and Andrew McCulloch (bereaved person with experience of the Coroner Service).

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Examination of witnesses

Witnesses: André Rebello and Dr Osborn.

Chair: Good afternoon, everyone. Welcome to the first session of the Justice Committee since our return from the summer break. We still have to do this largely in a virtual format.

I welcome all our witnesses, who will join us in due course. When I come to each panel I will ask the witnesses to introduce themselves.

By way of our normal procedures, I have to ask members of the Committee for their declarations of interests. I am a non-practising barrister and consultant to a law firm.

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

Maria Eagle: I am a qualified non-practising solicitor.

Richard Burgon: I was a solicitor before being elected.

Q1 **Chair:** I do not think there is anything from Keiran Mullan or Paula Barker.

This is the first session of our inquiry into the coroner service in England and Wales. I thank all those who have submitted evidence to us, in particular those who will give evidence to us today. The first panel includes André Rebello OBE, senior coroner at Liverpool and Wirral. Would you like to introduce yourself?

André Rebello: I am not a doctor but a solicitor. I have a physiology degree, and I am the coroner for Liverpool and the Wirral.

Dr Osborn: I am about to become president of the Royal College of Pathologists, and I am the national lead on non-forensic autopsy.

Q2 **Chair:** It is good to see you both. Thank you very much for your time.

Mr Rebello, what you said in your introduction highlights something that has changed a great deal over the years. When I started as a young barrister, most coroners were doctors and medical men and women, whereas now the majority are lawyers, are they not?

André Rebello: Yes. There are three who are still doctors by qualification. I have been a coroner since 1994 and the vast majority of coroners were lawyers. One or two in London were dually qualified, but mainly lawyers.

Q3 **Chair:** That is exactly right. Maybe that reflects the way the process has changed, the nature of coronial hearings and so on.

The Coroners and Justice Act 2009 was a major reform in a number of areas of the service. What are the principal changes—hopefully for the better—that you have observed since that time? If there are any for the

worse, what do you say about them?

André Rebello: The coroner service today, generally across the piece, cannot be recognised as the service I joined in 1994. There are far fewer coroner areas. Coroners now have mandatory annual training.

The problem is that we have an unevenness. Parliament decided we would have a local service. On behalf of the Coroners' Society, I pushed for a national service, but Parliament did not have that. We have a little bit of a postcode lottery because of the different resourcing of coroners. Many coroners, particularly those in the north-west, Milton Keynes and many other areas, have excellent court facilities—for example, in East Anglia and Essex—yet some coroners are still struggling to find courts in which to sit; officers are not located with the coroner, and the service is a bit of a mismatch because Government never funded the new burdens brought in by the Coroners and Justice Act.

There was certainly funding for the Chief Coroner's office to some extent—not to the extent I would have expected—but there was no funding of local authorities and police authorities for the more sophisticated and complex investigations, and to pay for expert witnesses and now possibly counsel to an inquest and things of that nature.

In Liverpool, people look to the Hillsborough inquests heard in Warrington and at the infrastructure built there for those tragic 96 inquests. We can only look on in envy. The amount spent in legal fees for South Yorkshire police and families was the best part of £18 million. You look at the infrastructure built and the science park just outside Warrington for the court and the high-tech facilities arranged. That sets the standards people expect.

I am very fortunate: a competent relevant authority has provided me with a purpose-built court. It was part of the Courts & Tribunals estate. It abandoned it and we took it over. Just before we took it over, £2.6 million had been spent. Unfortunately, local authorities were not given the funding to build, equip or staff coroners' courts.

When I first became a coroner, only a few coroners had a database; now, every coroner has one. There are two main suppliers of databases, and they are fairly evenly spread across all coroner areas.

Q4 **Chair:** I understand that. Is the funding that goes to local authorities, as opposed to national funding for the Chief Coroner, an element of specific grant, or is that rolled into the block grant?

André Rebello: It is just in the block grant, and it was never increased. The problem is that competent, conscientious local authorities that have realised the service we have to give to the bereaved have had to take from other non-statutory services; children's services, services for the elderly, library services and other things that local authorities always did very well have been totally stripped away. It is only because of other services suffering that local authorities are managing to keep their heads

above water. As you may be aware, in Northamptonshire the local authority could not keep its head above water and it was put into special measures. That is a real problem. There should have been money coming in the impact assessment to fund the Coroners and Justice Act. The MOJ used to have funds to run the coroner service under the 1988 Act. Its staff was stripped away.

Regulation 28 reports prevent future fatalities. Under rule 43—the old way of reporting matters that could prevent future fatalities—the MOJ had civil servants who drafted annual reports that pulled out themes so that everybody could see the issues of the day. The Chief Coroner has never been given those facilities; he has never had that transferred to him. Unfortunately, although far more reports to prevent future deaths are issued today, there is no analysis. It is not as useful as it used to be under the 1988 Act. That is down to Government and Parliament passing the law without the impacts being assessed. We were going to have a post-implementation review to see how the service was managing and what were the unintended burdens brought about by the service.

Chair: You have made your point very clearly.

Dr Osborn: I completely support everything André has just said. From a pathology point of view, the big thing is that there is no clear ministerial oversight of the coroner service. I understand that tagged on to one of the Ministry of Justice's Departments is someone who vaguely covers coroners. There is no actual Minister who has the coroner service in his or her portfolio and is answerable for it. That was one thing that did not happen.

The other thing is that the formation of the Chief Coroner was a fantastic idea, but unfortunately it has been hamstrung by the fact it has no power over any of the other coroners. Therefore, it has responsibility without any power, which is very difficult.

The chief coroners have been very good; they have produced guidelines, teaching and so forth, but the problem is that, as with similar things, all the people who go to those, adhere to them and follow the guidelines are not those who need to adhere to it, follow the guidelines and have the teaching. It is perhaps the people who do not bother to interact directly with the Chief Coroner, or are less happy to do so, who really need to be cajoled slightly more into following these sorts of things.

The Chief Coroner essentially has no power at all over any of the coroners. He can give advice, but that has been a very significant problem, which we will come to again and again with other things we raise.

It feeds into exactly what André said: you have a postcode lottery. You do not have a national coroner service and you need one. If I go to one jurisdiction to do a post-mortem, it is very happy for me to take histology to a higher level to find out the cause of death, inform the family and the

hospital. If I go to another jurisdiction, it absolutely forbids it and it is at the behest of the coroner. Whatever the Chief Coroner says, he has no control in telling them what to do. That has been a fundamental problem. It was an opportunity missed to make a national coroner service.

Chair: We have got that very clearly from both of you. That is very helpful.

Q5 **Andy Slaughter:** I did not declare my interest at the beginning. I am a non-practising barrister.

As a lawyer in a previous life, a council leader and in this role I have had a lot of dealings with the coroner service over the years. I have appointed a coroner; I have tried to sack a coroner. I can tell you that one is a lot easier than the other. The view I have formed is that it is a Heath Robinson service. You have different people employed in different ways. There is no structure to it; there is no clear chain of command. You talk about a difference in resources, but it is also very much at the grace and favour of how seriously the local authority takes it and matters of that kind.

Do you agree with that, or is that overly harsh? If you agree with it even in part, do we need a wholesale reform in the way the service is structured? Nobody minds whether it is a national service or a local service, but at the moment it is not serving victims and their families well. How can we make those changes that will ensure that it is a service fit for the current time?

André Rebello: That is a very complex, compound question, of which I would have disapproved in my court given our inquisitorial nature, but it is a very helpful question because it enables me to explain one or two basics. Coroners are judges. Each judge is independent in his or her judicial decision making. Not even the Lord Chief Justice, except when sitting in the Court of Appeal, or in an appellate capacity, can tell other judges how to make judicial decisions or exercise their judicial discretion. It is a given within the separation of powers and the rule of law that judges must be able to make decisions based on the facts before them applying the law.

Clearly, there is an appellate capacity for the administrative court, divisional court, Court of Appeal and the Supreme Court to oversee those matters. The Chief Coroner has issued guidance. Guidance is guidance; it is not standard operating procedures, and it would be quite wrong for the Chief Coroner to tell every coroner how to run a case by micromanaging it. That is not how the judiciary works, and it is the strength of our rule of law that that is not how the judiciary works.

With regard to a Heath Robinson service, depending on where you are observing it, I can see that the service may be very poor. If you are observing in other areas, the service is excellent. It depends on where the observer is. It is a form of parallax. It depends on where you are, what you see and what your experience is.

The vast majority of people who engage with coroners send us an awful lot of compliments and thanks. I have submitted 72 pages by way of a very comprehensive response to the questions you wished to ask. I would encourage all members of the Committee to read those, particularly the input from the families we serve.

When you are dealing with justice, you cannot please all the people all the time, but when you call relevant evidence and adjudicate upon it, the evidence is what it is. We cannot make things up to appease people.

That is the judicial process. We can still deal with that in a kind, compassionate and caring way. It is very important that the coroner's jurisdiction is an enabling one that supports people through the most traumatic and difficult times that families ever endure.

I am in a very privileged position as secretary of the Coroners' Society: all inquiries and telephone calls from the public come through me. I know everything is not perfect. We try our best. Through feedback to the course directors who deliver coroners' training, we give feedback to the Chief Coroner and try to moderate how coroners behave. We train coroners in judge-craft and in many of the skills we expect them to have to deliver this inquisitorial, judicial process.

There is a problem with resources, accommodation and staffing levels. There are no teeth to enforce the duties under section 24 of the relevant authority to provide accommodation, staffing and resources to run the coroner service. Unfortunately, before the Coroners and Justice Act 2009 was implemented the courts inspectorate was abolished.

I do not know whether this was part of the bonfire of quangos, but it was abolished. That was a missed opportunity. We need a courts inspectorate for coroners' courts. We need a courts inspectorate under the Minister. I think the present incumbent is the Under-Secretary, Alex Chalk. We need a courts inspectorate under the Ministry of Justice. That courts inspectorate could then judge coroner areas by inspection, pretty much like Ofsted, and check that the model coroner area appended to the Chief Coroner's annual report is being met; that resources have been provided to the coroner service; that the accommodation is suitable; that private space is given to bereaved families so they can have time with their loved ones; that coroners are working efficiently; and that the budgets are monitored.

It would be helpful for such an inspectorate to have teeth such that, if there was a failing of a relevant authority, the Secretary of State, under schedule 2 to the Act, could replace the relevant authority with another one from that area; or, if necessary, put the authority in special measures, such that the Secretary of State could send in someone to administer the area. That could be a retired coroner service manager, alongside a retired senior coroner, until the service is up to scratch. The relevant authority would have to pay for what was needed, because if

people do not fund and resource the coroner service and provide coroners with the appropriate staffing levels coroners can do only what they can.

Within my submission I quote one coroner as saying that we are as cheap as chips. Why would central Government want to nationalise a service when the vast majority of what we do is good? The reason I say we need to do more is that we should not have any dissatisfaction with what we do. When you work with the bereaved you have to get it right first time.

I do not know whether that deals with the issues Mr Slaughter raised in his long question—I cannot write that quickly—but hopefully I caught most of them.

Andy Slaughter: That is very helpful.

Q6 **Paula Barker:** Mr Rebello, you have touched on a number of the points I was going to raise. As we know, the Chief Coroner has set out how a model coroner's area should operate and the resources it should have at his disposal. You have talked already about a postcode lottery and differing facilities and funding streams. Is it possible to say approximately what proportion of coroners' areas have the resources as set out in the model and have achieved the standards as stated?

André Rebello: Without an inspectorate, it is not. One of the problems is that people are often embarrassed to say when they need help. I know of certain areas where coroners are struggling. It is not really appropriate for me to name names publicly, but there are some areas where coroners need new courts; coroners are split away from their officers; coroners do not have the wherewithal to hold inquests, and that causes delay. Some coroners do not have sufficient investigation officers to investigate deaths, yet an area such as the north-west has excellent facilities. Merseyside police could not be more helpful. In Greater Manchester, all four coroner areas have purpose-designed courts. I think Mr Daly visited the Rochdale, Oldham and Bury coroner quite recently and may well have seen brand-new facilities. They are going to build three courtrooms in the new facility, one of them sufficiently big for socially distanced juries.

Many relevant authorities take the coroner service very seriously, but they can do that only by robbing Peter to pay Paul. There is no money given to local authorities to support the rolling out of the Coroners and Justice Act. It was just a nonsense. Why should local authorities be expected to run a modern coroner service that has bereaved families at its centre with Victorian budgets? That is the problem. A significant number of local authorities have not increased the budget and coroners are struggling. There are real problems.

I give one word of warning. With regard to the Chief Coroner and the model coroner area, you are looking at a model coroner area that is two to three years old. The Secretary of State has a responsibility to publish the Chief Coroner's annual report. One or two political imperatives got in the way of this happening last year, such that very shortly I am

expecting the Secretary of State to publish a bumper edition covering two years of the Chief Coroner's annual reports. That report is much enhanced and evolved from the previous one you have all considered, and deals with things such as relying not on the number of deaths reported but the number of active inquests when looking at staffing levels, which is far more sensible because over the years in different areas, depending on who you were, it depended on what deaths were reported. Now we have regulations that control which deaths need to be reported to the coroner and, therefore, we expect standardisation.

The other thing is that the model coroner area is attached to that report, as are the inquests over 12 months and, for the first time, the salaries of all senior coroners and all area coroners. I have not seen them, but I understand they may prove interesting.

Q7 **Paula Barker:** You have touched in part on my next question. Coroners and coroners' officers need a complex skillset. How are they helped to develop this, and what improvements do you think we could see in the future? I know we have touched on the subject of funding and you have spoken about training as well, but what other things could be improved?

André Rebello: Judge-craft is covered in coroner training. The Chief Coroner trains all coroners. All coroners have mandatory residential training. In addition, there are one-day courses on medical aspects of what coroners do. Because there are fewer coroners with medical experience it is important that coroners learn about how the body works.

The important thing in that regard is that as a coroner you cannot give evidence to yourself. You may be a doctor; you may be a coroner, but you still have to hear evidence from an expert or witness to evaluate the evidence in the light of all the other evidence. Having a doctor as a coroner was thought by Parliament not to be a good idea unless that doctor also had legal qualifications, because to understand natural justice and things of that nature and to be able to administer judge-craft is a different skillset from that of being a doctor.

The Chief Coroner also trains all coroners' officers. There is a problem in that coroners' officers are short in number in some areas. The Chief Coroner has had a little bit of a battle with some police authorities and local authorities in making sure that coroners' officers are released for training. It is a no-brainer that, if you train people, when they come back you get an enhanced service, whereas if you do not go to training in the first place you can just assume that whatever you do is right. In training, particularly residential training, people learn an awful lot when talking in the margins with regard to how things work. You pick things up, take them back, adopt them and make things work.

Q8 **John Howell:** Dr Osborn, I want to ask about post-mortems. Will you explain how you go about holding a post-mortem? Why is there such a regional difference in the number of post-mortems taking place? Are some areas doing too many and others doing too few?

Dr Osborn: I think André can provide a better answer on the number of post-mortems. We do not decide to do the post-mortem; the decision is made by the coroner. The number done in a jurisdiction is down to the coroner.

To return to a few of the things André touched on, coroners' officers have such a fundamental role that it is impossible to overstate it. They have become increasingly thinly spread, and because of that their ability to provide useful information to pathologists and, I assume, coroners has become harder as time has gone on.

You are trying to establish what you need to do during a post-mortem and what tests you may need to conduct and so forth based on very limited information. This highlights the differences around the country and the postcode lottery to which André referred. We run courses at the college where we discuss different aspects of post-mortems and so forth. In some areas they are furnished with scene photographs, police statements, statements from coroners' officers and so forth. In other areas you get just two lines written on a piece of A4 saying, "Person found dead in Tesco", or something like that. There is literally that much difference.

That makes doing a post-mortem extremely difficult and feeds into one of the most significant problems with the post-mortem system, which is that you do not have enough pathologists doing them. One of the reasons for that is that they do not get the information they need; they are not funded properly to do the post-mortem, just as André said about the rest of the system. Therefore, for very little money they are laying themselves open to potential or perceived risk and it is just not worth their while at a professional, philosophical or financial level to get involved. That is a major issue.

How we decide to do a post-mortem is based on the information we get from the coroner via the coroners' officers. They are the ones who gain that information, which is absolutely vital. How we go about a post-mortem is identical essentially in all post-mortems we do. We systematically examine the outside of the body and then do an internal examination looking at all the organs to see if there is any disease or damage, depending on the likely cause, but the process is the same everywhere.

What does differ is whether a post-mortem is appropriate in the first place. The coroner may ring me and say, "Do you think we need to do a post-mortem in this case?" I will say yes, no or whatever. Usually, what systems you investigate, what samples you take and what further investigations you do are very much governed by the information you have.

As for the numbers, that is purely down to the coroner. It varies around the country depending on their interpretation of the law. This goes back to the Chief Coroner. I am not suggesting for one minute that the Chief

Coroner should tell people how to judge a certain inquest and so forth. What I am saying is that, if a crime was committed against me in Newcastle or London, I would expect it to be investigated according to similar standards around the country by the police investigating it. What you do not have in the coroner service is an analogous system, not because the coroners necessarily do not want to do it but because the Chief Coroner has no jurisdiction over the different areas. There may be guidelines, teaching and so forth, but he has no power to ensure that people follow or adhere to them in most circumstances.

That is a real issue for pathologists. It puts off pathologists because it blurs the margins and makes them very worried. Whatever anybody says, the general public think that the Royal College of Pathologists is in charge of all post-mortems in this country. We get multiple emails and letters from dissatisfied members of the public, when all other avenues have failed, to say that the coroner said this or that, or this or that happened, and asking what they can do about it. Inevitably, we say they have to go back to the coroner, or apply to the Chief Coroner and so forth. That happens very regularly because of a lack of facilities on the part of coroners' officers and so forth to be able to deal with the public's requests. I hope that answers your question to a degree.

Q9 **John Howell:** I can see how a national coroner service would help to make some of the standards even across the patch, but would it help to deal with the postcode lottery you have just explained in your answer?

Dr Osborn: A very good review of the coronial system was published in 2006 by Hutton. That really goes into the whole area and touches on finance, organisation and so forth. If you had a national system, you would alleviate many of these problems. If you had a system for dealing with requests and questions from the public that was a bit like the way patient affairs in hospitals deal with them, they would be able to address the queries and so forth raised by members of the public.

To give you an example of how severe the differences are, one of the hospitals in which I work is covered by two coronial jurisdictions. In one I can pick up the phone and call somebody, get an answer in three seconds and everything is sorted out. In the other I have absolutely no idea how I would get in touch with somebody, other than send an email that, if I am lucky, might be answered in three or four days' time.

They are hugely different levels. I am a professional person who is adept at getting what I want and know the secret telephone numbers to which no one else has access. If I am a member of the public without access to the internet, who perhaps is not the most au fait with the system, I have real trouble accessing those things in some areas. In other areas, it is fantastic.

Chair: That is extremely helpful.

Q10 **Dr Mullan:** This has been an extremely helpful discussion in highlighting

the variation that exists. In a practical sense, one of the things the Chief Coroner has talked about is the establishment of regional centres rather than individual offices. What would be your view on the benefits and drawbacks of a regional model?

Dr Osborn: From a pathology point of view, a regional model would be very good for us. Really and truly, what would be very good is to make a national coronial service where post-mortems were brought within the NHS in some way. How you do that is a different discussion. That would allow you to have regional centres with a mix of expertise. If you had a death that was not necessarily overtly suspicious—for example, a hanging or drowning, which always has a slight air of suspicion about it—you would have perhaps a forensic pathologist involved in the group; they could do that case. However, if you had a complex medical or post-operative case, somebody like me with my skillset with ready access to people in a tertiary/quaternary hospital could ring up a cardiologist who could tell me immediately the latest cardiac technique, and you would expect to see that. It would allow very much better use of the skillsets that people have; it would be very useful from a pathology point of view. It would also allow improved communication from coroners' officers and so forth to ensure that the information was available in those regional centres, which would help us tremendously.

André Rebello: Let me be just a little vulgar by mentioning money. When we talk about the fees prescribed in the coroners' fees regulations, a pathologist is supposed to be able to do a standard post-mortem for £96.80 and £276.90 for a special examination. I do not know how many of you have recently employed a plumber, bricklayer or joiner, but £96.80 often reflects tens of hours of reading medical records, examining the body, preparing slides, looking down the microscope, deciding what to send off to toxicology and what other special examinations are needed. When I order a post-mortem I want the cause of death, not a cause of death.

My friend the coroner for West Yorkshire (East), Kevin McLoughlin, in his submission to the Committee points out something that, on the face of it, looks quite stark. The post-mortem rate in Staffordshire is 18%; in North Yorkshire it is 65%. I can tell you that in Liverpool and Wirral it is 31%. He goes on to explain that natural causes in Liverpool and Wirral last year were 302 conclusions, but in north London only 13, but because he does not know this area he does not appreciate that that is 302 natural causes inquests, as opposed to what I would consider to be an additional 302 unnecessary post-mortems. If, based upon the medical records, through hearing evidence I can find the cause of death, I am not going to order a post-mortem against a family's wishes. I would much rather open and conclude an inquest in a timely manner.

Less invasive post-mortems by imaging are available in some areas. It is used in Liverpool and Wirral as an adjunct to forensic pathology for penetrative injuries and ballistics but not otherwise, because in my view

in those cases where other coroners may order a scan they get a cause of death rather than the cause of death. I object most strongly to families and communities being charged for coronial post-mortem investigations. If I order a post-mortem, the relevant authority funds it. Relevant authorities do not fund less invasive autopsy, and it is not right that we have this unevenness within the service.

You just need to look at the prescribed fees. They were put in the 2013 regulations, and for 11 years or so that is what we have been paying. How can we expect pathologists to stay working in autopsy pathology when this is not part of their NHS practice and it is only because of their dedication that we have any post-mortems being done?

Q11 **Dr Mullan:** I think that is a valid question.

Some of the evidence we have heard is that in terms of cost, time and families' views minimally invasive post-mortems would be a preferred approach in some circumstances. Dr Osborn, would you outline your views on the pros and cons of minimally invasive techniques? I understand that one of the potential benefits of regional centres would be to allow for wider use of minimally invasive techniques, if the facilities are available.

Dr Osborn: That is something it would set itself up for. You could easily have CT scanning there. The method of choice is CT scanning for adults. The Royal College of Pathologists has always been very pro minimally invasive autopsy; we are very pro the wishes of families. I can completely understand why people would not want their loved ones to undergo a post-mortem. What I would say is that a post-mortem is done in an extremely controlled and recognised way and very respectfully. While I understand that the concept may upset some people, it is done in a very respectful way.

Minimally invasive autopsy is very good but it is not the magical answer to all the questions everybody wants it to be. CT scanning is the method of choice for adults. If you do CT scanning, select your cases and do ancillary testing, which in itself is somewhat invasive—for example, you might need to make a small cut in the side of the neck to put in some fluid to look at the blood vessels, angiography and so forth—in good centres with well-trained staff you can get the answer to the cause of death in up to 70% of cases. In some studies it is 90%, but realistically it is about 70% of cases. But that is not the same as saying that for all cases coming through the door that might have a coronial post-mortem just putting them through a CT scanner will give you an answer in 70% of cases. You have to be very careful about it.

We are very pro this method, but the people involved have to be very skilled and have their skillset built up, and extremely good governance has to be involved. We will always need an external examination and that will need to be done by a suitably trained individual. There are legal and coronial law arguments about who that can be, but it needs to be

someone who is responsible and knows. There needs to be oversight by a pathologist reviewing all the information, preferably doing the external examination and reviewing the findings of the radiologist, who has been trained in post-mortem radiology finds, and together they should come to a cause of death. In a significant number of cases they will not come to a cause of death and there must therefore be a willingness to move to an invasive post-mortem.

Q12 **Dr Mullan:** You mentioned 70% and potentially 90% of cases. Is it that the wrong conclusion is drawn, or it is inconclusive and you expect to proceed to a full post-mortem?

Dr Osborn: The approximate figure of 30% is not that the wrong one is done, but you do not come to a conclusion based on the balance of probabilities, in the same way as you would in a normal invasive post-mortem that gives you the cause of death.

Q13 **Dr Mullan:** You have talked about the potential risks of using that technique inappropriately. Is it your view that we should proceed with caution, or would you say that a more widely rolled-out CT minimally invasive-based approach that could be improved over time would be preferable to what we are doing at the moment, or would you say we should roll it out only in a very considered and slow manner?

Dr Osborn: If you can roll it out in a properly funded, governed and organised manner, we are very happy to help you do that; we will work with anybody and that would be a really good solution, but it would not answer all the problems of the coronial service. It would not answer all the problems of the lack of pathologists, because you still need them; it would simply be a modern take on an age-old procedure. It is not better; it is just a new tool in our armamentarium, if you see what I mean.

Q14 **Dr Mullan:** But the evidence we have heard suggests that, for example, you would be able to conduct 17 in 24 hours versus perhaps one or two traditional post-mortems. Surely, that suggests there is some kind of saving in pathologists' time.

Dr Osborn: I have not seen that data. There is a lot of data around. You also have to be very careful in looking at the data. Does that mean just the speed with which you can scan the body? Does it mean these bodies have had angiography? Does this mean that is after you have had the discussion with the radiologist and pathologist to decide on the cause of death?

Q15 **Maria Eagle:** I am a Liverpool MP. Twenty-three years ago when I was elected, the first of my constituents who came to see me to ask for help were the bereaved families of some of the Hillsborough victims. I have been trying to help them ever since. These questions are for Mr Rebello.

Obviously, they had a particularly dire experience, as you will know, of the coronial system originally. It was better the second time around but still extremely arduous, long and difficult. What does the coroner have to

do when he has bereaved people in his court who do not have legal representation—it is meant to be an inquisitorial arrangement that does not need representation—but many other interested parties in that courtroom do? What does the coroner have to do to try to make that seem fair to the people without legal representation?

André Rebello: The vast majority of inquests are not controversial, in that invariably there is only one version as to the cause of death and only one version of the facts as to how that person came by the cause of death.

In cases where there is a death in a hospital setting, the hospital often does not have representation, but if it is a complex case where clinical negligence is alleged lawyers are often brought in. Those lawyers bring some resources to the coroner service, in that they will bring in paginated bundles, summaries and explanations to enable us to share proper disclosure effectively.

It is an enabling jurisdiction and it is the main skillset of a coroner to level the playing field, such that in the coroner's court the coroner asks all the questions first. I often feel quite embarrassed in that once I have finished asking questions there should not really be room for anyone else to ask any relevant questions—I should have asked them all. The problem when there is multiple representation is that quite often the inquisitorial nature of the inquest proceedings is hijacked, because all lawyers are trained in the adversarial courts and they bring those dark arts to bear within the coronial jurisdiction, often trying to widen the scope of the investigation and trawl for additional information that is not necessarily part of the means of arriving at the cause of death.

I understand that because quite often there will be clinical negligence proceedings and litigation follows, but the vast majority of people do not need representation. If we are dealing with article 2 and deaths where the state is involved, such as deaths in prison or police custody, I can fully understand why people feel they need to be represented, but even in those proceedings the coroner takes the lead and has to determine who the person is who has died and when and where that person died, by what means and in what circumstances.

One of the issues is sorting out the scope early on. When there is representation a wise coroner will encourage all advocates to contribute to the scope, which governs what is investigated and what can go into the inquest evidence. During the inquest evidence some issues fall away and new ones arise, and that falls to the coroner and jury.

I mention the jury, but because of Covid many coroners have up to 20 or 30 outstanding jury inquests with very little hope of hearing them in a short time. I would ask Government to consider—maybe the Committee has some influence here—whether we could suspend sitting with a jury in the short term, perhaps for a couple of years, and promptly investigate those deaths so lessons can be learned and deaths registered quickly. If

we have to sit with juries, many of these cases may go on for another four or five years while we catch up, because death does not stop.

Q16 **Maria Eagle:** That is an interesting point. I am sure the Committee will have noted your view on that.

André Rebello: It is just a solution to a major problem.

Q17 **Maria Eagle:** It is a solution, absolutely; that would be one way of dealing with it. One thing for certain is that anybody who has dealt with bereaved relatives knows that ongoing delay causes enormous pain—there is no doubt about that—for those left behind in the aftermath of a family member's death.

André Rebello: I hold my hands up. We have 23 outstanding jury cases. Apart from one that I have listed in November, where the number of witnesses is very few, I am not sure when we are ever going to hear them.

Q18 **Maria Eagle:** That is an interesting point.

Do you think it is fair that some people should be legally represented despite the efforts of the coroner to make the system work? Is it fair that in a particular proceeding some people should be legally represented while others are not?

André Rebello: That is interesting. If an NHS trust is to have a mouthpiece, invariably it needs a lawyer because the trust is a building and establishment that cannot speak for itself. I expect lawyers acting for a trust or any public body to approach the court in the capacity of an amicus whereby they are there to help everybody. Quite often, I have had lawyers instructed by an NHS trust supporting the family and going through documentation with the family.

One way around this would be to fund coroners to have solicitors and counsel to an inquest so all the family issues can be put properly, in the same way as judge-led inquests, and then perhaps no one needs to be represented because all the issues can be canvassed by turning the inquest into a restricted type of public inquiry.

Q19 **Maria Eagle:** To shift to what I always think of as rule 43 but is now regulation 28 and something else I have had to deal with as an MP, what is needed to make coroners' prevention of future deaths reports more effective in preventing avoidable deaths? After all, that is the purpose of them. It seems to me that those in authority do not always listen, even when they receive these reports, and do not always act on them. What can be done to make them more effective?

André Rebello: There are no teeth. It is a report, not a recommendation. Recommendations are outlawed by the law. However, one advantage of a local coroner service is that the establishment or individual who receives the report, if it is repeated, will have to come before the same court again. The public embarrassment of not having

addressed the issue in the first place is one way in which things can change.

The difficulty we have is that the Ministry of Justice was well funded with regard to writing these themed reports, but the Chief Coroner has not been given that wherewithal, and since we have had the Chief Coroner those annual reports have not been published. That is very sad.

Q20 **Miss Dines:** I declare my interest as a practising barrister. I have previously represented families at inquests, including in relation to the very sad death of a young man in custody. What can we do to improve the process to make sure these events are fairer, and what can we do in relation to the participation of lawyers?

André Rebello: In what way? Clearly, you have managed to represent people. What was stopping you representing people? Are you talking about funding?

Q21 **Miss Dines:** Funding is difficult, but what about more participation and encouragement for those who will not be able to get funding? How could they participate more proactively if there are not the funds for everybody to be legally represented? What can your service do to assist family members feeling part of the process rather than victims and purely grieving?

André Rebello: I have got that now. Clearly, in the vast majority of inquests no one needs representation. A coroner's officer works as a family liaison officer as well as a coroner's officer. The family is contacted by the coroner's officer who, certainly in my area, gathers all the issues and concerns of the family, and, where we can, we include those issues within the investigation. Obviously, they have to be relevant to the means by which and in what circumstances death occurred, who the person was and when and where death occurred, but the coroner's officer is often the mainstay support.

We also have an excellent charity, the Coroners' Courts Support Service, which works in half of coroners' courts. It greets and meets families, puts them at their ease and enables them to take part in the inquisitorial proceedings in coroners' courts. The Coroners' Courts Support Service has real problems, in that when it competes for public funding it is up against Victim Support and other people, and because it supports everyone who attends inquests, rather than just victims of crime, it tends not to get the funding. Therefore, we do not have the Coroners' Courts Support Service in every coroner's court, but, if anything comes out of this hearing, I would urge that every coroner's court be required to have the Coroners' Courts Support Service to greet and meet families and make sure they are not by themselves and induct them into the processes expected in that court. They work regionally and understand how the coroner system works locally and they are an excellent charity that should be encouraged to roll out everywhere.

With regard to court proceedings, the coroner has to level the playing field; the coroner has to do more listening than speaking. Once you have understood what people are saying, you help them to ask relevant questions to clarify things. I can tell you that when families are not represented and we have doctors in the witness box but the families want to go beyond the scope of the inquest, so long as the witnesses are happy to do so, as they always are, I am more than happy for the witnesses to help the families. Quite often, we have meetings afterwards where people are supported with regard to other matters that they would normally deal with through PALS—the Patient Advice and Liaison Service—outside. We try to work hand in glove with the support services within the NHS to support families.

Deaths in prison are somewhat more difficult. I can see the need for some legal representation in some of those cases.

Q22 **Miss Dines:** As with any judicial process, mistakes are sometimes made. What can be done to speed up the process of remedying errors?

André Rebello: That is a problem, because section 40 of the Coroners and Justice Act was not enacted. Section 40 covers every judicial decision that a coroner can make. If there is an appeal on everything the coroner says, we will have a very busy Chief Coroner and Deputy Chief Coroner because they have to rehear and re-adjudicate each and every decision. All we can do as coroners is try to get it right first time. The number of judicial reviews and section 13 Coroners Act 1988 challenges are perhaps lower than for any other legal jurisdiction; there are fewer challenges to coroners. That is because there is no real appeal from a coroner's decision. There has to be a judicial review or a section 13 challenge on insufficient inquiry or other defect in the process.

As for how we can speed that up, clearly, it goes beyond the coroner and falls on the administrative courts.

Q23 **Miss Dines:** Would you have liked section 40 of the Coroners and Justice Act to be implemented?

André Rebello: I am a coroner. Whatever law Parliament passes I will work with. If Parliament passes a local coroner service I will work in that; if Parliament wants to fund and set up a national coroner service I will work in that. I can see a lot of advantages in having an appellate process, but I can see a very high cost, because how many circuit judges would be involved in reviewing coroners' decisions? Who is an interested person? Is there a preliminary inquiry? Is there an investigation? Should an inquest be opened? Is there a post-mortem? Should that post-mortem be less invasive? Which witnesses should be called? What is the scope of the investigation? At the moment, technically it is only after the coroner has got it wrong and the conclusion of the inquest that the process should be challenged, which makes the appeal system perhaps more manageable from an Executive point of view in that the Executive have to fund the service.

Q24 **Miss Dines:** What is needed to make coroners' prevention of future death reports more effective in preventing avoidable deaths?

André Rebello: Funding for the Chief Coroner and providing the Chief Coroner with more staff and a stable website to be able to publish these things so they are searchable and coroners collectively can see what other reports have been issued by other coroners so we can draw the attention of other authorities to the fact this has already been raised and why it has not been fixed. The Chief Coroner was never properly funded to do the service.

Q25 **Andy Slaughter:** We have talked about some of the possible big reforms such as more resources, a national service and right of appeal. Frankly, it looks like very few of those things will happen in the near future. I go back to a comment made by Dr Osborn. He talked about a variable service where you could try to get in touch with a particular coroner service and literally get no response. I suspect that all MPs here have had that experience because we deal with lots of different coroner services. What is the short-term remedy if you are getting no response to emails or letters to coroners, coroners' officers and so forth? It happens increasingly in other parts of the judicial system now, but it is a particular feature of the coroner service. How do we deal with that?

André Rebello: Gosh! I get an awful lot of inquiries when people cannot get hold of a coroner. I manage to get hold of the coroner and the coroner responds to the person. The Coroners' Society website is one way you could try if you do not get any response from the coroner. As with Dr Osborn, I have some numbers that I can try, but I am the coroner for Liverpool and Wirral and this is my prime role. I cannot fix that problem in the coroner service nationally.

There was some suggestion that we have a full-time Chief Coroner. May I sound a slight note of caution in regard to a coroner at the end of his or her judicial career having some kind of sinecure and signing off from the judiciary? I would like a full-time equivalent Chief Coroner, with a Chief Coroner in charge and Deputy Chief Coroners working to make up the rest of the time so we have a full-time Chief Coroner. It would be better to have a judicial leader, as we have in His Honour Judge Mark Lucraft, who is going on to bigger and better things. He is now the Recorder of London. Clearly, having somebody working full time as Chief Coroner could be a problem. What would it do for that Chief Coroner's chances of promotion with regard to the senior judiciary?

Q26 **Chair:** You make that observation.

Dr Osborn: I raise one thing that we have alluded to but not touched on and is a real elephant in the room. It would be remiss of me not to mention it.

You will run out of pathologists to do post-mortems for you. I completely understand why many people on the panel are lawyers and so forth. The dual aspects of the coronial system are vitally important, and there is a

need for families to interact with it. However, there will be huge delays and problems because pathologists are not taking on post-mortems—it is not part of NHS work. There are already 580 consultant pathology vacancies in this country. There are not enough pathologists to do the diagnostic work in this country, and it has come down to the basic choice of trusts supporting cancer diagnosis, inflammatory bowel disease or post-mortems, which is not part of their role.

If that is not addressed, we will be having this conversation in five years' time and you will not have any pathologists. CT scanning is good, but it does not answer that problem.

Chair: That is a very helpful point on which to conclude. Gentlemen, I am very grateful to you for your very detailed evidence and your time. We are much obliged to you. Thank you for your help today.

Examination of witnesses

Witnesses: Deborah Coles and Andrew McCulloch.

Q27 **Chair:** We turn to the second panel. Deborah and Andrew, will you briefly introduce yourselves to us?

Deborah Coles: I am executive director of INQUEST.

Andrew McCulloch: I am a bereaved parent.

Q28 **Chair:** Thank you very much for helping us with our inquiry.

We have heard in some detail about the changes to the coroner service that have happened since the 2009 Act. From your perspectives, have those been changes for the better? Are there any areas where it has been a worse service? What do you say about the changes since 2009?

Deborah Coles: I will start off and hand over to Andy. INQUEST worked in depth on the Coroners and Justice Act, but I have to say it has not been a panacea. I would agree with the previous witnesses, particularly about the fact that because it is not a national service there are inconsistencies in resources, standards and practices across the system. It is fragmented and is not well resourced.

We accept there are some positives, particularly around coroners' regulations and rules, Chief Coroner guidance, more diverse recruitment of coroners and more full-time and legally qualified coroners. I do not need to remind you that the post of Chief Coroner had to be fought for, and we and the Royal British Legion worked on that.

What I will say has been informed by both inquest work with bereaved people and the evidence in our submission that we took from 55 families. Some talked of excellent coroners and coroners' officers and had very positive experiences of the process, but I am disappointed that far too many talked about being treated very badly by the process, with a lack of dignity, respect and empathy, and particular things I would have hoped

would be addressed by the Act around poor communication and no timely or understandable information about the process, particularly about the rights of bereaved people.

It is interesting to consider the earlier discussion about post-mortems because that is when families have first contact with the coronial process. Post-mortems raise cultural considerations, but that is the critical point at which information could and should be given to families about what an inquest is and about the process, yet families still describe an information vacuum that is often filled by ourselves and other organisations, like AvMA and RoadPeace. I fully recognise the importance of the Coroners' Court Support Service, but we know that is a patchy service. A lot of families simply do not receive information about what an inquest is.

State-related deaths—the area in which INQUEST works—tend to be ones that engage article 2 where there are concerns about somebody who has been in the care or custody of the state, or where there are questions about the responsibility of public or private bodies. That is our main area, but we are contacted routinely by families who are going through an inquest system. They go on to the internet and type in "INQUEST" and we pop up. As an illustration, we sent out 700 of our comprehensive information handbooks and had over 4,000 hits on our advice website. To me, that is indicative of a problem with communicating the purpose of an inquest and what families' rights are. The more complex the inquest the more families need to understand those processes.

Q29 **Chair:** Andy, do you have any observations on your experience?

Andrew McCulloch: I do not have any knowledge of the 2009 Act. My story begins in 2016 when our younger daughter, who was suffering from autism and was resident at a clinic/care home, died an avoidable death on the A1 at 3 o'clock in the morning when she should have been in the clinic.

I have to go back into some history about my daughter. She was 35 years old at that point. She had had mental health issues since she was 12. She had suffered from anorexia, obsessive-compulsive disorder and anxiety, but she was highly intelligent. She took her A-levels; she passed two As and a B and eventually went on to take a degree at the University of Sussex.

She could not manage her life. She was admitted to a clinic in Bedfordshire close to the A1 that specialised in dealing with autism. She had high-functioning autistic spectrum disorder. She died after about six months in that unit. We had complained about her lack of treatment and care, and we had warned them to take action to prevent her from being at risk.

On the day she died, they had allowed her to leave the clinic for 20 hours without permission, without doing anything, and at 3 o'clock in the

morning—during those 20 hours—she walked on to the A1 motorway and was run over by a lorry.

We had assumed there would be an inquest. Obviously, there had been failings in our mind, and in a lot of people's minds, about her treatment by various bodies, including the approved mental health professionals service in Bedford; the Sussex partnership trust, which had placed her there—she was a resident in Sussex where she had taken a degree at university; and, indeed, the clinic that was responsible for her care. To our minds, they all seemed to have some responsibility and questions to answer.

We received a note that there was going to be an inquest within about four months of her death. We prepared to go to that inquest. We were then told that, because the police had not been able to get their collision report together, it was going to be changed to a pre-inquest review; we did not know how lucky we were.

We went along to that pre-inquest review expecting to be taken through the processes of the court. We were told, in family-friendly terms—as the leaflet had told us from the coronial service—that it would be done and we would receive help from the coroner, who would lead us through the process.

We arrived. Luckily, a family friend came with us. Three of us were there—in our seventies—sitting on one side of the court, and on another side of the court were two people from the clinic and a lawyer representing the lorry driver. Her death was in no way the lorry driver's fault. There was no way he could have seen her on that stretch of road.

We were sitting there waiting. The coroner was late. Eventually, the coroner bustled in and, in an extraordinary way, started in a very loud voice saying, "I won't have any shouting in my court. If I do, if anybody raises their voice, they will be excluded from the court." He then looked at my wife and me, and said, "Only one of you can speak and you have only three minutes to speak. I have to tell you that this is, as far as I am concerned, a simple road traffic accident. I envisage an inquest whereby the police will be represented and the lorry driver will be represented; and that is it. I expect the process will take an hour to an hour and a half. Now, Mr McCulloch, I want to tell you that I am not concerned with why your daughter died; I am only concerned with the how. Would you like to speak?"

I got up and said, "Well, if you are only concerned with the how, perhaps you might consider how a mental health patient came to be on the A1 at 3 o'clock in the morning when she should have been in the mental health clinic." I have to say we did not even consider having legal representation. I believed from what I read that this was an inquisitorial process and I would not require legal representation. He said, "That is not a how, Mr McCulloch; that is a why; and I do not intend to answer it. You can take that question to the Care Quality Commission if you want an

answer, and now I propose to end the hearing and will see you all in about six weeks' time for the inquest."

It was like being slammed in the stomach. I can't tell you the pain, the agony. I'm sorry.

Chair: I understand. It is a distressing thing to recount, of course.

Andrew McCulloch: Luckily, the guy who was with us—the family friend—was a lawyer and had experience in these matters. He said he was appalled at the antics of this man. He said he had never seen anything like it. He said, "Right, you have to have legal representation." Far from this being just a simple inquisitorial process, it was very clear to us immediately that this was adversarial. Luckily, he had worked in this area and he put us on to some very good lawyers at Leigh Day. Merry Varney, the human rights lawyer there, took on our case and put us in touch with INQUEST, whom we worked with as well and who were extremely helpful.

Merry Varney looked at the case and said this is a human rights case; it is an article 2 inquest; it is not just an ordinary inquest. She contacted the coroner and came back to us afterwards and said, "There is no way you are going to get a fair inquest with this coroner following this line. We have to have an article 2 inquest."

So we went to a second pre-inquest review eight weeks after the first one. We had legal representation there from Doughty Street Chambers. I do not have the money for all this. They were very good. They agreed to work for a very small amount of money paid up front. The purpose of the second PIR was to demand an article 2 inquest, and if he could not grant that—which all the other interested parties agreed it should be—then he must recuse himself.

It was a very, very bad-tempered session. It was a very bad-tempered hearing. He actually openly accused our QC, in open court, of trying to blackmail him, which is an extraordinary thing to say. She was extremely good and very cool. Caoilfhionn Gallagher was her name. She said, "I think, sir, you might like to consider that remark and withdraw it." After a pause, he did. He then withdrew and said he would consider his position. He came back and said, "I will not grant an article 2 inquest and I will not recuse myself. We will proceed like this. What is more, I want all the interested parties to make out their submissions, but I don't want them to send them to me, because I am not a postbox. Send them to each other." The clerk of the court politely pointed out that that was not legal. They had to go through him.

We then proceeded to have two years of wrangling with this man. He would not grant us an article 2 inquest. He would not increase the scope of the inquest. He stood in the way; he delayed; he did not answer emails. We were unable to contact him. This went on for two years.

Eventually, we had to take him to judicial review. As you obviously realise—I do not know how much everybody else realises—judicial review is actually a very scary process.

Chair: Yes.

Andrew McCulloch: You do not get legal aid for that. If it was an article 2 inquest, we were likely to get some legal aid. We got no legal aid for that. So, if we took him to judicial review, we risked at least £25,000 to £30,000 in the process. What is more, the coroner concerned said that, if we lost, he would charge us for his costs, which are already paid for by the state. So, if there was any question of blackmail, the financial blackmail was coming from his side.

We went ahead. We sent the letter before action. There was more wrangling. Eventually, he recused himself on the grounds that he did not want it to be seen that he might be biased against us. That is an example of one coroner.

The next coroner was a man called Coroner Oldham. I can name him because he was a good guy. He came in and the first thing he said was, "I want to make the victim the centre of this inquest. I want to know who Colette was. I want to read about her. I want to understand her," and he agreed to the article 2 inquest. He agreed to call all the witnesses we had asked for and he asked for two expert witnesses: one psychologist and one psychiatrist, who were experts in dealing with autism. Our daughter had only been diagnosed with autism at the age of 33.

He came in, and, far from it being an-hour-and-a-half inquest, it was seven days. He found multiple failings on the part of the clinic, on the part of the Bedford AMHP service, and on the part of the Sussex partnership trust.

So, broadly, that is as quickly as possible my story.

Q30 **Chair:** That is very helpful. I know it must be a painful thing to recount as well. Of course, we all feel very sad and offer you condolences on the loss of your daughter.

Andrew McCulloch: It is surprising that it comes back.

Q31 **Chair:** I perfectly understand that. I am very grateful to you for sharing that; it is very powerful. Out of interest, is that first coroner still in office?

Andrew McCulloch: As far as I know, he is. As far as I know, he has not carried out many inquests recently. I do not think he has been suspended, and I am amazed.

Chair: Thank you very much. I need to move on, I am afraid, so I am going to go to Andy Slaughter for the next question. It may be then that you are able to come back and make a further point.

Q32 **Andy Slaughter:** Thank you, Chair, and thank you, Mr McCulloch. An

inquest such as the one that was eventually held in your daughter's case can reveal some very significant systemic and institutional failings, which is the role of the future death report in many cases. I think we are all familiar with the future death report. This is perhaps a question mainly for Deborah Coles. How effectively are they being used at the moment, and how could they be made more effective so that we can actually learn these lessons for the future?

Deborah Coles: Thanks, Andy. Just before Andy finished, I was going to remind the Committee what families tell us time and time again. I have been doing this job for 30 years and I have not yet met a family who has not described their motivation for going through a process that, let us remember, they have not chosen; it is the process that the state has given them as their way of finding out what happened to their loved one; and that is compounded when we are talking about state responsibility.

I take issue with Mr Rebello's description of lawyers trying to hijack inquests and widen the scope, because I think Andy has demonstrated an absolutely clear explanation of what he and his family wanted to know. They go through that process in the hope that they get the truth, they get answers, and they get an acknowledgment of any mistakes and failings in the hope that future deaths are prevented.

One of the really important things about inquests is their potential preventive value, which is not only in the interests of bereaved families but in the public interest. An inquest can try to ensure public scrutiny and hold people to account, but also identify false, dangerous and harmful practices, which, if put right, could prevent people from dying or being injured in the future.

INQUEST fought to have prevention of future death reports along with narrative conclusions from juries. The Hillsborough inquest is a very good example of narrative conclusions that document all the failings and concerns raised in the Hillsborough cases. At the moment, all the system does is to oblige coroners to make these reports. They are made to various public authorities. They may or may not get responded to. To be quite honest, too many of them just simply disappear into the ether because there is no existing framework to ensure that these are monitored and followed up to see whether or not action has been taken in response to them. There is no mandatory duty to implement these reports, which is why we have been arguing for many years—particularly recently in the Angiolini review, which was set up to look in detail at coroners' inquests—that there needs to be a national oversight mechanism so that there is a clear framework for following up what happens to these reports. Families repeatedly tell us that they go through these processes in the hope of meaningful change and, yet, they subsequently find out about deaths in similar circumstances, which, you can imagine, really does add to the trauma and can be very re-traumatising.

In the submission that we have laid out to the Committee, we have gone into some detail about what we think that framework could be. What is particularly important about it is that there has to be proper scrutiny; it needs to be accountable to Parliament. André Rebello mentioned the fact that not only have we not had the post-implementation review of the Coroners and Justice Act, but we have not seen a coroner's annual report for getting on for two years.

I think the preventive potential of inquests is one of its most important functions, but at the moment it is failing. It is not only failing bereaved families but it is failing the important public interest.

Chair: Thank you.

Andrew McCulloch: Could I briefly add to that on the question of legal representation? The idea that we do not have to be legally represented in cases like this is, I am afraid, complete nonsense. Had we not obtained legal representation between the first and second PIR, my wife and I would have gone into court with no knowledge of the law or any idea about it, and we would have been facing lawyers for the approved mental health professionals service in Bedford, lawyers for Sussex partnership trust, lawyers for the clinic, lawyers for the chief psychiatrist at the clinic, lawyers for the police, and lawyers for the lorry driver.

We would have been facing all those people, utterly unqualified, without a clue what the law was about it, with no help whatsoever. So, first of all, it is nonsense. You have to have legal aid available in cases like this.

Secondly, again adding to what Deborah said, the motivation is to try to prevent this from happening again to other people. The only thing that makes sense of the loss of your loved one is that maybe lessons will be learned and the same thing will not happen to someone else. I have to say, to some extent, that did take place. The Bedford AMHP service asked to work with my wife and me on dealing with autistic people and how they should be approached. That was a lesson learned, but—and, again, I agree with Deborah completely—there is no or not sufficient enforcement; well, there isn't enforcement at all.

Q33 **Andy Slaughter:** I have one short follow-up to that, which again is probably for Deborah Coles. Given what Mr McCulloch has just said, there is a huge amount of power and responsibility resting with the coroner, particularly where there is an inequality of arms. When coroners do get it wrong, what is the remedy? What changes need to be made to the system to ensure that justice can be achieved? Is it by way of appeal? Is it some other direct management responsibility? Is it the role of the Chief Coroner? It is certainly not working at the moment.

Deborah Coles: As has already been said, there is no appeals process. That was initially in the Act. The reality is that it is very difficult to challenge a coroner. Of course there is a high threshold in terms of judicial review, and we have already heard from Andy about how costly it

is and that funding is very difficult. There is no complaints process. The Chief Coroner cannot deal with individual cases. This becomes really difficult for those many families from whom we hear who want to complain about the way in which they have been treated. They want to complain about the fact that they feel that they have not been listened to. So much of this could be addressed at the start of the process by having a clear understanding of what the process is and clear expectations.

As Andy has said, I am sorry to come back to the issue of funding for families' representation. Any review of the coronial system that fails to address that fundamental issue, which is about justice and equality, which fails bereaved families at the moment, in doing so undermines the potential to prevent future deaths.

We only need to look at the independent reviews that have been carried out looking at the coronial system that have recommended that inequality of arms and the state of inquests need to be addressed. We most recently had the Angiolini review and the bishop's review. Contrary to Mr Rebello and his views that legal representation is not necessary, two Chief Coroners have supported the fact that, where there is a public body represented, families should have public funding.

I really question how a coroner can be both judge and represent the families' interests when you have teams of lawyers who turn up at inquests. The reality is that any of you who have been to an inquest with multiple legal teams will see that there is a culture of defensiveness at these inquests. Very often, those lawyers are working as a team to try to reduce the scope of the inquest, to try to limit the number of witnesses or argue against questions being left to a jury, if indeed there is one, or argue against a coroner making a prevention of future death report. That is the reality that families see on a regular basis.

I absolutely want to say here and now that I do not support any suggestion to remove juries. I accept that Covid has exacerbated a lot of delays that were already in the system, and they are in the system because it is an ill-resourced system. Often, one of the reasons why coroners cannot go ahead with inquests is that they cannot find suitable venues, and the facilities that a lot of families have to endure are utterly dreadful. The family evidence will speak to that.

Juries actually play an extremely important role at inquests, particularly where you are looking at the conduct of the state and article 2. One of the reasons you have an article 2 inquest is to ensure that we have an accountable state. I agreed with a lot of what was said by our earlier witnesses, but where it comes to issues around equality of arms and treatment of bereaved people, there are still very, very serious issues with the current system.

Chair: I have got your point there. Is there anything you would like to pick up, Sarah?

Miss Dines: I have a question for Mr McCulloch. Can I first say how sorry I am to hear about his daughter? Time does not heal that sort of loss. I am also very sad to see that things have not changed very much since I did my first case 20 years ago. The alienation and the lack of inclusion is ringing through your evidence, so thank you for coming along and sharing that with us. What effect do you think the presence of instructed lawyers had on that process and your experience so that we can learn moving forward, bearing in mind it is still an inquisitorial process?

Andrew McCulloch: Do you mean what difference did our legal representation make?

Miss Dines: Yes, in your experience of the process.

Andrew McCulloch: In our experience of the process, it made all the difference in the world. First, we had an extremely empathetic human rights solicitor, Merry Varney, who understood the situation completely. Secondly, she took on a very good barrister, Caoilfhionn Gallagher of Doughty Street Chambers, who was equally empathetic.

They had an understanding of the law, which we obviously did not understand. I seriously thought that this coroner would be there to help us through and that we would have an inquisitorial process, where we would all sit around to discuss what had gone wrong. That could not have been further from the truth. The fact is that it is a highly adversarial system. The legal representatives that all the interested parties had were aggressively defending their corner. They were not concerned with the truth of the situation coming out. They were not concerned with learning what might or might not have happened and what could be done to stop it happening. They were concerned with defending their clients' interests—financial interests.

Without Leigh Day, Doughty Street Chambers and INQUEST helping us, we would not have had a chance. It is not a question of just getting back at these people who, to our mind, have let us down—it is about trying to stop this happening again. The legal representation that we had was amazing, but I did not have a clue how we were going to pay for it. Eventually we had to crowdfund. Luckily, our lawyers were extremely easy-going about when they received any money, or if they received any money.

Q34 **Miss Dines:** I have a question for Deborah Coles. Bearing in mind your extensive experience with families and the system, do you think professionally that the inquisitorial approach is always appropriate? If you had free rein, what would you suggest?

Deborah Coles: It is an interesting question. What often makes the system adversarial is the fact that families will turn up at a pre-inquest review to find teams of lawyers, with access to all the resources and all the papers. They will immediately think, "What is going on here? Why have they got everything? Why are they all here as lawyers? Why didn't I know that I could access a lawyer?" If you can access a lawyer, you have

to go through protracted, distressing processes to try to get any funding. There is some funding available—that is one of the things that I should acknowledge—but it is a difficult process to go through.

I think that you can have a very effective inquisitorial process and conduct very robust and searching questions within an inquisitorial system. What frustrates me is that the accusations of being adversarial are very often directed at families and family lawyers. They do not recognise that the system itself creates that inequality. We deal with the more complex cases where state lawyers routinely turn up at inquests. There is a culture of institutional defensiveness. There is much more concern for reputation management, rather than a meaningful search for the truth.

The Ministry of Justice will tell you that it has been doing work—work in which I and some of our families have been involved—that it calls making inquests more sympathetic to bereaved people. I have to say that, in engaging with that work, I am also quite cynical, because it is absolutely ignoring the inherent inequality that exists in the system. It involves families being told, "You don't need lawyers," and state lawyers being told, "Just be a bit nicer to families, and then everything will be all right," rather than recognising the very important role that lawyers can play in supporting a bereaved person, who, at the end of the day, is going through this process, has lost a loved one in traumatic circumstances and is trying to manage their day-to-day life, let alone a complex inquest process where there are lawyers representing lots of different bodies. The lawyer representing a family and asking those questions that that family really need answered not only speaks to the family and recognises how traumatic these processes can be for families but protects the public interest. One of the good things about the inquest system is that, where you have a contentious death, it needs to hold people to account and to ensure that there is proper scrutiny we can all learn from.

Chair: That is helpful. Are there any other points for you to follow up, Sarah?

Q35 **Miss Dines:** Something that might help families would be if Miss Coles could tell us what families can do to get funding when they are not eligible for legal aid. Can she assist us with that?

Deborah Coles: They can go through what I have already described as very protracted funding processes. Those who fed back to the Ministry of Justice review of legal aid for inquests spoke extremely eloquently about the distress of having to talk about whether you own any expensive jewellery and going through pages and pages. My answer really is, why on earth should families be put through that? Why can we not recognise that non-means tested public funding should be available, particularly in the most complex cases?

If they cannot get funding, they can crowdfund or seek pro bono representation. Many of our lawyers do pro bono representation.

However, it goes back to the question of a level playing field and equality of arms. Why is it that there seem to be unlimited public resources available to the state or private funds, where corporate people are involved, but it is not seen as being right for families?

I think that this is an ongoing travesty of justice and an absolute national scandal. All those people who have looked at this issue agree. I have to say that I felt that the result of the Ministry of Justice review was an utter betrayal of bereaved families, who invested in that process. We honestly believed that there was going to be a positive change. That would make a real difference—along with timely, accessible information about rights in the process, so that from very early on in their interaction with the coronial system families know what to expect.

Andrew McCulloch: Can I add to what Deborah has said? We had to go down the road of crowdfunding, because taking on a judicial review was an incredibly difficult thing to do. Everyone talks about crowdfunding as if it were a simple panacea. It is incredibly difficult to set it up. It takes a lot of time. You have to make videos and to have events. When you are wrecked by the death of your daughter, are in a distressed state, are trying to hold your professional life together—to continue making some sort of living while you are doing that—and are trying to hold the family in one piece, to be expected to do that as well in order to get justice is a disgrace in a country like this. As they frequently say, this is the fifth or sixth richest country in the world. What on earth do we think we are doing in making people go through that?

The other thing about getting rid of the coroner and finding any sort of place to go to appeal is this. There is the JCIO—the Judicial Conduct Investigations Office. We went there. We were turned down immediately. They would not consider it. We went to the ombudsman to get rid of Coroner Pears. Would they look at it? No. They would not look at it at all. We wrote to the Chief Coroner, knowing that it was a waste of time really, because he cannot make those decisions. There was nowhere to go. The only possibility was a judicial review, and a judicial review would have been incredibly expensive, potentially. It is an utter disgrace that this country is like that.

Chair: I am sorry, but we have to move on. Time is pressing on us now, However, the point is well made. Thank you very much, Mr McCulloch, for making your point. It is extremely helpful to us. Sarah, do you have any more questions?

Q36 **Miss Dines:** I have one last question for Miss Coles, if we have time. In your experience, how well do you think that coroners do in trying to be fair to everyone in bereaved families, when some people are represented and some are not?

Deborah Coles: I think that it is a very difficult job for coroners. In fact, that is why so many coroners now really support families' applications to be legally represented. It is difficult enough to manage a complex

inquest, let alone to manage teams of lawyers. The importance of a family having their own lawyer cannot be underestimated in this kind of case. Many coroners recognise the valuable role that family lawyers play in identifying the key issues that need to be looked at in the course of the inquest.

There is another thing that the system absolutely lacks. I really feel that there needs to be an advisory forum for users of the inquest system and NGOs that support them, to try to ensure greater transparency and to get feedback from people who have been through the process so that we can develop best practice. That is lacking in the current system.

Chair: That is helpful.

Maria Eagle: I want briefly to bring up the issue of the Chief Coroner's development of specialist groups of coroners who are meant to deal with disasters and accidents that result in many deaths. Like instances where people die at the hands of state institutions, as it were, where the inquest has a particular role to play, disasters that lead to multiple deaths are another instance where things go very wrong. It is hard—let's not be unfair—but inquests into disasters have not particularly covered themselves in glory in the past. I speak as somebody who represents many of the Hillsborough families. Deborah Coles, do you think that that arrangement is a way forward that could improve the way in which inquests into disasters and major accidents with multiple deaths are handled?

Deborah Coles: The short answer is yes. We fully support a specialist cadre of coroners for article 2 cases, which would include exactly the type of case you are talking about. It would ensure that there was the necessary expertise to manage those highly complex cases. That may well be another judicial appointment—a judge or retired judge, as we saw in the Hillsborough cases.

I have just been on a working group with the organisation Justice looking at inquests and disasters. I support the idea that the previous Chief Coroner, Peter Thornton, put forward of a special procedure inquest. That would address some of the concerns that you are raising.

However, the other thing that I would say is that that does not deal with some of the issues that I have flagged up before about the culture of defensiveness. We fully support the Hillsborough families on a duty of candour and the Hillsborough law—the Public Authority (Accountability) Bill. That would also bring in reforms that, hopefully, would mean that you did not have a situation where you had such defensive responses by the state. It would also bring in the important funding that families need. What was very clear—you will be aware of this—was the contrast between the first and second Hillsborough inquests.

The other positive, not least about equality of resources, was the fact that they started with pen portraits, which are really important. Again, we

have made a recommendation about how vital those portraits are to humanise the process and to acknowledge the people who died, so that they are seen in life and not just in death. We are working with the Grenfell families. Obviously, that has gone to a public inquiry, which is not without its many challenges. One of the things those families complained about in the very early stages was the lack of information about the system. We ended up producing a leaflet for families to explain what the different processes were. That was from post-mortems—

Chair: Deborah, I am sorry, but I am going to have to interrupt you to speed things along, because we have a vote in 10 minutes and other Members need to ask questions.

Deborah Coles: I am sorry.

Q37 **Richard Burgon:** I thank Mr McCulloch, in particular, for the very useful evidence that he has given on the experience that, sadly, people all too often have.

There are three points that I want to pursue. INQUEST, which needs to be congratulated on its work, in my view, has often called for automatic non-means tested funding for specialist legal representation for families following a state-related death—

Chair: Richard, we are having a problem with your connection, I am afraid. We cannot hear you. Can you get a bit closer to the mic?

Richard Burgon: Can you hear me now?

Chair: We should be able to in a moment. Give it a go.

Richard Burgon: Is that okay?

Chair: Yes. Try now.

Richard Burgon: Great. I know that INQUEST has long called for automatic non-means tested public funding for specialist legal representation for families following a state-related death. Does Deborah want to expand on that call from INQUEST? It is very important that the Committee considers that in its evidence.

Deborah Coles: Yes. I made some of the comments before. It is particularly needed following state-related deaths or deaths that, by their very nature, are going to be particularly complex and where you have an unequal playing field.

What is so difficult about the system at the moment is that, for any families to get representation, they have to pursue applications that are complex, protracted, intrusive and really distressing. Some get funding, and some do not and have to contribute large funds.

Families have withdrawn completely from the process because of the distressing nature of that. I simply do not understand how it is deemed

acceptable that we still have such inequality of arms and public funding has not been made available when, as I said, there has been a succession of inquiries and reviews supporting this by people who have looked at the system in depth—and, indeed, by coroners who work within the system. I very much hope that this Committee will add its voice and support.

Last week, I had a conversation with Bishop James, who did the Hillsborough review, and the Victims' Commissioner, Vera Baird, about some ideas that they have about whether we should try to look at funding outside the legal aid system and whether, wherever there is a death involving a state body, that body should be responsible for funding legal representation, which could raise some interesting questions.

I feel that there always needs to be a pot of money for the public interest cases, which do not necessarily fit so neatly around questions about article 2. Mr Rebello was very much talking about non-contentious inquests. We see a lot of inquests where it is really important that families have access to legal representation. How that is funded is perhaps another question. However, there is no doubting the fact that this is a continuing national scandal and a travesty of justice when you consider what we are talking about here, which is bereaved people going through a system that they have been given as their means of finding out how and why their loved one died, in the hope that we as a society learn about and address any failings. At the moment, the system is undermined by the fact that the preventive potential is not always realised.

Chair: Richard, you have gone again, I am afraid. The sound has gone. We cannot hear you at all. We are having no luck there. We are running into some time difficulties as well, because this has gone on rather longer than expected. Paula, do you have a question you want to come in with?

Q38 **Paula Barker:** Yes, please.

Mr McCulloch, thank you for sharing Colette's story and your story with us. I am very sorry for your loss. We have heard about the impact that it has had on you, your wife and your family, in terms of raising funding for the judicial review and how you were treated in the first instance by the first coroner. Are there any other effects that the existing process for challenging coroners' errors has on bereaved people that you can share with us?

Andrew McCulloch: Yes. I have come into contact with a number of other bereaved families since then. What we all share is the utter frustration of not having our questions answered, not being treated with any respect and there being a complete lack of empathy on the part of the process.

One particular couple, whose son had died, said to me that it had been so bad that the father had not been able to work again since that happened, because of his treatment, and that they had given up. They said, "Please

will you carry on, because we can't? It has devastated our lives. We just can't do anything." The husband had not been able to work since that took place.

There was another case—an appalling case—of a couple whose child had died in hospital. He was very young—only about eight weeks old, I think. Clearly, mistakes were made. The coroner concerned went behind their backs and went to the hospital. The hospital had admitted fault in doing this. Before the inquest took place, it had admitted that it was responsible. The coroner went to the hospital and got it to change its plea to say that it was not responsible. This was at the Chelsea and Westminster Hospital. I am not going to name the coroner, but she took that action.

These people are young—much younger than I am. Their lives have been devastated. Again, they could not work. The loss of people's income—the loss of people's whole futures—is quite common. As I said, we were in our seventies at the time this hit us. There is not much that you can do then. I am writing a book about it. That is my way of coming to terms with it. However, it is so destructive. All that most people want is to find out why so that it does not happen again. That runs through everybody I know of.

Chair: I get that.

Paula Barker: Thank you for your evidence. It is very moving.

Chair: Hopefully, we have got Richard back for the last couple of questions.

Q39 **Richard Burgon:** Yes—apologies for the technical difficulties. I have raised the issue of funding, but I know that INQUEST is concerned, as has been mentioned, about the lack of an effective mechanism to follow up on the coroners' prevention of future deaths reports. As we have heard, that could lead to a failure to learn those very important lessons. I would like to ask Deborah—and also Mr McCulloch, if he feels that he would like to add anything—what model of accountability and following up on the prevention of future deaths reports she thinks could be put in place, and would like to be put in place, to make a real difference?

Deborah Coles: I have already touched on the INQUEST proposal for a national oversight mechanism, which would have the duty to collate, analyse and monitor learning outcomes and their implementation, and to make sure that that framework not only made all this information public, but was accountable to Parliament, perhaps by enabling parliamentary oversight or debate. Reporting to parliamentary Select Committees might be a good way forward. It is important to say that it is just not good enough simply to put these reports on the judiciary website and hope that they will be put to good use. They are not even searchable.

The other thing is that jury findings, which are often a very good overview of any systemic failings, are not collated or published anywhere, apart from when we publish them.

The very least that families are owed is that, where a report is made, those to whom it is made should make sure that they report back to families on what they have done or not done. I find it simply astonishing that we have a system that thinks it is acceptable not to keep families in the loop.

I believe very strongly in this framework. It would not be just for state-related deaths. For any death that has any possibility of learning, you could use these coroners' reports in a really positive way. I am pleased to say that the Justice report that has just come out has supported that framework. In her review, Elish Angiolini supported a similar type of body. It is a way of trying to ensure that something positive can come out of the horrendous and often very traumatic experience that families go through.

Chair: That is very helpful.

Andrew McCulloch: I agree completely with what Deborah has said. The structures she is talking about are good. However, there are other structures that are in place that people could consider. We had three serious incident reviews into Colette's death. There should be a way of making connections between serious incident reviews and the coroner's narrative conclusions. There needs to be a way of enforcing the narrative conclusions.

Chair: That is a helpful point. Richard, do you have any other questions?

Richard Burgon: No. That is very useful.

Chair: Thank you very much for your evidence. It cannot be easy, Mr McCulloch, but I really appreciate it. Thank you, Deborah.

This very important evidence has taken quite a long time, and I am informed that the House is about to vote in the next few minutes. I apologise to the other members of our panel, but, given the timeframe of this Bill, I do not think that it is likely that we will be able to go and vote and then reconvene the Committee in time properly to ask the questions that we want to ask you. I hope that you will understand and accept our apologies for that.

We do not always have control of when the House votes. Every time there is a Division, it takes 15 minutes, as a minimum. We are not allowed to sit during that period, so we cannot carry on. If there are a number of Divisions, as there may be, we could be leaving you hanging around for another hour or more. I hope that it would not be that long, but, frankly, we cannot tell.

Lisa and Ms Haworth Hird, I apologise that we have not been able to get

to your evidence today. I promise that we will get it rescheduled and that you will have priority then. I hope that the fact that you have heard some of this evidence will enable you to reflect on that when you give your evidence to us in the not too distant future. In fairness to everybody, rather than try to rush you in a very piecemeal fashion, we would like to play it that way.

I hope that that is okay for everybody and that you will understand. On that basis—I am told that the Minister does not have too much longer to go—today's session is concluded, with our thanks to all our witnesses.